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Intimate Partner Violence And Depressive Symptoms: A Moderated Mediation Model Of Religious Coping And Spiritual Well-Being In African American Women

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INTIMATE PARTNER VIOLENCE AND DEPRESSIVE SYMPTOMS:

A MODERATED MEDIATION MODEL OF RELIGIOUS COPING AND SPIRITUAL

WELL-BEING IN AFRICAN AMERICAN WOMEN

by

DULAMDARY ENKHTOR

Under the Direction of Dr. Sarah L. Cook

ABSTRACT

Religious coping and spiritual well-being were found to be culturally important resilience factors for African American women suffering from abuse and depressive symptoms. This study aimed to investigate whether: (1) spiritual well-being and its two components of existential and religious well-being mediate the Intimate Partner Violence (IPV)-Depressive Symptoms (DS) link; (2) positive and negative religious coping moderate the IPV-DS association; and (3) the mediating effect of spiritual well-being in the IPV-DS link is moderated by level of religious coping (i.e., moderated mediation). The study utilized data from 208 low income, suicidal and abused African American women, ages 18-55. Only the existential component of spiritual well-being was found to fully mediate the IPV-DS link. This indirect effect weakened at higher levels of negative religious coping. As predicted, higher levels of negative religious coping were

associated with higher levels of depressive symptoms. Surprisingly, higher levels of negative religious coping were also associated with increases in existential well-being which, in turn, led to decrease in depressive symptoms. The findings underscore the importance of addressing existential well-being and religious coping in clinical interventions and in training for mental health professionals. Clinical and research implications of these findings are discussed and future directions recommended.

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DEDICATION

I dedicate this work to my mother, Gotov Enkhdolgor, M.D., Ph.D., and to my grandparents, Tsedendamba Gotov, Gunhev Basdary, Lodoin Tserendulam, M.D. and Badamtseren Ochir, M.D., the first university professors and doctors of independent Mongolia, for they loved me and guided me to the mountaintops.

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1. INTRODUCTION

Due to the confluent impact of race, gender and socio-economic inequalities, intimate partner violence (IPV) disproportionately affects African American women (West, 2004). According to a national study on violence against women, 29% of African American women reported at least one violent incident in their lifetime by an intimate partner, which is 35% higher than the rate reported by European American women (Tjaden & Thoennes, 2000). Despite accounting for eight percent of the US population, African American women constitute 22% of all intimate partner homicide cases and 29% of all female victims of intimate partner homicide (Federal Bureau of Investigation (FBI), 2005). Due to the overlap between race and economic class, accounting for socioeconomic status (SES) reduces or eliminates ethnic difference in prevalence rates of IPV (Crowell & Burgess, 1996; Lockhart, 1991; Rennison & Planty, 2003; Tjaden & Thoennes, 2000), but does not change the severe impact of IPV on African American women.

Experiences of IPV often lead to depressive symptoms, along with a host of other mental health problems such as suicidal ideation and attempts, anxiety, Post-Traumatic Stress Disorder (PTSD), feelings of hopelessness and helplessness, dissociation, social isolation, cognitive distortions, and substance abuse (Houry, Kaslow, & Thompson, 2005; Houry, Kemball, Rhodes, & Kaslow, 2006; Kaslow et al., 2000; Kaslow et al., 2002; Ramos, Carlson, & McNutt, 2004). Houry, Kemball, Rhodes, and Kaslow's (2006) study revealed that African American women who were abused by their partners experienced more depressive symptoms than those who did not suffer from IPV.

Spiritual well-being and religious coping are protective factors for survivors of IPV (Gillum et al., 2006). Spirituality and religious coping appear to be especially vital for African

Americans compared to European Americans (Ellison, 1998; Krause, 2004). African American women, in particular, have a strong tradition of relying on spiritual and religious beliefs for strength and support when coping with historical oppression at the intersection of race, gender and class (Neighbors et al., 1983, 1998; Mattis, 2001; McAdoo, 1995). These findings suggest that spirituality and religious coping are culturally relevant factors that are likely to have an impact on the mental health outcomes of African American women who experience IPV. However, empirical research exploring the impact of spiritual well-being and religious coping on abused women, particularly African American women, is scarce, and the findings are mixed. Research shedding light on the factors that may moderate or mediate the relationship between IPV and depressive symptoms among African American women who were abused is even more limited.

The purpose of this dissertation was to address this gap in the literature. First, I investigated the mechanism underlying the relationship between IPV, spiritual well-being and depressive symptoms in an African American sample by examining whether *spiritual well-being* mediated the association between *IPV* and *depressive symptoms (DS).* Second, I explored the impact of religious coping on the relationship between IPV and levels of depressive symptoms by testing whether *religious coping* moderated the association between *IPV* and *depressive symptoms*. Third, I examined the mediating role of *spiritual well-being* in the IPV-DS relationship at different levels of *religious coping,* i.e. moderated mediation model involving these variables. The study sample consisted of suicidal and abused low-income African American women who received health care at Grady Hospital in Atlanta, GA.

It is important to note that the women in this sample endorsed a suicide attempt within the 12 months prior to the participation in the study and, therefore, the generalizability of the

findings to the non-suicidal population may be limited. Depressive symptoms and suicide are strongly linked, as depressed patients have a 20% risk of suicide in their lifetime (Gotlib & Hammen, 2002), and 71% of suicide attempters have a diagnosis involving depressive symptoms (Balazs et al., 2006). Therefore, this sample is likely to have particularly high rates of depressive symptoms that may impact the generalizability of these findings to women with IPV who have lower rates of depressive symptoms.

On the other hand, since IPV survivors are at much higher risk for suicidal behavior than women who have not experienced IPV (Elliott, et al., 1996; Kaslow, et al., 2000), the results of this study are still relevant to the wider population of African American IPV survivors. Religiosity/spirituality is negatively related to the risk of suicidal behavior among African Americans (Kaslow et al., 2004; Stack and Wasserman, 1995). It is not clear whether this association means that the suicidal sample would be less likely to endorse high rates of spiritual well-being and use of religious coping than a non-suicidal sample. The opposite may be true, that suicidal women are more likely to engage in existential reflection and religious coping having pondered decisions about life and death. Hence, it is difficult to assess the generalizability of the findings of a suicidal **sample** to the non-suicidal population.

1.1 IPV and Depressive Symptoms

For the purposes of this dissertation, IPV is defined as actual or threatened physical, emotional and sexual harm, including coercive/controlling behaviors experienced by women from their current or former partner, such as a husband, boyfriend or dating partner (Saltzman et al., 2002). Physical abuse is defined as use of physical force with the intention of causing pain, injury, harm or death, and includes acts such as punching, beating, slapping, kicking etc. (Saltzman et al., 2002). Psychological or emotional violence is defined as behavior designed to

belittle, humiliate and emotionally hurt the victim (Saltzman et al., 2002). Psychological or emotional violence includes threats, verbal assaults and insults, and screaming and yelling at the victim. Coercive and controlling behaviors such as limiting access to financial resources, and preventing socializing with family and friends are sometimes conceptualized as a distinct type of IPV, and sometimes considered to be part of psychological/emotional violence (Saltzman et al., 2002). IPV also includes sexual violence, which can be both physical, such as rape, and non-physical, such as verbal or psychological coercion to demand sex (Saltzman et al., 2002).

Symptoms of *depression* may include feelings of sadness, diminished interest or pleasure in the activities of daily life, weight loss or gain, disruption in sleep, psychomotor agitation or retardation, fatigue, sense of worthlessness, excessive guilt, impaired ability to concentrate, pessimistic outlook, indecisiveness, and suicidal ideation, causing clinically significant distress and impairment in daily functioning (DSM-IV TR, 2000).

IPV and depressive symptoms in women are consistently correlated (Rhodes, Lauderdale, He, & Howes, 2002). Women who were abused experience more depressive symptoms than non-abused women (Nixon et al., 2004, Rhodes et al., 2002; Sorenson, 1996). African American women, in particular, experience higher exposure to IPV and related depressive symptoms than European American women, due to the confluent and cumulative impact of multiple ecological stressors such as low SES and ongoing history of racial discrimination (Houry, Kemball, Rhodes, & Kaslow, 2006; Houry, Kaslow, & Thompson, 2005; Coker et al., 2002, Rhodes, Lauderdale, He, and Howes, 2002, Ramos, Carlson, & McNutt, 2004). A study focusing on African American women with similar characteristics and recruited at the same hospital as the current sample, revealed that women who reported one, two or three types of IPV were, correspondingly, two, three, and six times more likely to experience depressive symptoms than

their non-abused counterparts (Houry, Kemball, Rhodes, & Kaslow, 2006). Furthermore, African American women who have experienced IPV reported more severe and longer lasting depressive symptoms than European American survivors of IPV (Caetano & Cunradi, 2003; Ramos, Carlson, & McNutt, 2004). African American women who were abused were reported to have low self-esteem and learned helplessness, and feel hopeless and apathetic (Thompson, Kaslow, & Kingree, 2002; Walker, 2000; Campbell et al., 1996; Clements & Sawhney, 2000), which are all characteristics associated with depressive symptoms (Abramson et al., 1989).

Empirical research to date that attempts to explain the link between IPV and depressive symptoms focuses primarily on two theoretical models: one based on cognitive theory and another derived from attachment theory. According to the cognitive theory the association between IPV and depressive symptoms can be explained by negative cognitive schemas or set beliefs about self and others that are formed as the result of the abusive experiences (Foa & Riggs, 1995; McCann & Pearlman, 1990). Numerous studies confirm that the IPV – depressive symptoms link is mediated through maladaptive schemas such as expectation of being rejected, disrespected and abused, and being dependent/helpless and unsuccessful (Calvete, Estevez, & Corral, 2007; McCann, Sakheim, & Abrahamson, 1980; Dutton, 1992; Barnett, 2001). These maladaptive schemas lead to survivors developing depressive symptoms such as feelings of worthlessness, sense of being a failure, pessimistic outlook, and helplessness, as well as feeling of guilt, self-dislike and self-criticalness.

Another possible explanation for the association between IPV and depressive symptoms is based on attachment theory (Bowlby, 1969), which may have advantages over the cognitive approach since it combines both cognitive and interpersonal patterns. Bowlby (1969, 1973, 1980) stipulated in his theory that the quality of early childhood care and attention by a caregiver

influences children's working models of self and others. His theory was later extended to adult intimate relationships with research demonstrating a link between attachment security and quality of intimate relationships (Hazan and Shaver, 1987; Bartholomew, 1990). Whiffen (2005) hypothesized that the quality of interaction between intimate partners would influence their individual attachment security and found that distancing and avoidance of closeness in one partner is correlated with attachment insecurity in the other partner.

Research also reveals a link between IPV and insecure attachment styles. For example, in a study with a community sample, Scott and Babcock (2010) found that the women who reported more frequent IPV also had higher levels of attachment anxiety, expressed a fear of rejection and not being loved by their partners, and lower levels of attachment dependency, defined as believing that their partner is unreliable and untrustworthy. Scott and Cordova (2002) found a significant correlation between marital distress and depressive symptoms when individuals are insecurely attached. There is ample empirical evidence associating attachment insecurity to depressive symptoms, especially in the context of interpersonal stress (Whiffen, Kallos-Lilly, & MacDonald, 2001; Cyranowski et al., 2002; Besser & Priel, 2005; Anderson, Beach, & Kaslow, 1999; Ingram, Miranda, & Segal, 1998; Whiffen & Johnson, 1998; Roberts, Gotlib, & Kassel, 1996; Carnelley, Pietromonaco, & Jaffe, 1994). Although the above body of literature suggests that experiencing abuse from intimate partners is linked to insecure attachment, which in turn is linked to depressive symptoms in the women in this sample, the applicability of the findings to the African American population is unknown since most of the above studies reported that only 6-9% of their samples were African American, and some authors did not report any data on the racial composition of their samples (Whiffen, Kallos-Lilly, & MacDonald, 2001; Cyranowski et al., 2002; Besser & Priel, 2005; Anderson, Beach, & Kaslow, 1999; Ingram, Miranda, & Segal,

1998; Whiffen & Johnson, 1998; Roberts, Gotlib, & Kassel, 1996; Carnelley, Pietromonaco, & Jaffe, 1994).

1.2 Spirituality and Religious Coping as Culturally Relevant Concepts for African American Women

Spirituality and religious coping are universal concepts, and not unique to African American culture. However, research shows that both spirituality and religious coping play particularly salient roles for African Americans compared to the majority racial group (Douglas, et al., 2008; Krause, 2004; Ellison, 1998; Thomas & Holmes, 1992). African American women, in particular, strongly endorse relying on their spiritual and religious beliefs and practices for strength and support to confront and transcend limitations and obstacles, to gain insight and courage needed to engage in spiritual surrender, to interpret life lessons, and to grow and recognize their purpose in life (Neighbors et al., 1983, 1998; Mattis, 2001; McAdoo, 1995; Taylor & Chatters, 1991).

Although universal dimensions of spirituality exist across different cultures, studies suggest that African Americans turn to spirituality to endure and overcome historical social injustices such as forced migration and enslavement, and subsequent systematic discrimination (Boyd-Franklin, 1989; Mattis, 2002; Musgrave et al., 2002). Anthropological studies state that African Americans, under the influence of their cultural and historical origins, perceive themselves as spiritual and religious beings (Ani, 1990; Mbiti, 1989), for whom spirituality is an active and real force that guides and gives purpose in daily life (Stewart, 1999), and protects against stresses and challenges (Newlin, Knafl, & Melkus, 2002). Qualitative studies on African American spirituality have outlined distinct cultural characteristics including 1) faith in God or a Higher Power; 2) a personal relationship with God, oneself, and others; and 3) empowering

transformation and liberating consolation in the face of adversity and discrimination (Banks-Wallace & Parks, 2004; Mattis; 2000, and 2002; Newlin et al., 2002).

Religious coping is an essential component of the repertoire of coping strategies in the African American community (Taylor et al., 2004; Krause & Chatters, 2005; Dillworth-Anderson et al., 2002; Dunn & Horgas, 2000; Krause, 1998). For example, a national study comprising 3,570 African Americans, 891 non-Hispanic Caucasians, and 1,621 Blacks of Caribbean descent found that 90% of African Americans and 86% of Black Caribbeans endorsed the importance of religious coping, such as praying and looking to God for strength in dealing with stressful situations. In comparison, only 67% of non-Hispanic Whites stated the value of prayer, and 60% of non-Hispanic Whites endorsed looking to God for strength (Chatters, Taylor, Jackson, & Lincoln, 2008). Ellison and Taylor (1996) found in their study of African Americans that women practiced religious coping more than men. Furthermore, Fallot and Heckman's (2005) study of 666 predominantly African American women trauma survivors with comorbid mental health and substance use disorders found that women in their study relied on religious coping to a much higher degree than the general population. Fallot and Heckman's (2005) study that has a similar sample to the current one provides empirical evidence for the importance of spirituality and religious coping not only among African American women but specifically African American women who survived trauma including IPV.

1.3 Spiritual Well-being

The term *spiritual well-being* is defined as wellness that encompasses one's sense of purpose in life, and connectedness with God and others (Paloutzian & Ellison, 1982; Ellison, 1983). Paloutzian and Ellison (1982) conceptualized spiritual well-being as a two-dimensional construct that describes a state of being. One dimension refers to religious well-being and

reflects an individual's well-being in relationship with God. This dimension includes items that refer to the quality of the individual's relationship with God, the sense of satisfaction or dissatisfaction derived from one's relationship with God, and the feeling of closeness and support or distance and judgment perceived from God. The second dimension of the construct is conceptualized without religious references, and is termed existential well-being. In this dimension, well-being is defined as life satisfaction and sense of purpose and meaning in life.

The concept of spiritual well-being has a corresponding assessment instrument, the Spiritual Well-being Scale (SWBS; Paloutzian & Ellison, 1982), which is the most frequently used empirical measure for spiritual well-being in general, and in African American samples (Lewis, 2008) in particular. Examples of the items of the religious dimension of the SWBS are: "I believe that God loves me and cares about me" and "I believe that God is distant and could care less what happens to me". The items in the SWBS existential dimension include: "I don't know where I belong in this world" and "I feel that life is a positive experience".

Paloutzian and Ellison's (1982) conceptualization of spiritual well-being appears to be relevant to the two dimensions of African American spirituality based on earlier research (Banks-Wallace & Parks, 2004; Mattis, 2000, 2002; Newlin et al. 2002), namely faith in God, and a personal relationship with God, self and others. This conceptualization of spiritual well-being was criticized by Lewis (2008) for failing to adequately capture the transforming and liberating aspect of African American spirituality. Nevertheless, Miller et al. (1998) found the best fit for African American sample to be their five-factor model underlying the structure of the SWBS, providing further evidence of its cultural suitability for African Americans. Their proposed model includes five subscales: (1) Connection with God, (2) Satisfaction with God and day-to-day living, (3) Future/Life contentment, (4) Personal relationship with God, and (5)

Meaningfulness of life.

Utsey and colleagues (2005), however, found that the Miller's five-factor model (Miller, 1998) did not provide an adequate fit for their community sample of African Americans after conducting a confirmatory analysis. Utsey (2005) argued that Miller's study was flawed due to small sample size, low number of items in two out of the five factors, and inadequate reporting of the statistical findings. The original two-factor model proposed by Ellison (1983) was also critiqued by Utsey (2005) for inadequacy of the fit for his African American sample. In contrast, Genia's (2001) factor analysis supports the original two-factor model of SWBS, however Genia's sample was predominantly European American. Despite various critiques, the two-factor model of SWBS consisting of religious and existential well-being still remains the most widely used and well validated measure of spiritual well-being with variety of samples including the African American ones (Lewis, 2008).

Paloutzian and Ellison's (1982) conceptualization of religious well-being can be critiqued for being biased towards mono-theistic religions that have a single God figure as opposed to multi-theistic religions such as Hinduism, many native religions in Africa, the Americas and Asia, and religions that do not have the same concept of an ultimate deity, e.g. some branches of Buddhism, or Taoism, or denominations where relationship with saints, angels and significant religious figures plays an essential role in a person's spirituality, e.g. Catholicism. Although African American spirituality is not monolithic, the sample of this study is quite homogenous in terms of religious affiliation. Given that the majority of this sample identified themselves as Christian, and only 2% stated being Catholic, this criticism is not very relevant to this particular sample.

The religious dimension of Paloutzian and Ellison's (1982) spiritual well-being concept

is not relevant to atheists or agnostics, since the items refer to "God", and as such it may not have an operational value for these populations. However, this criticism is not central for this study since only eight percent of the sample denied religious affiliation. These eight percent of the participants were included in the study because the existential dimension of the SWBS, which does not include any references to God or religion, is still applicable to atheists and agnostics.

1.4 IPV and Spiritual Well-being

Empirical evidence using samples with similar characteristics to the current one points to a significant correlation between IPV and spiritual well-being such that abused women report lower levels of spiritual well-being than their non-abused counterparts (Kaslow et al., 2002; Meadows et al., 2005, Mitchell et al., 2006). Again, this link can be explained theoretically through either cognitive theory or attachment theory. When looking through the prism of cognitive theory both religious and existential dimensions of the Paloutzian and Ellison's (1982) construct of spiritual well-being as well as the five factors revealed by Miller and coworkers (1998) appear to be related to maladaptive cognitive schemas caused by IPV, which in turn are linked to depressive symptoms. The experience of IPV leads to cognitive schemas concerning sense of worthlessness, pessimistic outlook on life and the future, and a sense of isolation and disconnect from God and others (Foa & Riggs, 1995; McCann & Pearlman, 1990). These negative cognitive schemas are diametrically opposed to the components of the spiritual well-being construct, such as the sense of meaning and purpose in life, sense of contentment, and feeling connected to and satisfied with God and others (Paloutzian & Ellison, 1982; Miller et al., 1998).

When applying the perspective of attachment theory, researchers in the psychology of

religion field argue that for religious individuals God may serve as an attachment figure with whom they have a valuable relationship. (Granqvist & Kirkpatrick, 2004; Granqvist, Mikulincer, & Shaver, 2010; Kirkpatrick, 1992, 1998). Such a relationship with God is illustrated by the statement from a participant in Black's (1998) study of spiritual narratives of African American women living in poverty, who said that she "enjoys an egalitarian relationship with God, which seems like a friendship of long standing" (p. 446).

There are two models concerning attachment styles and attachment to God: correspondence and compensation (Granqvist, Mikulincer, & Shaver, 2010), both of which have supporting empirical evidence (Granqvist & Kirkpatrick, 2008). Based on the correspondence model, individual's attachment style with God corresponds to their attachment style in their human relationships. Thus, individuals with secure attachment style perceive God as loving, and not distant or punishing (Brokaw & Edwards, 1994; Granqvist 2002; Kirkpatrick & Shaver, 1992). Individuals with avoidant attachment style tend to be agnostic or atheist and/or perceive God as distant and inaccessible (Granqvist & Kirkpatrick, 2008; Kirkpatrick & Shaver, 1992), whereas anxiously attached individuals are likely to have a clingy and anxious relationship with God (Beck & McDonald, 2004; Rowat & Kirkpatrick, 2002).

The compensation model suggests that insecurely attached individuals compensate for their insecure relationship history by turning to God for a secure base (Kirkpatrick & Shaver, 1990; Rowat, Kirkpatrick, 2002). Insecurely attached individuals were found to rely on their relationship with God for emotion regulation in times of distress and be higher on religiousness than secure individuals (Mikulincer & Shaver, 2007; Granqvist & Hagekull, 1999). Hall et al. (2009) provided empirical support for their proposition that these two models need not be mutually exclusive and can co-occur in a single individual. Following the earlier application of

attachment theory to explain the link between IPV and depressive symptoms, the quality of an individual's attachment to God may either enhance or buffer this correlation depending on whether individual has insecure or secure attachment to God and the extent to which she can compensate for her attachment insecurity through her relationship with God. Since none of these studies provide racial composition of their samples, it was hard to evaluate the applicability of these findings to African American women.

1.5 Spiritual Well-being and Depressive Symptoms

A significant body of literature links spiritual well-being to health outcomes directly and indirectly to depressive symptoms (Hill & Pargament, 2003; Briggs & Shoffner, 2006). For example, people who score high on measures of spiritual well-being were found to have better overall psychosocial competence (Pargament et al., 1988), and greater emotional well-being and life satisfaction (Kim, Heinemann, Bode, Sliwa, & King, 2000; Emmons, Cheung, & Tehrani, 1998). Those who report a closer connection to God were shown to have psychological benefits, such as less depressive symptoms (Smith, McCullough, & Poll, 2003) and higher self-esteem (Genia, 2001; Maton, 1989; Ellison, 1983; Payne, Bergin, Bielema, & Jenkins, 1991), and experience less loneliness (Kirkpatrick, Kellas & Shillito, 1993; Ellison, 1983). The sense of meaning and purpose in life, conceptualized to be components of the construct of spiritual well-being (Paloutzian & Ellison, 1982), buffers against depressive symptoms (Briggs & Shoffner, 2006).

Research conducted specifically on African Americans demonstrated that higher levels of religious involvement are strongly and positively linked to life satisfaction, happiness and psychological health (Levin & Taylor, 1998). Higher levels of spiritual well-being were linked to lower risk for suicidality among African American women (Meadows, Kaslow et al., 2005;

Kaslow et al., 2004; Walker et al., 2005).

1.6 Spiritual Well-being as a Mediator of the Relation between IPV and Depressive Symptoms

Few empirical studies investigated the relationship between spiritual well-being and mental health outcomes, including depressive symptoms, among women who were abused (Ahrens et al., 2010) and even fewer examined these constructs in samples of African American women (Kaslow, 2004; Meadows et al., 2005). The scarce evidence to date with this population is mixed. The majority of studies document the inverse relationship between spirituality and religious coping and depressive symptoms among African American women who were abused (Watlington & Murphy, 2006; Mitchell et al., 2006). The two studies that researched these variables (Watlington and Murphy, 2006; Mitchell et al., 2006) had very small sample sizes (n=65 in each case), which may have compromised the external validity of their findings.

Coker et al.'s (2002) study, on the other hand, had a large sample (n=1152) of battered women seeking services at an urban hospital, the majority of whom were African American, and found that the women who scored higher on religiosity did not experience mental health benefits including lower rates of depressive symptoms. Their findings are, however, compromised because their spirituality index only included two items. The participants were asked to rate the extent to which they agreed with the following two statements: 1) "What religion or spirituality offers most is comfort in times of trouble and sorrow", and 2) "Your whole approach to life is based on your religion". Having only a two-item measure of such a complex concept as spirituality or religiosity reduces the construct and content validity of the measure.

The existing empirical evidence suggests that spiritual well-being functions as a mediator of the link between stressors and mental health outcomes. Mediation occurs when mediator

variable determines how the predictor variable impacts the outcome variable, provided that the IV and DV are significantly associated (Baron & Kenny, 1986). Mitchell and colleagues (2006) found in the sample with similar characteristics to the current one, that spiritual well-being mediated the association between IPV and depressive symptoms such that women who experienced higher levels of IPV reported lower levels of spiritual well-being which in turn led to higher levels of depressive symptoms. I re-evaluated this mediation model in this sample to confirm Mitchel and colleagues' (2006) findings.

1.7 Religious Coping

Religious coping refers to people's "use of religion and spirituality to deal with stressful and traumatic experiences in their lives" (Pargament et al., 2000). Pargament et al. (1998) distinguish between *positive and negative religious coping strategies*. Positive religious coping result in individuals feeling more connected to God and others, and creating positive meaning in life. Examples of positive religious coping methods are asking God for forgiveness for oneself, seeking spiritual support from God and collaborating with God in religious coping. Other examples of positive religious coping include focusing on religion, spiritual connection, such as seeking God's love and care, and purification, such as asking God to help with letting go of anger. Positive religious coping also encompasses benevolent religious reappraisal, in other words, positive religious interpretation and meaning making. Examples of benevolent religious reappraisal include having an image of God as a benevolent entity or seeing stressors as opportunities for spiritual growth.

In contrast, negative religious coping leads to disconnection from God and others, and a sense of guilt and being punished (Pargament et al., 1998). The negative strategies include having an image of God as a punishing entity, for instance, "God has abandoned me or must be

punishing me". Other negative religious coping strategies are having thoughts signifying spiritual discontent, and interpersonal religious discontent such as "My church does not support me", or demonic cognitive interpretations ("This must be the work of devil"), and questioning the power of God.

The Religious Coping Scale (RCOPE) (Pargament et al. 1998) and Brief Religious Coping Scale (Brief RCOPE) (Pargament et al. 1998) allow a more nuanced exploration of the links between religious coping and mental health outcomes including depressive symptoms. As hypothesized, positive religious coping was tied to positive outcomes, such as lower levels of psychological distress, and sense of personal spiritual growth following life stressors, while negative religious coping was linked to higher levels of depressive symptoms, lower satisfaction with life, and sense of isolation from others (Pargament et al., 1998). However, both of these instruments were validated on predominantly European American samples and their relevance for African Americans is unknown. Pargament's dimensions of religious coping partially overlap with the findings of the content analysis of the narratives of 23 African American women about their use of religion and spirituality in coping with adversity (Mattis, 2002).

The main functions of religious coping identified in Mattis' (2002) qualitative study were to: "interrogate and accept reality; gain the insight and courage needed to engage in spiritual surrender; confront and transcend limitations; identify and grapple with existential questions and life lessons; recognize purpose and destiny; define character and act within subjectively meaningful moral principles; achieve growth; and trust in the viability of transcendent sources of knowledge and communication, e.g. dreams, and intuition" (p. 309). Mattis's (2002) study appears to have captured quite comprehensively the dimensions of spiritual and religious coping that are relevant to African American women given its overlap with other similar studies (Lewis,

2008). A significant shortcoming of Mattis' (2002) study is the omission of any mention of possible negative functions of religious and spiritual coping.

The partial overlap between Pargament's construct and Mattis' findings brings into question the cultural appropriateness of the RCOPE instruments for use with an African American population. However, given that Mattis' sample was comprised of only well- educated middle class African American women, her findings may not generalize to a wider African American female population and, especially not to this study's sample of low-income suicidal and abused African American women. Although Pargament's construct of religious coping and its corresponding instruments RCOPE and Brief RCOPE may not be fully appropriate for the African American population, they still are the most comprehensive and widely accepted instruments that are available at this point, capturing both positive and negative aspects of religious coping (Pargament, Feuille, & Burdzy, 2011).

1.8 Religious Coping and Depressive Symptoms

The results of the meta-analysis of 49 studies with over 13,000 participants in total (13% of whom were African American), that used Pargament's (1998) operational definition of religious coping, demonstrate that greater positive religious coping was associated with greater emotional well-being, personal growth, and life satisfaction, and lower levels of depressive symptoms, anxiety and posttraumatic stress symptoms (Ano & Vasconcelles, 2005). Positive religious coping was related to fewer depressive symptoms, anxiety and hostility (Koenig & Larson, 2001; Pargament, 1997, 2002; Schnittker, 2001). Positive religious coping has also been linked to better psychological adjustment in people experiencing various life stressors, such as transplant surgery, physical illness, and natural disasters (Smith, Pargament, Brant, & Oliver, 2000; Tix and Frazier, 1998; Koenig, Pargament, & Nielsen, 1998). These findings go beyond

what can be accounted for by nonreligious variables, such as general coping and demographic factors, which led researchers to suggest that "religious coping adds a unique component to the prediction of adjustment to stressful life events" (Tix & Frazier, 1998, p. 420).

Religious coping as defined by Pargament (1998) includes perception of support from one's church that, in turn, is likely to be influenced by the extent of the actual support people receive from their church communities. This is particularly true of African Americans. Taylor and Chatters (1988) found that two thirds of the participants in their national survey of African Americans reported that they received support from their church congregation. Studies show that religious support is correlated with lower levels of depressive symptoms and greater life satisfaction (Fiala, Bjorck, & Gorsuch, 2002; Krause, Ellison, & Wulff, 1998). This link is stronger for people dealing with stressful situations, e.g. economic hardship (Maton, 1998) or war (Pargament, Koenig, & Perez, 2000).

In contrast, negative religious coping was associated with symptoms of psychological distress, such as depressive symptoms, negative mood, suicidality, anxiety, panic attacks, and poorer quality of life (Exline et al., 2000; Hays, Meador, Branch, & George, 2001; Krause, Ingersoll- Dayton, Ellison, & Wulff, 1999; Pargament et al., 2000; Pargament, Smith, Koenig, & Perez, 1998; Pargament, Zinnbauer, et al., 1998; Trenholm, Trent, & Compton, 1998). Relatedly, in a study with low-income African American women who experienced IPV, negative religious coping was related to greater PTSD symptomology (Bradley, Schwartz, & Kaslow, 2005).

1.9 Religious Coping as a Moderator or a Mediator

Coping can serve as both a mediator and a moderator (Holmbeck, 1997). Moderation effect occurs when independent variable (*IPV*) is related to dependent variable (*depressive symptoms*) but only under specific conditions of the moderator variable (*religious coping*) (Baron

& Kenny, 1986). Pargament (1997) argued that religious coping is conceptualized as a mediator between spirituality and mental health, or a moderator affecting the relationship between stressors and mental health outcomes.

Fabricatore and colleagues' (2004) study of 175 mostly European American undergraduate students examined religious coping as a mediator between religiousness, and well-being and distress, and as a moderator between the stressor and mental health outcomes. The authors found that collaborative religious coping, which is an example of positive religious coping that refers to collaborating with God to deal with stressors, mediated the relationship between self-reported religiousness and well-being and distress. Collaborative religious coping did not moderate the effect of the stressors on mental health outcomes. In contrast, deferring religious coping, which means deferring to God to solve one's problems, had a negative moderating effect on the relationship between the stressors and mental health outcomes. Lee's (2007) study of 127 mostly Caucasian students also treated religious coping as a moderator and found that religious coping measured by RCOPE buffered the impact of stress on depressive symptoms.

Bradley, Schwartz, and Kaslow (2005) in their study of 134 African American women hypothesized religious coping as a mediator between the stressor and mental health outcomes and found that negative religious coping mediated the relation between the IPV and PTSD symptoms.

Although religious coping can be conceptualized as both a moderator and a mediator, research to date provides more empirical evidence for religious coping as a moderator between a stressor such as IPV and a mental health outcome, e.g. depressive symptoms (Pargament, 1997; Lee, 2007; Fabricatore et al., 2004). The research described above also suggests that positive

religious coping would buffer depressive symptoms in women who experienced IPV, while negative religious coping is likely not to buffer symptoms of depressive symptoms in this sample, and may even exacerbate depressive symptoms.

1.10   Religious Coping and Spiritual Well-Being

Research to date provides empirical evidence for the relation between religious coping and spiritual well-being. For instance, Arnette, Mascaro, Santana, Davis and Kaslow (2007) demonstrated through path analysis in a longitudinal study involving 74 low-income African American women found that higher levels of positive religious coping were related with higher levels of existential and religious well-being at both baseline and 10 weeks later. Their path analysis revealed that positive religious coping predicted higher levels of religious well-being 10 weeks later.

The exact mechanism of the link between religious coping and spiritual well-being is not clear since the few studies that examined the relationship between these constructs produced inconsistent findings. Pargament (1997) argued that religious coping mediates the association between spirituality and mental health. Consistent with this argument, Fabricatore (2004) found that positive religious coping mediated the link between religiosity and depressive symptoms in a sample of 175 mostly Caucasian undergraduate students. In contrast, Watlington & Murphy (2006) found that religious coping did not mediate the association between spirituality (concept similar to religious well-being) and depressive symptoms in a sample of 65 African American women who were abused, and proposed that it may act as a moderator of spirituality-depressive symptoms link. Utsey and colleagues' (2007) study of 281 African American community participants found that spiritual well-being, measured by the SWBS, partially mediated the relation between culture-specific coping (which included dimensions of religious coping) and the

quality of life comprising physical health, psychological well-being, quality of social

relationships, and environmental well-being.

1.11   Interplay of Spiritual Well-Being and Religious Coping on the IPV-DS Link

Based on the literature review, this study proposed a moderated mediation model to

examine the mechanism through which spiritual well-being was responsible for the relation

between IPV and DS at different levels of religious coping (see Figure 1.1).

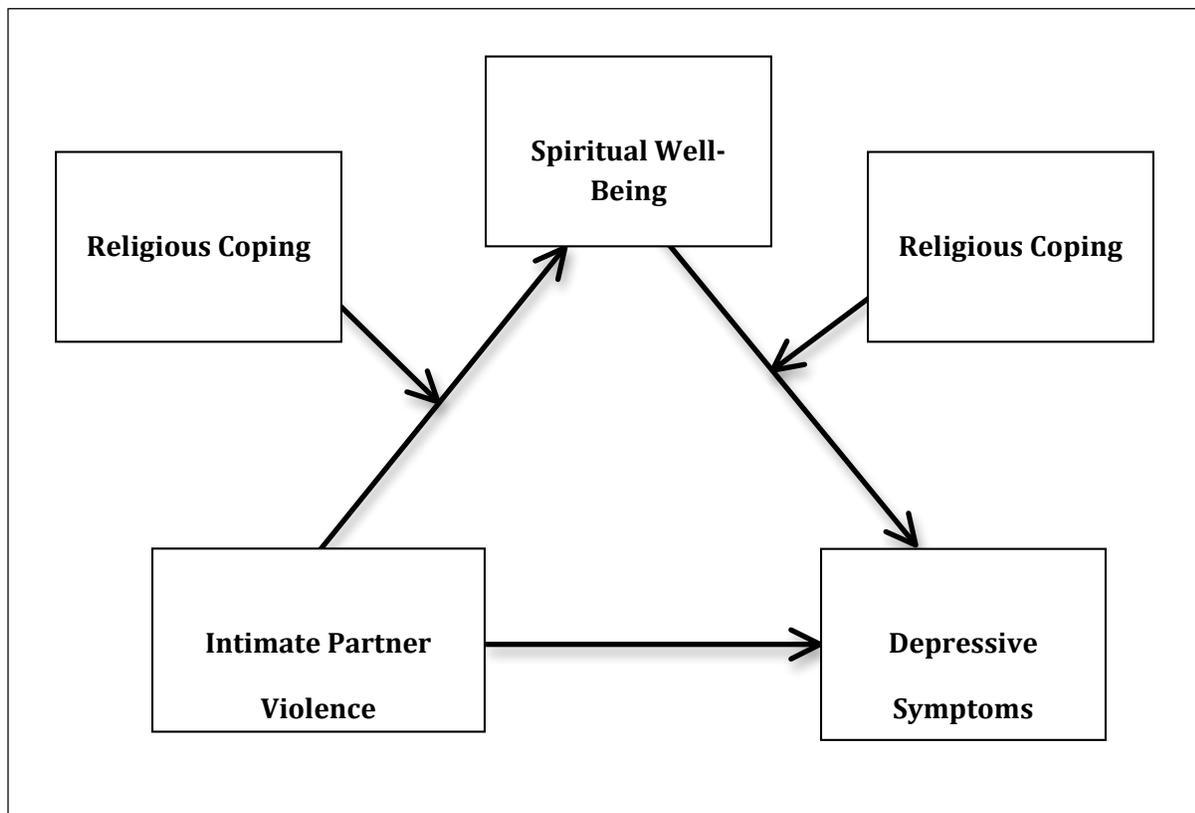**Figure 1.1 Moderated mediation model**

Moderated mediation models attempt to explain both when and how an IV-DV effect

takes place (Preacher, Rucker & Hayes, 2011). IPV was selected as the independent variable

(IV) due to its significant impact on both spiritual well-being and depressive symptoms.

Research suggests that African American women exposed to IPV were at a significantly higher

risk for depressive symptoms (Houry et al., 2005; Houry et al., 2006; Coker et al., 2002; Rhodes et al., 2002; Ramos et al., 2004). Thus, depressive symptoms were determined to be the dependent variable (DV) in this model. Spiritual well-being was defined as a mediator or mechanism through which IPV has an effect on DS. This means that higher levels of IPV result in lower levels of spiritual well-being (Kaslow et al., 2002; Meadows et al., 2005, Mitchell et al., 2006), which in turn is expected to lead to higher levels of depressive symptoms (Smith et al., 2003; Levin & Taylor, 1998; Briggs & Shoffner, 2006). The definition of spiritual well-being as a mediator between IPV and DS among abused and suicidal African American women is consistent with the empirical evidence in a sample with similar characteristics to this study (Mitchell, 2006).

Following Watlington & Murphy's (2006) suggestion that religious coping may act as a moderator between religious well-being and depressive symptoms among abused African American women, the current model conceptualized religious coping as a moderator. Furthermore, this integrated model considered that religious coping would moderate the mediating effect of spiritual well-being on IPV-DS link. Specifically, religious coping was hypothesized to moderate both the link between IPV and spiritual well-being (Fabricatore, 2004) as well as the link between spiritual well-being and depressive symptoms (Pargament, 1997; Fabricatore, 2004). That is, if women who were abused engage in high levels of positive religious coping, it may buffer the effect of IPV on spiritual well-being. Furthermore, when the level of spiritual well-being is high, positive religious coping is more likely to act as a buffer against depressive symptoms. A variation of this model was explored inserting negative religious coping instead of positive religious coping as a moderator. If women who were abused engage in high levels of negative religious coping, it would exacerbate the negative impact of IPV on

spiritual well-being. With the diminished levels of spiritual well-being, negative religious coping is more likely to strengthen the negative link between spiritual well-being and depressive symptoms.

1.12   Aims and Hypotheses

The overarching purpose of the current study was to investigate the link between IPV and depressive symptoms, and the role of religious coping and spiritual well-being in this relationship in a sample of low-income, abused, suicidal African American women. This study is the first to investigate the interplay between culturally important constructs such as spiritual well-being and religious coping on the mechanism underlying the relationship between IPV and DS in this population. The current study had three specific goals and corresponding hypotheses.

Aim 1 was to examine the mediating effect of existential well-being and religious well-being, subcomponents of spiritual well-being, on the association between IPV and depressive symptoms. Mediation models explain how or why there is an effect of the criterion on the outcome. The literature review demonstrated the existence of robust findings showing evidence for all three pathways of the proposed mediation model. Specifically, the studies suggested positive effect of IPV on depressive symptoms, negative effect of IPV on spiritual well-being and negative effect of spiritual well-being on DS.

The limited research available to date that investigated all of the above constructs with this population implied that the association between IPV and DS occurs through spiritual well-being (Mitchell et al., 2006). The current study aimed to test the hypothesis replicating Mitchell and her colleagues' (2006) study with a larger sample. Furthermore, Mitchell and her co-workers (2006) tested the mediation effect of the spiritual well-being concept as a whole, without separating its two dimensions of existential and religious well-being. Based on Arnette and

colleagues (2006) conclusion that these two dimensions are distinct and therefore, should be investigated separately, this study added more specificity and nuance to the investigation by testing the mediation effect of the existential well-being and the religious well-being dimensions of the spiritual well-being construct. The specific hypotheses for the Study Aim 1 were:

a) *Spiritual well-being* would mediate the relationship between *IPV* and *depressive symptoms* such that the higher levels of *IPV* would lead to lower levels of *spiritual well-being* which in turn, would lead to higher levels of *depressive symptoms*;

b) *Existential well-being* would mediate the relationship between *IPV* and *depressive symptoms*, with the higher levels of *IPV* leading to lower levels of *existential* well-being, which in turn would lead to higher levels of *depressive symptoms*.

c) *Religious well-being* would mediate the relationship between *IPV* and *depressive symptoms*, with the higher levels of *IPV* leading to lower levels of *religious* well-being, which in turn would lead to higher levels of *depressive symptoms*.

The Aim 2 was to examine the moderating effect of religious coping on the IPV-DS association. The research to date provided empirical evidence for religious coping as a moderator between IPV and depressive symptoms (Pargament, 1997; Lee, 2007; Fabricatore et al., 2004). The literature review suggests that positive religious coping would buffer depressive symptoms in women who experienced IPV, while negative religious coping is likely not to buffer symptoms of depressive symptoms in this sample, and may even exacerbate depressive symptoms. Thus, it was hypothesized that:

a) *Negative religious coping* would moderate the relationship between *IPV* and *depressive symptoms* such that it would exacerbate the effect of *IPV* on *depressive symptoms* i.e. the higher levels of *negative religious coping* would strengthen the IPV-DS relation.

b) *Positive religious coping* would moderate the relationship between *IPV* and *depressive symptoms* such that it would buffer the effect of *IPV* on *depressive symptoms* i.e. at higher levels of *positive religious coping*, the *IPV-DS* link will be weaker.

The Aim 3 was to investigate whether the strength of the mediational effect of spiritual well-being on IPV-DS link changes at different levels of positive and negative religious coping. First the findings of the Study Aim 1 determined if the components of spiritual well-being acted as mediators of the IPV-DS link, and then, this model tested if spiritual well-being components interacted with positive or negative religious coping in such a way as to impact the relation between IPV and DS. It was hypothesized that:

a) Negative religious coping would moderate the indirect effect of IPV on DS through existential well-being such that higher levels of IPV would lead to lower levels of existential well-being, which in turn would lead to higher levels of DS. The magnitude of this relationship was expected to be greater at higher levels of negative religious coping.

b) Negative religious coping would act as a moderator of indirect effect of IPV on DS through religious well-being such that higher levels of IPV would lead to lower levels of religious well-being which would result in higher levels of DS. The magnitude of this effect would be greater at higher levels of negative religious coping.

c) Positive religious coping would moderate the indirect effect of IPV on DS through existential well-being, such that, high levels of IPV would lead to low levels of existential well-being, and low levels of existential wellbeing would lead to higher level of depressive symptoms. The magnitude of this relationship was expected to be smaller at higher levels of positive religious coping.

d) Positive religious coping would act as a moderator similarly when the religious well-being is a mediator, i.e. high levels of IPV would lead to low levels of religious well-being, and low levels of religious well-being would result in high levels of depressive symptoms. The magnitude of this relationship was hypothesized to be smaller at higher levels of positive religious coping.

2. METHOD

I conducted a secondary analysis of the existing data from a study completed at a large public, university-affiliated hospital serving a local population in a major metropolitan city.

2.1 Participants

Two hundred and eight African American women were recruited from a hospital in the South-Eastern US in July 2000 to August 2006. Only women who endorsed IPV and a suicide attempt within the previous 12 months were eligible to participate in the study. Exclusion criteria included inability to complete the pretreatment interview due to cognitive impairment, acute psychosis, or delirium, and non-African American race/ethnicity.

The women's ages ranged between 18 and 55 with the mean age of 34.77 (SD=9.38). Seventy four percent of the sample completed high school or GED, or had some schooling (less than 12th grade); the remaining 26% completed or had some college or technical education. Eighty five percent of the sample was unemployed. Fifty-four percent of the sample had monthly income of less than $ 250, 72% received less than $ 500 a month, 94% received less than $ 1000 a month, and only 6% received $ 1000 or more a month.

Seventy-seven percent of the sample (n=150) reported having had one abusive intimate relationship, and only 3% (n=6) of women reported not having had an abusive partner. The remaining 20% (n=39) had more than 1 abusive partner in their lifetime. At the time of their participation in the study, 60% of the sample was in an abusive relationship, 31% were not in any relationship, and 9% were with a non-abusive partner. Of the 141 women who were in a relationship at the start of the study only 8 (6%) reported having a female partner. Eighty three percent of the women attempted suicide during an abusive relationship, current or past.

Fifty-four percent of the sample identified themselves as Baptist, 11% as belonging to

other Christian denominations, an additional 19% identified themselves as Christian non-denominational, 2% as Catholic, 1% as Muslim, 5% as "other" (the majority of women in this category listed themselves belonging to Christian denominations), and 8% reported having no religious affiliation.

2.2 Procedure

Prior to the data collection, the university's institutional review board approved the original study, as did the hospital's Research Oversight Committee. The university's institutional review board approved the current secondary data analysis study.

Recruitment. Research team members consisting of undergraduate and graduate students and post-doctoral fellows recruited African American women who sought services in medical and emergency care clinics in the hospital. In addition, some of the participants were referred for the study by hospital staff following an IPV or suicide incident. Researchers were available on call 24 hours a day for hospital referrals concerning recruitment of potential participants. The recruiters conducted brief screening to determine the eligibility criteria. If the person met the criteria for the inclusion in the study, they were given information about the study and were invited to participate. All participants provided written informed consent. If the person did not meet the eligibility criteria, they were informed about the relevant mental health services offered at the hospital.

Assessment. A comprehensive battery of measures was administered for the pretreatment post-treatment, 6-month, and 12-month follow-up interviews. For this study, only relevant part of the baseline data (T1 or pre-treatment) was analyzed. The assessments were administered verbally by team members who were trained and supervised weekly by licensed psychologists. The demographic data were collected prior to the assessment battery and were based on self-

reports. Participants who completed pretreatment interview were compensated $20 plus transportation costs.

2.3 Measures

IPV was measured by *Index of Spouse Abuse* (Hudson & McIntosh, 1981), a 30-item measure that assesses the severity of physical violence (e.g. *"My partner beats me so badly that I must seek medical help"*), emotional abuse (e.g. *"My partner screams and yells"*), and controlling behaviors (e.g. *"My partner acts like I am his personal servant"*) received by women from their intimate partners. Participant ratings range from "never" to "very frequently" on a 5-point Likert scale. The ISA has good internal consistency reliability, convergent validity and discriminant validity (Hudson & McIntosh et al., 1981). Its psychometric properties have been tested on samples of African American women (Cook, Conrad, Bender & Kaslow, 2003; Tolman, 2001; Campbell, King, Parker, & Ryan, 1994). Cronbach alpha for this sample was 0.96.

Depressive symptoms were assessed through the 21-item *Beck Depression Inventory II* (BDI-II) (Beck et al. 1996). Each item of this self-report measure contains 4 statements reflecting increasing levels of severity for each symptom. For example, the item on sadness ranges from *"I do not feel sad"* to *"I feel so sad or unhappy that I can't stand it"*. The total scores range 0-63. Total score of 0-13 is considered minimal range, 14-19 corresponds to the mild range in depressive symptoms, 20-28 is moderate, and 29-63 falls in the severe range of depressive symptomology (Beck et al. 1996). The BDI-II has good internal consistency, and adequate content, factorial, and discriminative validity (Beck et al. 1996; Dozois et al. 1998). The BDI-II has a coefficient alpha of .92 for the sample of outpatient population (n = 500), 4 percent of whom were African-Americans (Beck et al., 1996). One week test-retest correlation of .93

resulted from a study of 26 outpatients who had been referred for depressive symptoms and took the BDI-II during their first and second therapy sessions (Beck et al., 1996). The BDI-II has been widely used with African American research participants. The Cronbach's alpha for this sample was 0.90.

Spiritual well-being was measured by the *Spiritual Well-being Scale* (SWBS), a 20-item self-report measure of well-being that contains 2 dimensions: religious well-being (RWB), and existential well-being (EWB). It also provides a measure of overall spiritual well-being by totaling the scores for RWB and EWB (Paloutzian & Ellison, 1982, 1991). RWB is conceptualized as spiritual well-being in terms of individual's relationship with God (e.g. *"My relationship with God contributes to my sense of well-being"*). The EWB evaluates a respondent's satisfaction and purpose in life (e.g. *"I believe there is some real purpose for my life."*) Items are rated on a 6-point Likert scale (1 = strongly agree and 6 = strongly disagree), with higher scores indicating greater levels of well-being. The measure was developed and validated using a sample of European American students (n=206) (Paloutzian & Ellison, 1982). Test- retest coefficients with a one-week interval were .96 for the RWB, .86 for the EWB, and .93 for the SWB, and the reported test-retest coefficients ranged from .88 to .99 for the three scales at 4, 6, and 10 weeks (Bufford, Paloutzian, & Ellison, 1991). Internal consistency is also good with Cronbach's alpha coefficients ranging from .87-.91 for the RWB, .78 - .91 for the EWB, and .76 - .93 for the SWB (Ellison, 1983; Fernander, Wilson, Staton, & Leukefeld, 2004; Genia, 2001). Evidence of the instrument's convergent validity was demonstrated in a study where the RWB, EWB, and SWB were negatively correlated with a measure of loneliness and positively correlated with measures of life purpose, intrinsic religious orientation, and self-esteem (Ellison, 1983). The measure was found to have good psychometric properties with

African American research pools as well (Lewis, 2008). Cronbach's alpha coefficients for the current sample for the composite SWBS was 0.90, for RWB subscale 0.85, and for EWB subscale 0.84.

    Religious coping was measured by *Brief RCOPE*, a 14-item instrument (Pargament, Smith, Koenig, & Perez, 1998) which is an abbreviated version of the 63-item RCOPE (Pargament, Koenig, & Perez, 2000). It contains two subscales: positive religious coping scale (PRCOPE) and negative religious coping scale (NRCOPE). PRCOPE assesses healthy or positive religious coping strategies. PRCOPE strategies include religious forgiveness, seeking spiritual support, collaborative religious coping, spiritual connection, religious purification, and benevolent religious reappraisals of distressing situations (e.g. "*Sought God's love and care").* The NRCOPE measures negative coping and includes spiritual discontent, punishing God reappraisals, abandonment by church and God, demonic reappraisal, and reappraisals of God's powers (e.g. "*Wondered what I did for God to punish me").* The Brief RCOPE items are rated on a 4-point Likert scale (*not at all, somewhat, quite a bit,* and *a great deal)*. Scores range from 7 to 28 and are calculated by dividing the sum of the item ratings by the number of items. The instrument was validated on predominantly European American samples, with good internal consistency (*a*=.81 to .90) and good discriminant validity (Pargament et al., 1998). However, subsequently, it has been used with samples with similar characteristics to the current one. Cronbach's alpha coefficients for the RCOPE composite for current sample was 0.80, for the PRCOPE subscale was 0.92, and for the NRCOPE subscale was 0.81.

3. RESULTS

3.1 Preliminary Analysis

Cronbach's alpha coefficients, reported under each measure, fell within .81-.96 range showing high internal consistency of the measures in relation to this sample. The initial diagnostic work confirmed that all the variables met the criteria for normal distribution and homoscedasticity. Histogram plots showed that the variables were normally distributed. The only exception was the distribution of the Religious Well-Being (RWB) subscale and the Positive Religious Coping (PRCOPE) subscale. Both subscales were negatively skewed, as most participants reported high scores on religious well-being and positive religious coping. Square transformation of the RWBS values resulted in the variable scores falling within the normal distribution limits. For PRCOPE values cubed transformation was required to solve the problem of the extreme negative skewness of the sample distribution.

3.2 Descriptive Statistics

The descriptive statistics revealed that the women who participated in this study reported exposure to very high levels of IPV ($M=95$, $SD=30$). As a reference point, the authors of the ISA measure recommended the scores above 25 for non-physical abuse subscale and above 10 for physical violence subscale as clinical cutting points (Hudson & McIntosh, 1981). The participants also had extremely elevated levels of depressive symptoms ($M=35$, $SD=12$) given that scores above 29 indicate severe depression (Beck et al., 1996). This sample endorsed high levels of religious well-being ($M=46$, $SD=10$) as compared to the maximum possible score of 60, and somewhat lower levels of existential well-being ($M=36$ out of 60, $SD=10$). The participants reported fairly high levels of positive religious coping ($M=17$ out of 21, $SD=5$), and lower levels

of negative religious coping (*M*=12 out of 21, *SD*=6). The variability of religious well-being and, particularly, positive religious coping was very low, with the majority of participants reporting high levels on both of these variables. The descriptive statistics for all of the study variables are in Table 3.1.

Table 3.1 The descriptive statistics for the study variables

Variable	Measure	Valid n	Range	Mean	SD
Intimate Partner Violence	ISA	208	30-150	95.05	29.57
Depressive symptoms	BDI	208	0-62	35.33	12.28
Spiritual Well-being	SWBS	207	30-120	82.82	17.38
Religious Well-being	RWBS	207	10-60	45.97	9.58
Existential Well-being	EWBS	207	10-60	36.34	10.03
Religious Coping	Brief RCOPE	207	3-42	28.02	7.82
Positive Religious Coping	PRCOPE	207	0-21	16.51	5.16
Negative Religious Coping	NRCOPE	207	0-21	11.52	5.77

3.3 Inter-correlations

Correlation tests were conducted prior to testing the hypotheses to reveal relationships between variables. All the variables were statistically significantly inter-correlated except IPV and religious well-being, IPV and positive religious coping, and IPV and negative religious coping. As can be expected, positive and negative religious coping were not correlated at statistically significant level. Since none of the variables had correlation coefficients above .8 level this ruled out problem of multicollinearity. The only variables that were inter-correlated at

higher levels were the two subscales of spiritual well-being with their composite variable, which

was to be expected. Since these variables are tested each in a separate model as potential

mediators of IPV-depressive symptoms link, their mutual correlation does not present an

obstacle. Table 3.2 shows the correlation coefficients for all the variables. The scatterplots of the

correlations between the variables revealed linear correlations meeting the prerequisite for

mediation and moderation tests.

Table 3.2 The correlation coefficients between all the variables

	BDI	ISA	RWBS	EWBS	PRCOPE	SWBS	NRCOPE
BDI	1	.189*	-.224*	-.534*	-.201*	-.432*	-.441*
ISA	.189*	1	0.036	-.198*	0.06	-0.095	-0.121
SWBS	-.432*	-.095	.881*	.892*	.477*	1	.468*
RWBS	-.224*	.036	1	.572*	.469*	.881*	.376*
EWBS	-.534*	-.198*	.572*	1	.378*	.892*	.452*
PRCOPE	-.201*	0.06	.469*	.378*	1	.477*	0.019
NRCOPE	.441*	.121	-.376*	-.452*	-0.019	-.468*	1

The correlations are significant at .05 level.

3.4 Aim 1: Testing Mediation

The meditational effects of the spiritual well-being composite, as well as the religious

well-being subscale and existential well-being subscale, were examined to test whether or not

these three variables mediated the relationship between IPV and depressive symptoms. I used the

SPSS macros for estimating indirect effects in simple mediation models proposed by Preacher

and Hayes (2004), whose bootstrapping technique is considered to be the best mediation test

available. According to Hayes (2009), the modern mediation tests such as Sobel test and

bootstrapping do not require as prerequisites the associations between the independent variable

(IPV), mediator (religious well-being) and the dependent variable (depressive symptoms) as

proposed earlier by Baron and Kenny (1986). Therefore, the non-significance of the correlation between IPV and religious well-being should not preclude mediation test. Due to its nonparametric nature, bootstrapping also circumvents the problem of insufficient power that arises if the assumption of normality in the sampling distribution of the indirect effect is not met and can be used with smaller samples with greater confidence (Shrout & Bolger, 2002; Preacher & Hayes, 2004).

The SPSS macros include a series of regression analyses to test the Baron and Kenny (1986) requirements for mediation. They also provide a test of the indirect effect according to Sobel (1982, 1988) to determine if the correlation between the predictor and the outcome was significantly reduced after controlling for the mediator variable. However, constituting an improvement to both of these approaches Preacher and Hayes' (2004) macros bootstrap the estimate of the indirect effect, an estimated standard error for the effect, and the 95% and 99% confidence intervals for the population value of the indirect effect (Preacher & Hayes, 2004). The null hypothesis that there is no indirect effect can be rejected if zero does not fall within the defined confidence interval.

The bootstrapping technique involves taking a large number of samples (e.g. 1,000) from the raw data of a sample size equal to the original sample size (e.g. 208) and computing estimates of the indirect effect for each sample. In this example, the estimated indirect effect is derived by computing the mean indirect effect for 1,000 samples of 208. The average standard deviation of the 1,000 indirect effect estimates constitutes the estimated standard error. Confidence intervals are generated by sorting the observed effects of 1,000 estimates from low to high, with the lower limit set as the 25th score and the upper limit defined as the 976th score in the distribution. Similarly, to calculate 95% confidence intervals for 1,000 estimates, the lower

and upper limits would be set as the 5th and 996th scores, respectively.

Figures 3.1-3.4 show the results of the bootstrap procedures with each path including the mean bootstrapped coefficient and the standard error in the brackets. Path model 1 in Figure 3.1 reveals the direct effect of IPV on depressive symptoms.
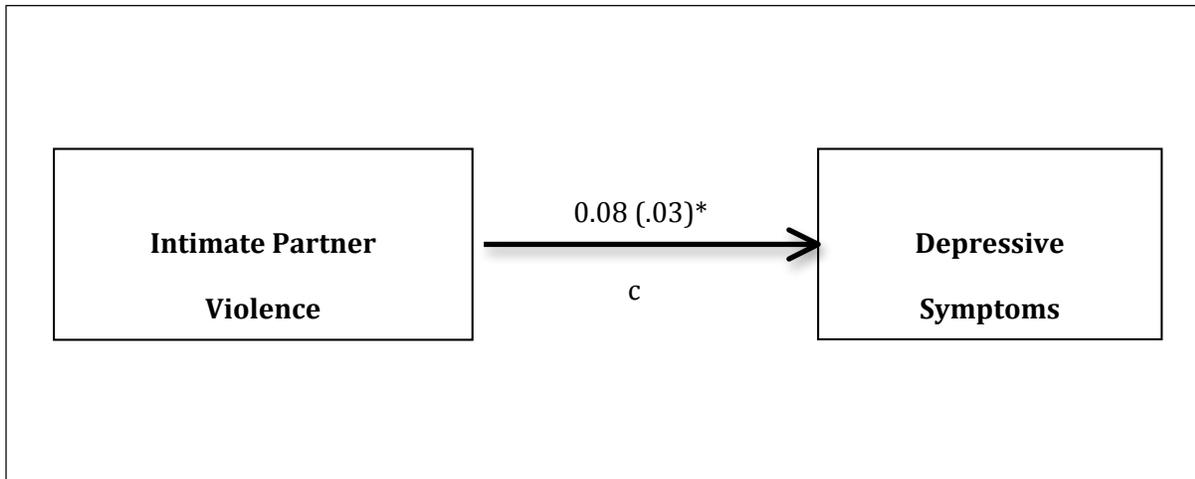
Figure 3.1 Path model 1: IPV and DS

The subsequent path models in Figures 3.2-3.4 show the results of the mediation analyses for each of the hypothesized mediator variables. As can be seen in Figures 3.2 and 3.3 neither spiritual well-being nor religious well-being mediated the relationship between IPV and depressive symptoms.
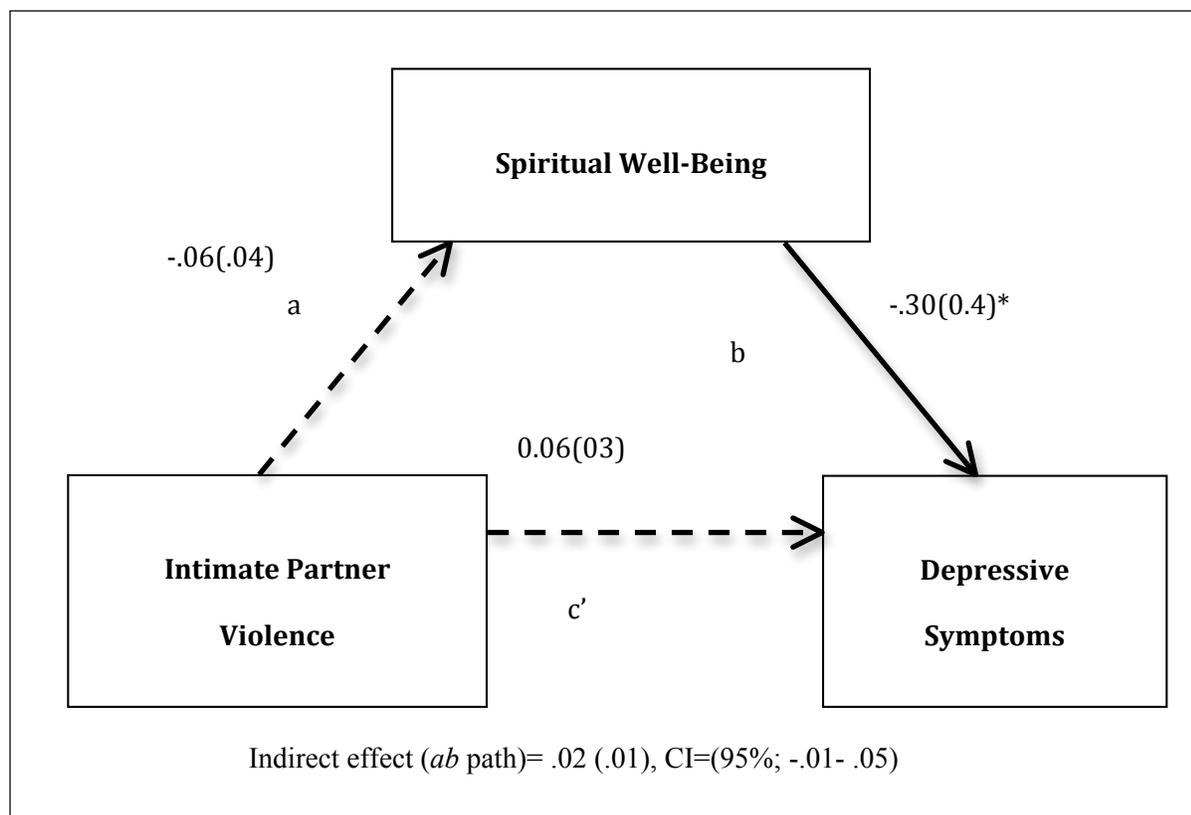
Figure 3.2 Path model 2 with spiritual well-being as a mediator.
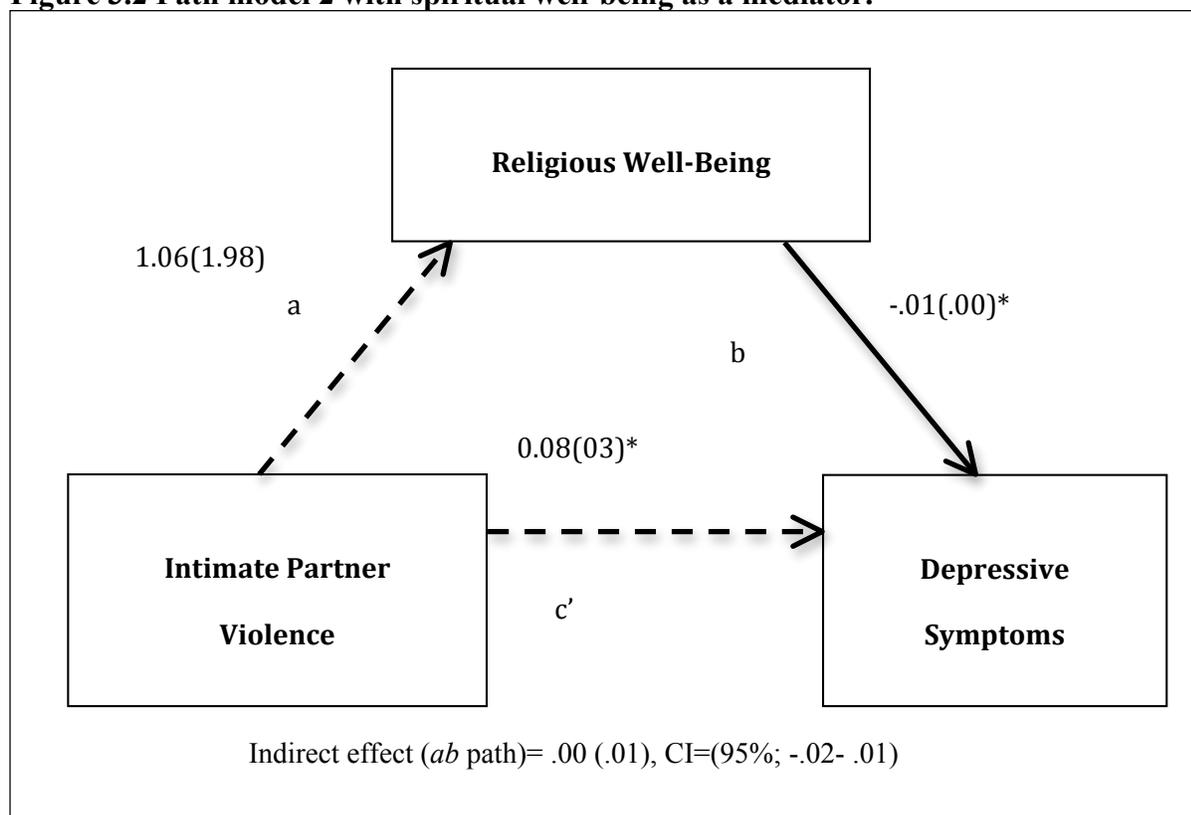
Figure 3.3 Mediation results: Path model 2 with religious well-being as a mediator

As evidenced in Figure 3.4 existential well-being was the only variable that mediated the relation between IPV and depressive symptoms. The paths *a, b* and *c* were statistically significantly different from zero while the direct effect of the IV on the DV (*c'* path) was not statistically significant which indicated that existential well-being fully mediated the link between IPV and depressive symptoms. The indirect effect (*ab* path) was significantly different from zero meaning that mediation between the three variables is likely to have occurred. The bootstrapped indirect effect was .04 with estimated standard error of .02 ($p<.01$) within the confidence intervals (95%; .01- .08). The model explained 29% of the variance (R^2) of the DV (depressive symptoms), $F(2, 204) = 41.95$, $p < 0.0001$.

Figure 3.4 Mediation results: Path model 2 with existential well-being as a mediator

3.5 Aim 2: Testing Moderation

Prior to testing for the moderation effect, the independent variable (IPV) and the moderator (PRCOPE and NRCOPE) were centered based on the suggestion by Aiken and West (1991). "Centering" means putting scores of each variable into deviation score form by subtracting the sample mean from all participa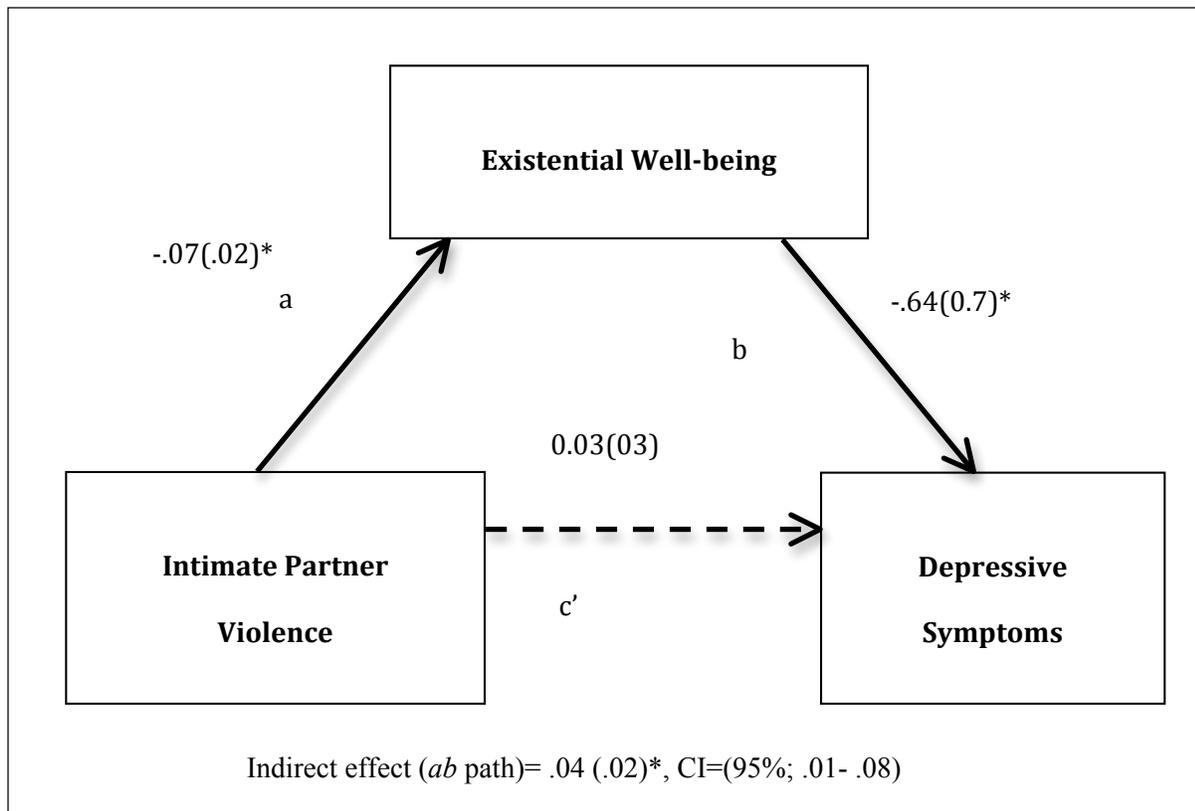nts' scores on the variable, which results in a revised sample mean of zero. "Centering" solves the multicollinearity problem between the independent variable and the moderator, and the interaction terms without affecting the level of significance of the interaction terms or the simple slopes of regression lines.

After centering the variables, I tested for the moderation effect of each of the religious coping subscales (positive and negative religious coping) between the independent variable (IPV) and the dependent variable (depressive symptoms) using regression analysis (Holmbeck, 1998). Using SPSS, I entered the IPV as the independent variable (IV) and the hypothesized moderator (MOD) variable (positive or negative religious coping) first as the main effects in the regression equation, then I entered the interaction between the IV and the MOD. The regression equation for this test is : $Y = d + a\text{IV} + b\text{MOD} + c\text{IVMOD} + E$, where c refers to the moderation effect. The regression analyses showed that only negative religious coping statistically significantly moderated the relationship between IPV and depressive symptoms. The full model testing for the moderation effect of negative religious coping accounted for 26.3% of the variance (R^2), $\Delta R^2 = .05$, $F(3, 206) = 24.16$, $p < 0.0001$. The interaction between IPV and negative religious coping was significant ($\beta = .23$, $B = .016$, $SE = .004$, $p < .0001$).

Since a statistically significant moderation effect was found, post-hoc tests were conducted to explore the form of the interaction (Frazier, Tix, Baron, 2004, Cohen et al., 2003). In addition to the Mean level of MOD, I computed two new conditional moderator variables for

high and low values of the MOD (1 SD above and 1 SD below the mean):

HighMOD=MeanMOD - 1 SD

LowMOD=MeanMOD - (-1 SD).

Similarly, I also computed two new variables for high (1 SD above Mean) values of IPV and low (1 SD below Mean) values of IPV, in addition to the Mean IPV. Next I ran five post-hoc regressions, simultaneously entering IV main effect (at mean, high and low levels of IV), one HighMOD, MeanMOD, or LowMOD and the interaction (IVxHighMOD, IVxMeanMOD, or IVxLowMOD). The post-hoc regressions contained the following five interactions:

1) MeanIPV x MeanNRCOPE,

2) HighIPV x MeanNRCOPE,

3) LowIPV x MeanNRCOPE,

4) MeanIPV x HighNRCOPE, and

5) MeanIPVxLowNRCOPE.

The statistical significance tests for each regression line revealed that all simple slopes were significant at $p<.001$.

I generated the slopes for the Low MOD condition, Mean MOD condition, and the High MOD condition based on the regression equation as shown in Figure 3.5. The relationship between IPV and depressive symptoms varied based on the levels of NRCOPE. When women used high levels of negative religious coping, they had high levels of depressive symptoms and the link between the IPV and depressive symptoms was weak. The women who were at the mean level in terms of negative religious coping were shown to have lower levels of depressive symptoms and the IPV was likely to have a stronger positive correlation with depressive symptoms. The participants who were low in their use of negative religious coping demonstrated

the strongest link between their levels of IPV and depressive symptoms. This means that when women engaged in more negative religious coping they experienced higher levels of depressive symptoms, which depended less on their level of exposure to IPV.
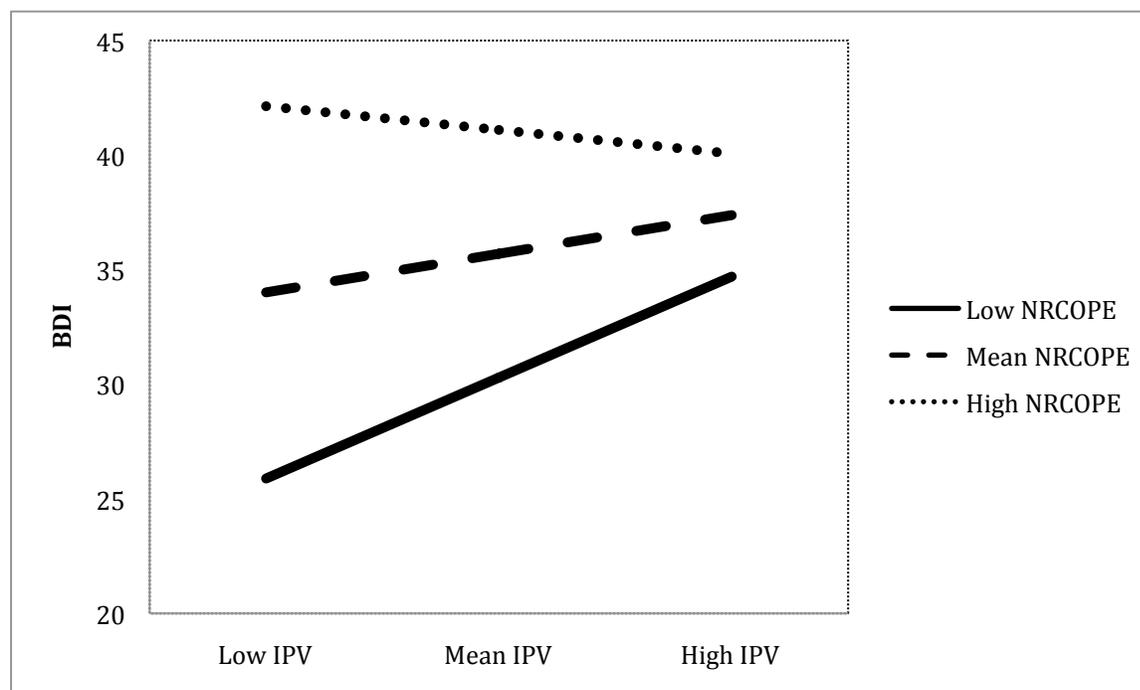
Figure 3.5 Moderation results: The effect of IPV on DS (BDI) at Low (M-1SD), Mean and High (M+1SD) levels of NRCOPE

3.6 Aim 3: Moderated Mediation

I tested a moderated mediation model to assess whether the strength of the mediating effect of existential or religious well-being on IPV-DS link is contingent on the level of positive or negative religious coping. Muller, Judd, and Yzerbyt (2005) stated that moderated mediation "happens if the mediating process that is responsible for producing the effect of the treatment on the outcome depends on the value of a moderator variable" (p. 854).

Preacher, Rucker and Hayes (2007) described five moderated mediation models based on the hypothesized interactions between the moderator and mediator variables. All five models were considered for the current study model. Model 5 provided the best fit for the hypothesized

model in which religious coping would moderate both the pathway between IPV and existential or religious well-being and between the either component of spiritual well-being and depressive symptoms. Testing moderated mediation involves running two regression equations. The first regression is referred to as the Mediator Variable Model and predicts the mediator variable from the independent variable. The second regression is the Dependent Variable Model and it predicts the outcome variable from the predictor and mediator variables. Preacher and colleagues (2007) provide guidelines for the relevant syntax based on the chosen model. I composed the appropriate syntax, and used SPSS macros to perform both of these regression models simultaneously. The output provided conditional indirect effects at specific values of the moderator as well as bootstrap standard errors at 1000 bootstrap reiterations.

I ran 4 models based on the 4 hypotheses of the Study Aim 3:

a) NRCOPE as a MOD of the IPV-EWB and EWB-DS mediation pathways

b) NRCOPE as a MOD of the IPV-RWB and RWB-DS mediation pathways

c) PRCOPE as a MOD of the IPV-EWB and EWB-DS mediation pathways

d) PRCOPE as a MOD of the IPV-RWB and RWB-DS mediation pathways

Only the model a) yielded statistically significant results, i.e. the estimated range of the CI at 95% did not include 0. Figure 3.6 summarizes the model with the regression coefficients and standard errors for each regression. The results show that existential well-being fully mediated the IPV-DS link such that higher levels of IPV led to lower levels of EWB which in turn led to higher levels of depressive symptoms. Negative religious coping moderated only the IPV-EWB pathway, and did not show statistically significant moderation effect on the EWB-DS pathway.
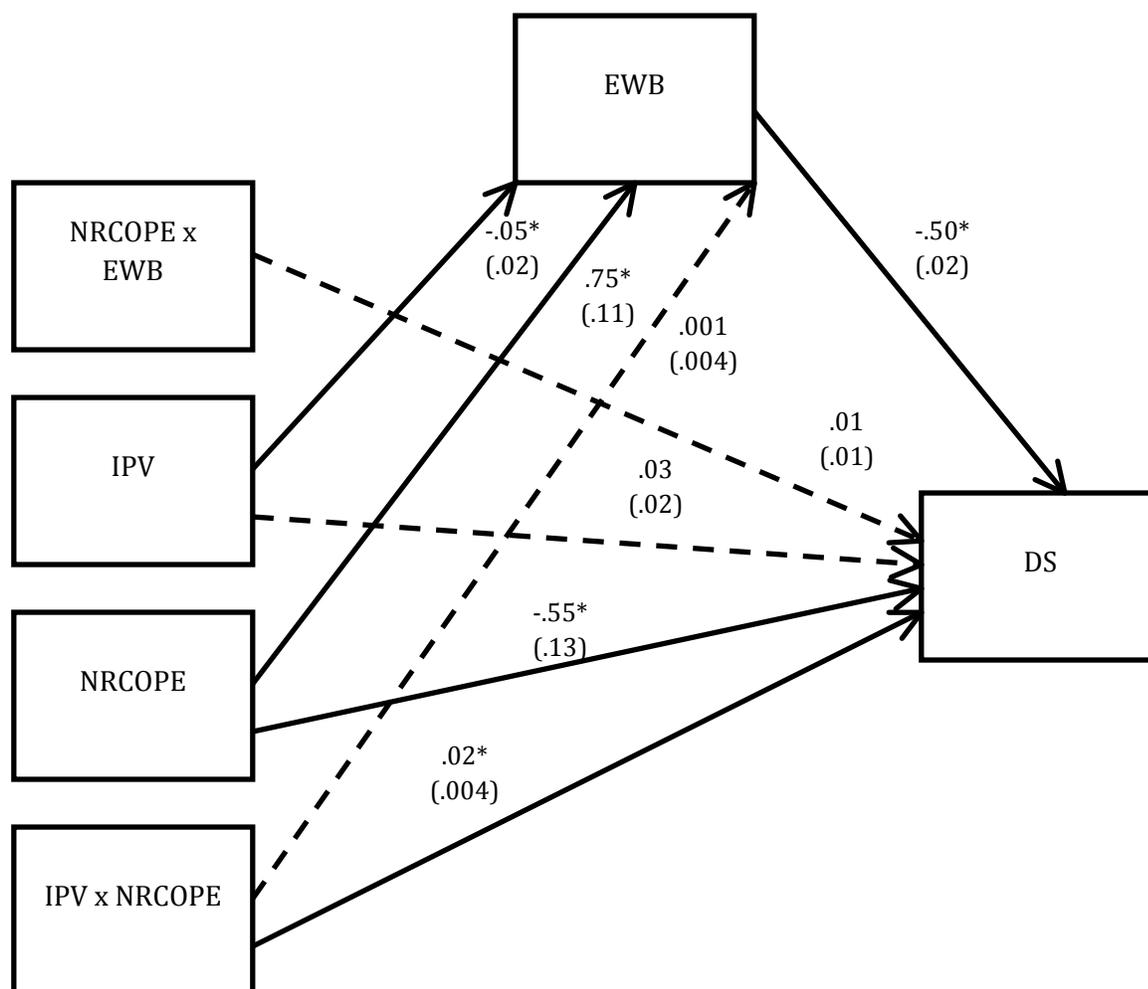
*p<.05
Indirect effect (*ab* path)=.03* (.02), CI (95%;.02-.09) at Low NRCOPE
Indirect effect (*ab* path)=.02* (.01), CI (95%;.01-.05) at Mean NRCOPE
Indirect effect (*ab* path)=.02 (.01), CI (95%;.01-.00) at High NRCOPE

Figure 3.6 Moderated mediation results with existential well-being as a mediator of the IPV and DS link and NRCOPE as a moderator of the IPV-EWB and EWB-DS paths

Conditional indirect effect statistics that were computed at low, medium and high values of the moderator (NRCOPE M +/- 1SD) produced statistically significant results only at the mean and low levels of NRCOPE. At high levels of negative religious coping the indirect effect of IPV on DS through existential well-being (IPV-EWB pathway) became statistically non-significant. The indirect effect of IPV on DS through EWB decreased in size at higher levels of NRCOPE. The role of negative religious coping in this model was a complex one, as it had a large negative direct effect on DS, a small positive effect on DS through its interaction with IPV, and a very large positive main effect on EWB that in turn had a large negative main effect on DS. Thus at the end, higher levels of NRCOPE did not strengthen the indirect effect of IPV on DS through EWB but weakened it. In other words, existential well-being fully mediated the link between IPV and DS such that higher exposure to IPV led to lower levels of existential well-being, which in turn led to higher levels of depressive symptoms. This indirect effect of IPV on DS through existential well-being became weaker at higher levels of negative religious coping. Although negative religious coping, when combined with IPV, contributed to higher level of depressive symptoms, it also had beneficial impact by increasing existential well-being and reducing depressive symptoms.

4. DISCUSSION

This study is the first to investigate whether the indirect effect of IPV on depressive symptoms through spiritual well-being would change with the level of religious coping. This work contributes to filling the gap in the research by examining not only spiritual well-being, but also its component constructs of religious and existential well-being to explain mechanisms underlying the IPV-DS link. This study is the first, to my knowledge, to determine if positive and negative religious coping act as moderators of this link in a sample of low income, suicidal and abused African American women.

As hypothesized, existential well-being fully explained the effect of IPV on depressive symptoms in this sample (Hypothesis 1b in the mediation model and hypothesis 3a in the moderated mediation model). However, contrary to the hypothesis (3a), higher levels of negative religious coping were found to weaken the indirect effect of IPV on DS through existential well-being rather than strengthening it. None of the hypothesized models (1a, 1c, 2b, 3b, 3c, 3d) involving positive religious coping and religious well-being delivered statistically significant findings. Thus religious well-being did not mediate and positive religious coping did not moderate the relation between IPV and depressive symptoms.

An extensive literature review was conducted in an attempt to explain the current findings in light of the existing empirical evidence. Since there are no prior studies using a moderated mediation model to explore these constructs at the level of detail and complexity of the current study, it is difficult to compare the above findings to earlier research. One way to explain the confirmed hypotheses (1b and 3a) is that exposure to IPV leads to reduction in the survivor's satisfaction in life decreasing her existential well-being which in turn results in increase in depressive symptoms. These findings partially replicated the results of a study by

Mitchell and colleagues' (2006) that found that spiritual well-being as a composite variable mediated the IPV-DS link in a sample of abused and suicidal African American women with similar levels of suicidality, IPV and depressive symptoms. Since Mitchell and her colleagues (2006) did not separate the religious and existential components of spiritual well-being, it is difficult to compare their findings to the results of this study. The difference in the findings regarding the mediating effect of spiritual well-being may be due to Mitchell and colleagues' small sample size ($n = 65$) compared to this study sample ($n=208$).

Existential well-being as conceptualized in this study refers to the sense of satisfaction and purpose in life (Paloutzian & Ellison, 1982). The results of this study confirm earlier findings by Briggs and Shoffner (2006) who reported that the only significant contributing factor of spiritual well-being to depressive symptoms in a sample of predominantly African American men and women was meaning and purpose in life, such that participants with stronger sense of meaning and purpose in life had fewer depressive symptoms.

As hypothesized, negative religious coping moderated the link between IPV and depressive symptoms in both the simple moderation (2a) as well as the moderated mediation (3a) models. This means that the extent to which the women engaged in negative religious coping influenced the strength of the effect of IPV on depressive symptoms through existential well-being. Further analysis revealed that at high levels of negative religious coping, the association between IPV and depressive symptoms was weak, meaning that when women engaged heavily in negative religious coping they were highly depressed regardless of the extent of IPV they received. When women resorted to an average level of negative religious coping, the level of IPV they were exposed to was more strongly associated with the level of their depressive symptoms, such that more IPV led to higher levels of depressive symptoms. The relation

between IPV and depressive symptoms was negative and strongest when the participants engaged in relatively low levels of negative religious coping. The women who engaged less in negative religious coping had lower levels of depressive symptoms.

These findings complement earlier results from Fabricatore and colleagues (2004) study of 175 mostly European American undergraduate students. The authors found that collaborative religious coping, which is a type of positive religious coping that refers to collaborating with God to deal with stressors, did not moderate the effect of the stressors on mental health outcomes. In contrast, deferring religious coping, which means deferring to God to solve one's problems, and is somewhat parallel with the negative religious coping concept utilized in this study, had a negative moderating effect on the relationship between the stressors and mental health outcomes. These findings contradict the results of Lee's (2007) study of 127 mostly Caucasian students that found that religious coping measured by the RCOPE buffered the impact of stress on depressive symptoms. The divergence with Lee's (2007) findings might be attributable to his use of the RCOPE as a composite measure, as opposed to investigating positive and negative religious coping separately. Lee (2007) did not specify if and how he addressed the potential opposite effect of positive versus negative religious coping on mental health outcomes based on the earlier empirical evidence (Pargament, 1997).

The unexpected buffering effect of negative religious coping against depressive symptoms both directly as well as through enhancing existential well-being which in turn reduced depressive symptoms suggests that negative religious coping is not all harmful. It appears that even negative religious coping contributes to enhancing one's sense of meaning and purpose in life and can help reduce depressive symptoms following exposure to IPV. The items in the NRCOPE instrument essentially describe the struggle of theodicy, which refers to attempts

to reconcile the notion of an omniscient, omnipotent and omnibenevolent God with the existence of violence and injustice in the world. Blumenthal (1993) suggested that it is legitimate for the survivors of both child abuse and Holocaust to "worship God through protest". For justification, Blumenthal cited the Biblical story of Job who questioned God's justice in the face of suffering but did not waiver in his loyalty to Him and was subsequently rewarded. Furthermore, existential psychologists and theologians (May, 1995; Tillich, 2000; Fowler, 1981) argued that grappling with spiritual and existential doubts, especially in the face of injustice, is healthy and a potentially growth inducing aspect of being human.

Using attachment theory, the findings suggest that the exposure to IPV heightens the survivor's insecure attachment and has a detrimental impact on her self-image. This, in turn, leads to her losing her sense of purpose in life and decreases her overall existential well-being, resulting in higher levels of depressive symptoms. The women in this sample who were exposed to violence from their intimate partner, may have projected their insecure attachment style into their relationship with God, and as a result, engaged in high levels of negative religious coping.

Through the prism of the cognitive theory, the findings imply that the exposure to IPV leads the survivor to have negative self-image and distorted beliefs about the intimate relationships and the world, resulting in decreased existential well-being and subsequent increase in depressive symptoms. Her distorted self-cognitions and negative beliefs are likely to cause her to engage in negative religious coping.

4.1 Limitations

The study aimed to investigate culturally important variables in a sample of underprivileged African American women from a historically underrepresented population. Given that the sample had very specific characteristics (suicidal, with high level of depressive

symptoms, exposed to IPV, and low-income), the results of this study may not apply to general population, or even a population of African American women with different characteristics (Watlington & Murphy, 2006; Arnette et al., 2007). The majority of participants identified themselves as Christian, which may limit the generalizability of the findings to non-Christian populations.

The analysis involved cross-sectional data, which did not allow confirmation of causal directions between the variables. The causality between the variables in this study was based on the review of prior longitudinal research which suggested that low levels of spiritual well-being and negative religious coping lead to depressive symptoms and psychological distress (Dew et al., 2010; Pirutinsky et al., 2011; Pargament et al., 2004). Although no empirical evidence was found to suggest this, it is a plausible speculation that depressive symptoms may cause negative religious coping and decrease in spiritual well-being or that the causality between these constructs is bidirectional. Longitudinal studies would be necessary to test the directional causality of these variables.

The data in this study were from retrospective self-reports, which introduced potential response bias due to memory. The majority of participants endorsed high levels of positive religious coping and high levels of religious well-being which contradicts prior empirical evidence given the severity of their depressive symptoms and high levels of exposure to IPV (Arnette et. al., 2007; Smith, McCullough, & Poll, 2003; Ano & Vasconcelles, 2005). More real time data, such as daily reports or diaries, as well as having collateral respondents, e.g. family and church community would enhance the validity of the data.

Since the majority of the participants endorsed high levels of positive religious coping and religious well-being this resulted in low variability. At least, in case of religious well-being

this might have been due to the design flaw in the SWBS that results in ceiling effects, especially among Christian respondents (Genia, 2001). Although statistical transformations were conducted to ensure that the criteria for normal distribution were met, it would be beneficial to validate these results with a larger sample with more normal distribution along these two variables. In the meantime, it is advisable to consider the findings that positive religious coping is not a significant moderator and religious well-being is not a significant mediator in the IPV-depressive symptoms link, with caution. The wealth of empirical evidence about the vital role of religious well-being and religious coping for African American women (El-Khoury et al., 2004; Cooper et al., 2003; Fallot & Heckman, 2005) suggests that this study was limited due to the relative homogeneity of the sample variance with regards to these two variables.

4.2 Implications

Despite the limitations of this study there are many implications for policy and clinical practice. The results of the mediational models suggest that the primary prevention efforts to address depressive symptoms among African American female survivors of IPV should focus on reducing their exposure to IPV. Secondary prevention initiatives should incorporate interventions designed to increase their existential well-being, which includes helping the survivors to create a vision for brighter future and purpose in life, and sense of happiness and contentment in their lives. Tertiary interventions would focus on reducing depressive symptoms once they have already manifested following the IPV exposure and reduction in existential well-being.

Existential well-being fully mediated the link between IPV and depressive symptoms which highlights the importance of addressing a person's sense of meaning and purpose in life. This confirms that it is the post-violence narrative that determines the impact of that event on the person's well-being. This finding points to the importance of addressing the patient's meaning-

making after their exposure to violence. This might be accomplished through variety of clinical interventions such as narrative therapy, cognitive restructuring, and existential approaches.

The finding that the IPV-DS link is weakened at higher levels of negative religious coping implies that the higher the level of negative religious coping, the more important it is to address the negative religious coping as well as IPV in therapy and prevention efforts against depressive symptoms. Furthermore, statistically significant, albeit small interaction effect of IPV and negative religious coping on depressive symptoms implies that addressing negative religious coping is particularly important for people who have been exposed to intimate partner violence. Therefore, it is important to include in-depth questions about the IPV survivor's nature of religious coping and spirituality at intake and assessment so that negative religious coping can be appropriately addressed in interventions.

Clinical assessments and interventions need to be sufficiently nuanced to differentiate the maladaptive dimensions of negative religious coping from aspects that constitute a normal part of existential struggle and may ultimately be beneficial (May, 1995). For instance, wondering what she did for God to punish her, or feeling punished by God for lack of devotion (NRCOPE items) may result in self-reflection that may lead to corrective action and growth. Accepting responsibility in women who were abused was associated with depressive symptoms suggesting that abused women blame themselves when they are abused which in turn may cause depressive symptoms (Mitchell et al., 2006). "Decided the devil made this happen" (Item 13, Brief RCOPE) may provide an explanation that shifts the blame from self or the partner, reducing the burden of guilt and hurt.

The findings of this study highlight the need for mental health professionals to address spiritual well-being and religious coping in their work with African American women. A survey

showed that American psychotherapists are predominantly Atheist, while their client base identifies with religious and spiritual beliefs (Delaney, Miller, & Bisono, 2007). Evidence suggests that psychotherapists do not address spirituality with their clients due to discomfort, lack of training, or simply seeing spiritual issues as being beyond the domain of psychotherapy (Delaney et al., 2007). These reports are not surprising considering survey findings that only 18% of the graduate programs in counseling psychology offered a course focused on religion or spirituality (Schulte, Skinner, & Claiborn, 2002) and only 13% of clinical psychology programs in the U.S. and Canada indicated that their curricula included a religion or spirituality course (Brawer, Handal, Fabricatore, Roberts, & Wajda-Johnston, 2002).

Some psychotherapists when faced with clients' spiritual concerns refer them to religious leaders who may not be trained to address IPV and mental health or who may not be able to see the client at sufficient frequency (Worthington & Aten, 2009, Coyle & Lochner, 2011; Crossley & Salters, 2005). Meanwhile, addressing spiritual well-being was found to lead to better therapeutic outcomes and overall satisfaction with life for the client (Koenig, 2001). However, clients for whom spiritual issues are central in their lives were concerned about turning to secular mental health professionals (Mayers et al., 2007). These studies suggest that the needs of potential and existing clients for whom spirituality matters and who may be engaging in negative religious coping are not being met by mental health professionals.

African Americans in general, and African American women in particular, use mental health services to lesser extent than Caucasians (US DHHS, 2001, Matthews & Hughes, 2001). African American women reported more negative impressions after interacting with mental health professionals and a reduced desire to use these services in the future, compared to Caucasian women (Diala et al., 2000). Multiple factors such as economic disparity, racism,

cultural stigmas associated with mental illness and IPV, distrust of Caucasian-dominated health care system, cultural value on self-reliance, as exemplified by the "Strong Black Woman" concept (Thompson-Sanders et al., 2004), and lack of culturally competent services appear to influence this trend (Conner et al., 2010; El-Khoury et al., 2004; Hollar, 2001; Ward & Heidrich, 2009; Nicolaidis et al., 2010). African American female survivors of IPV, in particular, were found to be more likely to use prayer as a coping strategy and less likely to seek help from mental health professionals than Caucasian women (El-Khoury et al., 2004; Cooper et al., 2003). Given these factors, it is all the more vital that mental health professionals make efforts to address African American IPV survivors' spiritual and existential concerns, particularly negative religious coping, in psychotherapy.

There is growing literature in psychology highlighting the importance of addressing spiritual issues in psychotherapy, including with African American women. These sources suggest that it is advisable to incorporate questions about spirituality and religious coping at the intake, in assessment and therapy (Arnette et al. 2007; Coyle & Lochner, 2011). Beach and colleagues (2011) examined the efficacy of a culturally sensitive relationship enhancement program enhanced with a focus on prayer on a sample of 393 African American married couples, and found that it produced superior outcomes for wives compared to the culturally adapted version without the prayer component and the control condition. A meta-analysis of 46 studies (N=3,290) concluded that patients in religious and spirituality therapies showed greater improvement than those in alternate secular psychotherapies both on psychological (d=.26) and spiritual (d=.41) outcomes. Incorporation of religious and spiritual components should be based on the desires of the client and although there is little evidence to date, it may be more suitable for persons who report high levels of spiritual and/or religious commitment (Worthington et al.,

2011). It is advisable to meet the client where she is and gently challenge some of the maladaptive religious coping patterns from within her own spiritual framework. An example would be using Biblical stories (e.g. Job) to discuss emotions and thoughts associated with negative religious coping when working with Christian clients.

Research on attachment theory (Granqvist & Kirkpatrick, 2008; Kirkpatrick & Shaver, 1992) suggests that women engaging in negative religious coping may be replicating their insecure attachments in human relationships in their relationship with God. This implies that addressing clients' attachment style to God in psychotherapy may be a helpful way to start challenging patterns of negative religious coping. Cognitive restructuring interventions may also be useful in "chipping away" at distorted and negative cognitions in religious coping, such as beliefs that God has abandoned them or was punishing them.

Wittink and colleagues (2008) qualitative study of older African Americans' perceptions of spirituality, religious activities, and depressive symptoms highlighted the need to address spirituality in depression care with African American clients. Williams and Wiggins (2010) suggested that including spiritual practice and traditions in psychotherapy would constitute a culturally competent approach in mental health interventions with African American women. Specifically, culturally competent interventions with this population incorporated gospels and spirituals (Frame et al., 1999), dance (Williams & Wiggins, 2010), and art (Alexander & Sussman, 1995).

4.3 Future Directions

The current study revealed the complexity of the role of negative religious coping in the IPV-DS association, which included both beneficial and harmful effects. This implies that it is too simplistic to consider negative religious coping as having purely deleterious effect on

existential well-being and depressive symptoms. These findings highlight the need for further exploration of this construct using both qualitative and quantitative methods especially with this understudied population. The relationship of negative religious coping to attachment styles with God and cognitive distortions in particular may provide important empirical evidence and/or theoretical frameworks that could inform effective interventions by mental health professionals to address negative impact of religious coping.

This study as well as Arnette and colleagues' research (2007) found that existential well-being and religious well-being are distinct phenomena that have different relations with spiritual well-being, IPV and depressive symptoms. Therefore, it is advisable for future research to investigate these constructs separately rather than combining them as spiritual well-being. This study also suggests that positive and negative religious coping are distinct constructs and should be studied separately rather than as a composite variable.

The results of the current study and the mixed findings of the studies involving spirituality and religious coping point to the need for further exploration of these concepts as they pertain specifically to African American women. Although this study confirmed earlier research showing the link between existential well-being and religious coping, much of the variance in existential and religious well-being was unexplained by religious coping (Arnette et al., 2007), which suggests that further studies are needed to explore the relationship between these variables, as well as any additional factors that may influence existential and religious well-being. For instance, in a similar sample of underprivileged, low-income, abused, and suicidal African American women, income and relationship status were found to have negative effect on existential well-being (Arnette et al., 2007).

Although this study used the most reputable standardized measures to assess culturally

relevant constructs, the appropriateness of the SWBS and Brief RCOPE for this population is still in question (Utsey, 2005). Both of these instruments and the constructs they measure were developed on primarily European American samples. Based on her literature review on African American spirituality, Lewis (2008) argued that SWBS captures only the relational aspect of African American spirituality, i.e. developing personal relationships with God, others, and self. She critiqued the SWBS for failing to capture the other two important dimensions of African American spirituality that pertain to empowering transformation and liberating consolation (Lewis, 2008). It is recommended that future research begin with open-ended qualitative research to minimize bias from preexisting ideas developed with other populations. Such culturally grounded qualitative analysis could form the basis for the development and standardization of more culturally tailored quantitative measurements.

A study conducted by Samples and colleagues' (2011) found that the race of the interviewer has an effect on the disclosure of African American female participants. The study was conducted with a sample similar to the current one, and found a significant difference on the interviewees' reports of daily hassles and intimate partner violence to African American and European American evaluators. With regard to overall life stress, African American women reported higher levels of total life stress, time pressure stress, social acceptability stress, and social victimization to African American than to European American interviewers. They also endorsed higher levels of both physical and nonphysical intimate partner violence to interviewers of the same race as themselves as compared to interviewers from a different racial background. There were no group differences in terms of work stress, social-cultural differences, and finances. These data suggest that the IPV rates reported in the current study may underestimate the true scope. However, although the number of reports of IPV may be biased, relationships

among variables will probably not be duly effected.

Excessive negative religious coping may indicate immature faith conception. Fowler (1981) proposed 6 stages of faith development starting from 1) Intuitive-Projective, 2) Mythic-Literal, 3) Synthetic-Conventional, 4) Individuative-Reflective, 5) Conjunctive, and culminating with 6) Universalizing. Resorting to high levels of negative religious coping would imply grappling at the mythic-literal stage during which people are preoccupied with reciprocity and have a rigid understanding of spiritual and moral principles. As an individual struggles to reconcile what seems irreconcilable by becoming increasingly more reflective, flexible and broader in her perspective, she develops her ability to create life enhancing meaning and progresses towards higher stages of faith development, which would correspond to lower levels of negative religious coping. In the final universalizing stage of faith development, a person feels at one with God and with others, including people with beliefs that differ from hers. Research to explore how religious coping in general, and particularly negative religious coping, relate to the stages of faith development may shed light on mechanisms that could inform future clinical interventions.

4.4 Conclusion

The purpose of this study was to investigate whether the indirect effect of IPV on depressive symptoms through spiritual well-being would change with the level of religious coping in a sample of low income, suicidal and abused African American women. A moderated mediation analysis revealed that only existential well-being, a subcomponent of spiritual well-being, mediated the link between IPV and DS, such that higher levels of IPV led to lower levels of existential well-being resulting in more severe depressive symptoms. This indirect effect of IPV on DS through existential well-being was stronger at higher levels of negative religious

coping. Although the overall moderation effect of negative religious coping was associated with more severe depressive symptoms, surprisingly, negative religious coping also had positive effect on existential well-being. These findings highlight the importance of addressing spirituality, existential well-being and religious coping styles with African American female clients, particularly following the experiences of IPV.

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APPENDIX

Measures

Brief RCOPE

These items deal with ways you've been coping with the stress in your life. There are many ways to try to deal with problems. These items ask what you've been doing to cope with this one. Obviously, different people deal with things in different ways, but I'm interested in how you've tried to deal with it. Each item says something about a particular way of coping. I want to know **to what extent** you've been doing what the item says. How **much** or how **frequently**. Don't answer on the basis of whether it seems to be **working** or not–just whether or not you're doing it. Use these response choices. to rate each item separately in your mind from the others. Make your answers as FOR YOU as you can.

> 0 = Not at all
> 1 = Somewhat
> 2 = Quite a bit
> 3 = A great deal

_____1.   Looked for a stronger connection with God.

_____2.   Sought God's love and care.

_____3.   Sought help from God in letting go my anger.

_____4.   Tried to put my plans into action with God.

_____5.   Tried to see how God might be trying to strengthen me in the situation.

_____6.   Asked forgiveness for my sins.

_____7.   Focused on religion to stop worrying about my problems.

_____8.   Wondered whether God has abandoned me.

_____9.   Felt punished by God for my lack of devotion.

_____10.   Wondered what I did for God to punish me.

_____11.   Questioned God's love for me.

_____12.   Wondered whether my church had abandoned me.

_____13.   Decided the devil made this happen.

_____14.   Questioned the power of God.

Beck Depression Inventory-II   (BDI-II)

This questionnaire consists of 21 groups of statements. Please listen to each group of statements carefully, and then pick the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. If several statements in the group seem to apply equally well, choose the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 or 18.

1.   Sadness
   0   I do not feel sad.
   1   I feel sad much of the time.
   2   I am sad all of the time.
   3   I am so sad or unhappy that I can't stand it.

2.   Pessimism
   0   I am not discouraged about my future.
   1   I feel more discouraged about my future than I used to be.
   2   I do not expect things to work out for me.
   3   I feel my future is hopeless and will only get worse.

3.   Past Failure
   0   I do not feel like a failure.
   1   I have failed more than I should have.
   2   As I look back, I see a lot of failure.
   3   I feel I am a total failure as a person.

4.   Loss of Pleasure
   0   I get as much pleasure as I ever did from the things that I enjoy.
   1   I don't enjoy things as much as I used to.
   2   I get very little pleasure from the things I used to enjoy.
   3   I can't get any pleasure from the things I used to enjoy.

5.   Guilty Feelings
   0   I don't feel particularly guilty.
   1   I feel guilty over many things that I have done or should have done.
   2   I feel quite guilty most of the time.
   3   I feel guilty all of the time.

6.	Punishment Feelings
   0	I don't feel I am being punished.
   1	I feel I may be punished.
   2	I expect to be punished.
   3	I feel I am being punished.

7.	Self-Dislike
   0	I feel the same about myself as ever.
   1	I have lost confidence in myself.
   2	I am disappointed (unhappy) with myself.
   3	I dislike myself.

8.	Self-Criticalness
   0	I don't criticize or blame myself more than usual.
   1	I am more critical of (find more fault with) myself than I used to be.
   2	I criticize myself (blame) myself for all my faults.
   3	I blame myself for everything bad that happens.

9.	Suicidal Thoughts or Wishes
   0	I don't have any thoughts of killing myself.
   1	I have thoughts of killing myself, but I would not carry them out.
   2	I would like to kill myself.
   3	I would like to kill myself if I had the chance.

10.	Crying
   0	I don't cry anymore than I used to.
   1	I cry more than I used to.
   2	I cry over every little thing.
   3	I feel like crying, but I can't.

11.	Agitation
   0	I am no more restless or wound up than usual.
   1	I feel more restless or wound up than usual.
   2	I am so restless or agitated it's hard to stay still.
   3	I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest
    0   I have not lost interest in other people or activities.
    1   I am less interested in other people or things than before.
    2   I have lost most of my interest in other people or things.
    3   It's hard to get interested in anything.

13. Indecisiveness
    0   I make decisions about as well as ever.
    1   I find it more difficult to make decisions than usual.
    2   I have much greater difficulty in making decisions than I used to.
    3   I have trouble making any decisions.

14. Worthlessness
    0   I do not feel I am worthless (good-for-nothing).
    1   I don't consider myself as worthwhile and useful as I used to.
    2   I feel more worthless (good-for-nothing) as compared to other people.
    3   I feel utterly worthless (totally good-for-nothing)

15. Loss of Energy
    0   I have as much energy as ever.
    1   I have less energy than I used to have.
    2   I don't have enough energy to do very much.
    3   I don't have enough energy to do anything.

16. Changes in Sleeping Patterns
    0   I have not experienced any change in my sleeping pattern.
    1a   I sleep somewhat more than usual.
    1b   I sleep somewhat less than usual.
    2a   I sleep a lot more than usual.
    2b   I sleep a lot less than usual.
    3a   I sleep most of the day.
    3b   I wake up 1-2 hours early and can't get back to sleep.

17. Irritability
    0   I am no more irritable (cranky) than usual.
    1   I am more irritable (cranky) than usual.
    2   I am much more irritable (cranky) than usual.
    3   I am irritable (cranky) all the time.

18. Changes in Appetite
    - 0   I have not experienced any change in my appetite.
    - 1a   My appetite is somewhat less than usual.
    - 1b   My appetite is somewhat greater than usual.
    - 2a   My appetite is much less than usual.
    - 2b   My appetite is much more than usual.
    - 3a   I have no appetite at all.
    - 3b   I crave (want) food all the time.

19. Concentration Difficulty
    - 0   I can concentrate (pay attention) as well as ever.
    - 1   I can't concentrate (pay attention) as well as usual.
    - 2   It's hard to keep my mind on anything for very long.
    - 3   I find I can't concentrate (pay attention) to anything.

20. Tiredness or Fatigue
    - 0   I am no more tired or fatigued than usual.
    - 1   I get more tired or fatigued more easily than usual.
    - 2   I am too tired or fatigued to do a lot of the things I used to do.
    - 3   I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex
    - 0   I have not noticed any recent change in my interest in sex.
    - 1   I am less interested in sex than I used to be.
    - 2   I am much less interested in sex now.
    - 3   I have lost interest in sex completely.

Spiritual Well-Being Scale (SWBS)

For each of the following statements circle the choice that best indicates the extent of your agreement or disagreement as it describes your personal experience.

1 = Strongly Agree
2 = Moderately Agree
3 = Agree
4 = Disagree
5 = Moderately Disagree
6 = Strongly Disagree

1 2 3 4 5 6	1. I don't find much satisfaction in private prayer with God.
1 2 3 4 5 6	2. I don't know who I am, where I came from, or, where I am going.
1 2 3 4 5 6	3. I believe that God loves me and cares about me.
1 2 3 4 5 6	4. I feel that life is a positive experience.
1 2 3 4 5 6	5. I believe that God is impersonal and not interested in my daily situations.
1 2 3 4 5 6	6. I feel unsettled about my future.
1 2 3 4 5 6	7. I have a personally meaningful relationship with God.
1 2 3 4 5 6	8. I feel very fulfilled and satisfied with life.
1 2 3 4 5 6	9. I don't get much personal strength and support from my God.
1 2 3 4 5 6	10. I feel a sense of well being about the direction my life is headed in.
1 2 3 4 5 6	11. I believe that God is concerned (cares) about my problems.
1 2 3 4 5 6	12. I don't enjoy much about my life.
1 2 3 4 5 6	13. I don't have a personally satisfying relationship with God.
1 2 3 4 5 6	14. I feel good about my future.
1 2 3 4 5 6	15. My relationship with God helps me not to feel lonely.
1 2 3 4 5 6	16. I feel that life is full of conflict (problems) and unhappiness.
1 2 3 4 5 6	17. I feel most fulfilled when I am in close communication with God.
1 2 3 4 5 6	18. Life doesn't have much meaning.
1 2 3 4 5 6	19. My relationship with God contributes to my sense of well-being.
1 2 3 4 5 6	20. I believe there is some real purpose for my life.

INDEX OF SPOUSE ABUSE (ISA)

Please answer questions for: _____Current Partner
_____Partner within last year

This questionnaire is designed to measure the degree of abuse you have experienced in your relationship with your partner. It is not a test, so there are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

1   Never
2   Rarely
3   Occasionally
4   Frequently
5   Very Frequently

_____   1.   My partner belittles me (makes me feel small).
_____   2.   My partner demands obedience to his/her whims (demands that I do everything that he or she says).
_____   3.   My partner becomes surly (rude, mean) and angry if I tell him/her that he/she is drinking too much.
_____   4.   My partner makes me perform sex acts that I do not enjoy or like.
_____   5.   My partner becomes very upset if dinner, housework or laundry is not done when he/she thinks it should be.
_____   6.   My partner is jealous and suspicious of my friends.
_____   7.   My partner punches me with his/her fists.
_____   8.   My partner tells me I am ugly and unattractive.
_____   9.   My partner tells me I really couldn't manage or take care of myself without him/her.
_____   10. My partner acts like I am his/her personal servant.
_____   11. My partner insults or shames me in front of others.
_____   12. My partner becomes very angry if I disagree with his/her point of view.
_____   13. My partner threatens me with a weapon.
_____   14. My partner is stingy in giving me enough money to run our home.
_____   15. My partner belittles me intellectually (makes me feel like I'm not smart).
_____   16. My partner demands that I stay home to take care of the children.
_____   17. My partner beats me so badly that I must seek (get) medical help.
_____   18. My partner feels that I should not work or go to school.
_____   19. My partner is not a kind person.
_____   20. My partner does not want me to socialize (get together) with my friends.
_____   21. My partner demands sex whether I want it or not.
_____   22. My partner screams and yells at me.
_____   23. My partner slaps me around my face and head.
_____   24. My partner becomes abusive (is mean or mistreats me) when he/she drinks.
_____   25. My partner orders me around.
_____   26. My partner has no respect for my feelings.
_____   27. My partner acts like a bully towards me.
_____   28. My partner frightens me.
_____   29. My partner treats me like a dunce (like I'm stupid).
_____   30. My partner acts like he/she would like to kill me.