The Roles of Religion and Spirituality Among African American Survivors of Domestic Violence

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The investigation examined religious involvement, spirituality, religious coping, and social support as correlates of posttraumatic stress symptoms and depression symptoms in African American survivors of domestic violence. Sixty-five African American women who experienced domestic violence in the past year provided data on demographics, severity and frequency of physical and psychological abuse during the past year, aspects of current social support, types of current coping activities, religious involvement, spiritual experiences, and symptoms related to depression and posttraumatic stress disorder. Women who evinced higher levels of spirituality and greater religious involvement reported fewer depression symptoms. Religious involvement was also found to be negatively associated with posttraumatic stress symptoms. Women who reported higher levels of spirituality reported utilizing higher levels of religious coping strategies, and women who reported higher levels of religious involvement reported higher levels of social support. Results did not support hypotheses regarding social support and religious coping as mediators of the associations between mental health variables, religious involvement, and spirituality. © 2006 Wiley Periodicals, Inc. J Clin Psychol 62: 837–857, 2006.

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Although domestic violence affects women of all racial and socioeconomic backgrounds, the intersection of gender, race, and socioeconomic status place African American women at an increased risk for experiencing violence from an intimate partner (Campbell & Gary, 1998; Negg, Halaman, & Schultzer, 1995; Rennison & Welchans, 2000). Between 1993 and 1998, African American women were victimized by intimate partners at a significantly higher rate than persons of any other race (Rennison & Welchans, 2000). Further, statistics have indicated that among African American women between the ages of 15 and 34, homicide by an intimate partner is the leading cause of death (Office of

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Justice Programs, 1998). Indeed, studies have shown that African American women are more likely than their European American counterparts are to sustain serious and lethal injuries because of the violence they endure from an intimate partner (Fagan, 1996; Hampton & Yung, 1996). Therefore, domestic violence has been identified by the The National Black Women's Health Project as the number one health issue for African American women (Joseph, 1997).

The negative psychological sequelae associated with domestic violence include depression, anxiety, posttraumatic stress disorder (PTSD), substance abuse, and suicide ideations and actions (e.g., Cunradi, Caetano, Clark & Shafer, 1999; Hampton & Gelles, 1994). Research suggests that rates of depression, suicide attempts, psychosomatic symptoms, and stress are 4 times greater among women who are victims of domestic violence as compared to nonvictims (Stets & Straus, 1990). Although less is known about the mental health effect of domestic violence on African American women, Campbell and Soeken (1999) found that depression symptoms lasted beyond the abuse for African American women, but not for non-African American women. Further, Campbell and Belknap (1997) found a significant association between depression and domestic violence in a predominantly (76.6%) African American sample.

Over the past two decades, a growing body of research has attempted to identify various strategies women employ to protect themselves from the devastating impact of domestic violence on their mental and physical health. Despite the need for greater inclusion of ethnically diverse samples in studies of domestic violence (e.g., Wyatt et al., 2000), the research examining coping strategies that may be potentially relevant to African American women is scarce. Although a number of various coping strategies have been highlighted in the empirical literature (i.e., emotion-focused coping, problem-focused coping), very little is known about how particular cultural variables are associated with mental health outcomes.

The use of religion and spirituality has been repeatedly documented as a traditional means of coping in the African American community (e.g., Hill, Hawkins, Raposa, & Carr, 1995). Throughout much of American history, religious institutions have occupied an important position in the African American community and studies have reported that a majority of African Americans are affiliated with a religious denomination (e.g., Taylor et al., 2000). The overarching role of religion in the lives of African Americans can be linked to religion being a vehicle to speak to issues of oppression, quest for liberation, love, hope, and justice (Anderson & Black, 1995). According to Moore (1991), the church is a forum to promote a sense of community, provide positive role models, and provide an outlet for shared experiences into a new identity.

Religion plays a particularly important role in the lives of African American women. African American women tend to be socialized into the church at a younger age than African American men, scoring higher on measures of religious salience than their male counterparts (Taylor & Chatters, 1991). Further, African American women have been found to be more likely to use prayer to cope with obstacles than have African American men (Neighbors, Jackson, Bowman, & Gurin, 1983).

Research has indicated that African Americans are generally more religious than European Americans, regarding religion as more personally important and attending religious services more often than their respective counterparts do (Ellison, 1998; Gallup, 1984). Consequently, this would suggest that the examination of religious variables is particularly critical for African American women, as they tend to rely on these means of coping more than traditional mental health services (Myers, 1987).

A few studies have begun to examine the association between intrinsic religiosity (i.e., a personal sense of the importance of spirituality and religion) and mental health

outcomes among victims of domestic violence. For instance, Astin, Lawrence, and Foy (1993) examined the impact of intrinsic religiosity (as measured by a single item) on PTSD symptomatology among a sample of abused women. Although intrinsic religiosity was found to be negatively correlated with one measure of PTSD (i.e., the Impact of Events Scale) such that those high in intrinsic religiosity reported lower levels of PTSD, it was positively correlated with another measure of PTSD (i.e., the PTSD symptoms checklist). Sullivan (1993) measured intrinsic religiosity to determine its impact on PTSD symptoms in abused women and found that intrinsic religiosity was related to lower levels of PTSD symptomatology. Coker et al. (2002) used a two-item religiosity index in their study of battered women that included: (a) "what religion or spirituality offers most is comfort in times of trouble and sorrow," and (b) "your whole approach to life is based on your religion." It was found that higher levels of religiosity were not associated with a reduction in risk of negative mental health outcomes; however, the two-item measure renders these results inconclusive because the measure may not be as reliable when used with small samples.

Although the examination of the association between religious variables and mental health outcomes among a domestic violence sample is still in its infancy, the extant literature on religious coping demonstrates that religious variables are related to less depression, anxiety, and hostility (e.g., Koenig & Larson, 2001; Pargament, 1997, 2002; Schnittker, 2001). It is this evidence that has raised questions about the underlying mechanisms linking these variables to better mental health outcomes. For instance, it has been suggested that social support serves as a bridge between religious variables and mental health outcomes (e.g., Aneshensel, 1992). Further, others have argued that religious coping mediates the association between spirituality and mental health outcomes (e.g., Pargament, 1997). Yet, these mediation models have not been examined among victims of domestic violence, although there is at least some evidence to suggest that one of these models might be particularly relevant for an African American sample. For instance, Jang and Johnson (2004) found that African American women who were religious tended to have more social support from family and friends and tended to be less distressed than African American women who were not religious. Likewise, their model suggests that for African American women, the association between religious involvement and mental health outcomes can be at least partly explained by social support and sense of control.

The purpose of the present study was to extend the line of research on domestic violence in the lives of African American female victims of domestic violence by examining the association between two culturally relevant coping mechanisms—religious involvement and spirituality—and two mental health outcomes (i.e., depression and PTSD) among a sample of African American women who experienced domestic violence within one year prior to their participation in the study. It was hypothesized that religious involvement and spirituality would be negatively associated with two mental health outcomes: posttraumatic symptoms and depression symptoms (i.e., greater religious involvement and spirituality will be associated with fewer depressive and posttraumatic symptoms). It was also hypothesized that social support would mediate the association between religious involvement and the two mental health outcomes. Finally, it was hypothesized that religious coping would mediate the association between spirituality and the two mental health outcomes.

Method

Participants

Participants were 65 women of African descent recruited from domestic violence agencies in Maryland and Washington, DC between April, 2004 and May, 2005. All agencies

were comprehensive domestic violence agencies offering family psychotherapy, safe shelter, victim advocacy, community education, and crisis hotline counseling. The criteria for being accepted into the study included: (a) over 18 years of age, (b) of African descent, and (c) experienced physical abuse in the past 12 months.

Procedure

Authorization to collect data was obtained from the Institutional Review Board of the University of Maryland, Baltimore County. Domestic violence agencies within the Maryland and Washington DC metropolitan area were contacted to obtain permission to recruit women at their agencies. Of the six agencies contacted, five agencies agreed to participate in the study. Participants receiving counseling and shelter services were recruited at the end of group sessions or at times deemed appropriate by agency staff. At this time, the primary investigator explained the purpose of the study, and asked if they would be willing to participate in a study investigating women's responses to domestic violence. It was further explained that participating or refusing to participate was unrelated to, and would have no bearing on the services the women were receiving at the agency. Finally, participants were informed that they would be compensated $10 for their participation in the study. Potential participants then read the informed consent and decided whether to participate.

Partners of men receiving services for intimate partner violence were referred to the primary investigator by agency staff if they met study eligibility. The primary investigator contacted eligible participants by phone to explain the purpose of the study and answer any questions that the participant might have. Interested participants were sent the packet and the consent form. Participants were contacted by phone after the packet was received to further explain the consent form. Participants then signed the consent form, completed the packet, and mailed the materials to the primary investigator. Once the materials were received, the primary investigator sent the payment in the mail to the participant.

Measures

The questionnaire packet included questions regarding demographics, severity and frequency of physical and psychological abuse during the past year, aspects of current social support, types of current coping activities, types of services utilized, religious involvement, spiritual experiences, and symptoms related to depression and posttraumatic stress disorder.

Demographic questionnaire. Questions eliciting age, ethnicity, marital status, length and type of relationship with the current partner (i.e., the partner who recently assaulted the woman), employment status, educational status, religious affiliation, religious involvement, and income were used for describing the sample.

Physical and psychological aggression. The Revised Conflict Tactics Scale (CTS-2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996), the most widely used measure for assessing marital violence, was used to assess levels of physical assault, physical injury, sexual assault, and psychological aggression experienced by the female. The CTS-2 is a 78-item scale that asks about the relationship conflict behaviors of the respondent and the respondent's partner. Five subscales make up the CTS-2: Negotiation (5 items; e.g., "suggested a compromise to an argument"), Psychological Aggression (8 items; e.g., "called

partner fat or ugly"), Physical Assault (12 items; e.g., "kicked, bit, or punched partner'), Sexual Coercion (7 items; e.g., "used force to make partner have sex"), and Injury (6 items; e.g., "partner was cut or bleeding"). Although separate reliability or validity information has not been published for African Americans, the original version of the CTS has been used in national surveys that have included a substantial number of African American adults. Internal consistency for studies using an African American female sample has been found to be good. For example, Kocot and Goodman (2003) found the Cronbach's alpha for the physical assault subscale to be .94 in their sample of African American women. The subscales used for this study have been found to have good internal consistency (Psychological Aggression = .79; Physical Assault = .86; Sexual = .87; Injury = .95; Straus et al., 1996).

The physical aggression items from the CTS1 (Straus, 1979) were used to screen women for study eligibility.[1] Women were asked whether a significant other within the past year (a) threw something at her, (b) pushed grabbed or shoved her, (c) slapped her, (d) kicked, bit, or hit her with a fist, (e) hit or tried to hit her with something, (f) beat her up, (g) choked her, (h) threatened her with a knife or gun, or (i) used a knife or fired a gun. Only women who answered affirmatively to at least one of these eight questions met the physical violence criterion for the study. All women screened met study eligibility.

Social support. The Interpersonal Support Evaluation List (ISEL; Cohen, Mermelstein, Kamarack, & Hoberman, 1985) is a 40-item true–false instrument that measures the perceived availability of four social support resources: tangible support, self-esteem support, belonging support, and appraisal support. Each subscale consists of 10 items. The Tangible subscale measures perceived availability of material aid (e.g., "There is no one I could call on if I needed to borrow a car for a few hours"); the Appraisal subscale measures the perceived availability of someone to talk to about one's problems (e.g., "There is at least one person I know whose advice I really trust"); the Self-Esteem subscale measures the perceived availability of a positive comparison when comparing one's self with others (e.g., "Most of my friends are more interesting than I am"); and the Belonging subscale measures the perceived availability of people one can do things with (e.g., 'There are several different people with whom I enjoy spending time").

The ISEL was found to be moderately correlated (r = .46) with another validated measure of social support, the Inventory of Socially Supportive Behaviors (ISSB; Barrera, Sandler, & Ramsay, 1981). Demonstrating its discriminant validity, the ISEL was found not to be correlated significantly with a measure of social anxiety, the Social Anxiety and Distress Scale (SADS). Normed on samples of college students, the ISEL has been found to have good internal reliability with alpha coefficients ranging from .88 to .90 for the total scale. The internal reliability for the subscales has been found to be satisfactory: Appraisal (.77–.92), Self-Esteem (.60–.68), Belonging (.71–.74), and tangible support (.60–.68) (Cohen & Wils, 1985). The ISEL has been shown to have good internal consistency in a sample of African American women who were victims of abuse (alpha = .92; Kocot & Goodman, 2003). The ISEL was used in this study to measure overall social support. Total scores could range from 0 to 40, with higher scores indicating more support.

[1]The CTS1 items were chosen to screen for physical violence as opposed to the CTS2 items because it provides a briefer screening tool to assess physical violence than the 12 physical assault items of the CTS2. It was thought that these items were sufficient to select those women who had been victims of physical violence in the past year.

Religious coping. The Turning to Religion subscale of the COPE (Carver, Scheier, & Weintraub, 1989) is a four-item religious–spiritual coping subscale. Respondents were asked to indicate the extent to which they employed spiritually based coping when confronted with the abuse over the past year using a 4-point scale (1 = *I didn't do this at all*; 2 = *I did this a little bit*; 3 = *I did this a medium amount*; 4 = *I did this a lot*). Scores could range from 4 to 16. The subscale has been found to have high internal consistency ($r = .92$; Carver et al., 1989). Further, the subscale has been found to be associated with optimism ($r = .15$) and monitoring ($r = .20$)[2] among a sample of undergraduate students coping with stress (Carver et al., 1989).

Religious involvement. Religious involvement was assessed by combining two commonly used questions of religious attendance (Wingrove & Alston, 1974) with six questions from the Religious Background and Behavior Scale (RBB; Connors, Tonigan, & Miller, 1996). The two-item measure of religious attendance asks the following questions: (a) "How often do you attend religious services" using a 6-point scale ranging from 1 (*Never*) to 6 (*More than once a week*), and (b) "Besides religious services, how often do you take part in other activities at a place of worship" using a 9-point scale ranging from 1 (*Never*) to 9 (*Several times a week*). For the six items taken from the RBB, respondents are asked to indicate on an 8-point scale, the frequency with which they had engaged in the following behaviors during the past year: thought about God, prayed, meditated, attended worship services, read–studied scriptures-holy writings, and had direct experiences of God. Altogether, scores can range from 8 to 63. Attendance at religious services has not been tested for reliability and validity, but it has been studied for over 50 years in the Gallup Poll (Wingrove & Alston, 1974). The correlation coefficient in this study was .58 for the two-item measure and the alpha was .73 for the eight-item measure created for the study.

Spirituality. Spirituality was assessed using the Daily Spiritual Experiences Scale (DSE; Underwood & Teresi, 2002). The DSE is a 16-item scale that measures aspects of day-to-day spiritual experiences (e.g., "I feel God's presence," "I find strength in my spirituality," "I feel God's love for me through others"). The first 15 items are scored using a 6-point scale (i.e., 1 = *many times a day*, 2 = *every day*, 3 = *most days*, 4 = *some days*, 5 = *once in a while*, and 6 = *never or almost never*). The 16th item (i.e., In general, how close do you feel to God?) has four response categories: *not close at all, somewhat close, very close, as close as possible*. Originally, it was scored such that lower scores reflect more frequent daily spiritual experiences. However, for the sake of ease in interpreting the results, the measure was scored such that higher scores reflect higher daily spiritual experiences (i.e., 6 = *many times a day*, 5 = *every day*, 4 = *most days*, 3 = *some days*, 2 = *once in a while*, and 1 = *never or almost never*). Scores could range from 16 to 94. High internal consistency is reported for the scale, with alphas ranging from .94 to .95 (Underwood & Teresi, 2002).

Depression. The Beck Depression Inventory (BDI; Beck, Steer, & Garbin, 1988; Beck et al., 1961) was used to assess depressive symptoms. The BDI contains 21 items with scores ranging from 0 (*low depression*) to 3 (*maximum depression*) for each item. Total BDI scores between 14 and 20 are indicative of moderate depression, whereas

[2]Monitoring is seeking out information about one's situation and its potential impact. It is a subscale of the Miller Behavioral Style Scale (Miller, 1987).

scores above 21 suggest severe depression. The BDI has been found to have good reliability, with a split-half reliability coefficient of .86, and a test–retest reliability coefficient of .75 (Beck et al., 1988).

The concurrent validities for the BDI with respect to clinical ratings and the Hamilton Psychiatric Rating Scale for Depression (HRSD) are high. The mean correlations of the BDI samples with clinical ratings on the HRSD were .72 and .73, respectively, for psychiatric patients and .60 and .74, respectively, for nonpsychiatric patients (Beck et al., 1988). Concerning discriminant validity, the BDI was more highly correlated with scores on the depression subscale of the SCL-90 than on the anxiety subscale of the SCL-90 (Beck et al., 1988).

Posttraumatic stress disorder. The PTSD checklist (PCL; Weathers et al., 1993) is a 17-item self-report instrument based on the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (American Psychiatric Association, 1994) criteria for PTSD. Participants were asked to rate on a scale of 1 (*not at all*) to 5 (*extremely*) the extent to which they were bothered by each of the 17 items in the past month. Respondents in the study were asked to consider each symptom with respect to their experience of abuse. Scores could range from 17 to 85.

The PCL has demonstrated good internal consistency (coefficient alpha = .97) in a sample of 123 Vietnam veterans (Weathers et al., 1993). In a sample of 169 low-income, battered African American women the Cronbach's alpha for the PCL was .96 (Kocot & Goodman, 2003). Further, the PCL has demonstrated a test–retest reliability of .88 for participants with 1-week retest intervals, and concurrent validity with other PTSD scales such as the Mississippi Scale (.93; Weathers et al., 1993) and the Clinician Administered PTSD Scale (.93; Blanchard, Jones-Alexander, Buckley, & Forneris, 1996). In a sample of motor vehicle accident victims and sexual assault victims, the PCL yielded sensitivity of .94 and specificity of .83 and diagnostic efficiency of .94 with a cut-off score of 44 (Blanchard et al., 1996).

Data Analytic Procedure

A power analysis was conducted using G*Power to determine the appropriate sample size for detecting the upper limit of a medium effect size ($f^2 = .22$). Conventional effect sizes are as follows: small (.02), medium (.15), and large (.35). With five predictors in the multiple regression equation, 65 subjects were calculated as a sufficient number of subjects with power equal to .80, the conventional minimum for detecting significance (Cohen, 1977).

Prior to the analysis, all variables were examined for accuracy of data entry, missing values, and fit between their distributions and the assumptions of multivariate analyses. Demographic data were analyzed to allow comparisons with other studies. Correlations were conducted to determine the univariate relationships among predictor variables and outcome variables. Multiple regression analyses were conducted to test the unique contribution of independent variable to the prediction of the dependent variables. All multiple regression analyses controlled for personal income, physical assault, psychological aggression, and time since most recent physically abusive episode. Personal income and time since most recent physically abusive episode were treated as dichotomous variables for the multiple regression analyses. Personal income was coded 1 for *less than $10,000* and 2 for *more than $10,000*. Time since most recent physically abusive episode was coded 1 for *within the last 6 months* and 2 for *6–12 months ago*. All other variables were treated as continuous variables.

Results

Sample Description

Participants ranged in age from 18 to 52. All the participants were of African descent with most of the participants (73.8%) identifying as African American. The largest percentage of the participants identified as Baptist (46.2). Most of the women (75.4%) were recruited from shelter services. With regard to education, employment, and income, 56.9% of the participants received less than a college education, 61.6% reported being unemployed at the time of the study, and 54.7% of the participants reported a personal income of less than $10,000 in the past year. At the time of the study, approximately 30.8% of the participants reported that they were currently involved in a relationship with the abusive partner. In a separate question, approximately 21.6% of the participants reported having contact with the abusive partner at least once a month in the role of a couple. Approximately 63.5% of the women reported being separated from their partner for less than 6 months. With regard to the most recent episode of physical abuse, 13.8% reported physical abuse within the month of completing the study (see Table 1).

Physical Abuse Characteristics

As Table 2 depicts, participants reported relatively high levels of physical abuse exposure. The vast majority (84.6%) experienced at least one incident of severe physical abuse during the 12 months preceding their involvement in the study. About 53.2% of participants reported at least one incident of severe injury, and roughly 49.2% reported at least one incident of severe sexual violence.

Characteristics of Measures

Table 3 presents the descriptive univariate statistics for each variable measured in the study. Adequate internal consistency was found for all measures in the study. Further, mean scores were consistent with scores from previous studies using similar samples (e.g., Kocot & Goodman, 2003). With regard to current symptomatology, most of the study participants met screening criteria indicating diagnosable levels of PTSD and depression. Using the recommended screening cutoff of 44 for probable PTSD diagnosis, 47.7% of the current sample met criteria for PTSD.[3] Symptom scores on the BDI are classified in the following categories: minimal, 0–13; mild, 14–19; moderate, 20–28; and severe, 29–63. Twenty-one percent met criteria for moderate depression, 36.9% met criteria for severe depression, and the remaining scored below the cutoff for moderate depression.

Bivariate Relations Among Study Variables

Pearson correlations of all study variables are presented in Table 4. As illustrated in Table 4, several correlations were found among the main study variables.

[3] A limitation of this cutoff is that the total score of the PCL does not necessarily indicate endorsement of symptoms in a pattern that fits the *DSM-IV* criteria (endorsing 1 = re-experiencing items, 2 = arousal items, and 3 = avoidance items).

Table 1
Sociodemographic Characteristics

Variable	Number	% Sample (n = 65)
Mean age		
32.22 (*SD* = 7.45, range 18–52)	—	—
Ethnicity		
African	10	15.4
African American	48	73.8
Caribbean	4	6.2
Any other African background	3	4.6
Recruitment source		
Shelter	49	75.4
Outpatient group therapy	10	15.4
Victim outreach	6	9.2
Religious affiliation		
Baptist	30	46.2
Lutheran	2	3.1
Pentecostal	4	6.2
Holiness	3	4.6
Catholic	2	3.1
Muslim	2	3.1
AME	2	3.1
Methodist	2	3.1
Other	15	23.1
None	2	3.1
Educational status		
Did not finish high school	17	26.2
Did not finish high school but have a GED	11	16.9
High school diploma	9	13.8
Some college	18	27.7
Bachelor's degree	8	12.3
Graduate school	2	3.1
Employment status		
Fulltime	21	32.3
Part-time	4	6.2
Unemployed, worked within the past year	23	35.4
Unemployed, did not work in the past year	17	26.2
Personal income		
Less than $10,000	35	54.7
$10,001–$20,000	8	12.3
$20,001–$30,000	8	12.3
$30,001–$40,000	6	9.2
Over $40,000	7	10.7
Marital status		
Married and living together with partner	5	7.7
Married but not living together currently	23	35.4
Not married and living together with spouse	4	6.2
Never married	25	38.5
Divorced	7	10.8
Widowed	1	1.5
Relationship information		
Currently involved with abusive partner	20	30.8
Currently not involved with abusive partner	45	69.2

(*continued*)

Table 1
Continued

Variable	Number	% Sample ($n = 65$)
Contact		
Daily or almost every day	4	6.2
3–5 times per week	4	6.2
1–2 times per week	2	3.1
1–2 time per month	1	1.5
less than once a month	3	4.6
Never	11	16.9
Not applicable	38	58.5
Length of time separated		
Less than one week	4	6.2
1–2 weeks	10	15.4
3–4 weeks	8	12.3
1–2 months	9	13.8
3–4 months	8	12.3
5–6 months	1	1.5
7–9 months	7	10.8
10–12 months	4	6.2
More than 12 months	6	9.2
Not applicable	6	9.2
Time since most recent physical abusive episode		
Less than 1 week ago	5	7.7
1–2 weeks ago	12	18.5
3–4 weeks ago	9	13.8
1–2 months ago	16	24.6
3–4 months ago	3	4.6
5–6 months ago	3	4.6
7–9 months ago	8	12.3
10–12 months ago	9	13.8

Posttraumatic stress symptoms. Higher levels of exposure to physical assault ($r = .38$, $p < .01$) and psychological abuse ($r = .25$, $p < .05$) were related to higher levels of PTSD symptoms. Further, higher levels of religious involvement ($r = -25$, $p < .05$) and higher levels of social support ($r = -.59$, $p < .01$) were associated with lower levels of PTSD symptoms.

Table 2
Prevalence of Interpersonal Victimization in Past 12 Months

	Type of violence							
	Physical		Sexual		Injury		Psychological	
Level of violence	*n*	%	*n*	%	*n*	%	*n*	%
None	0	0	25	38.5	11	16.9	9	13.8
Minor	62	97	38	58.5	54	73.8	61	90.8
Severe	55	84.6	32	49.2	35	53.2	60	92.3

Table 3
Characteristics of Measures

Measure	*M*	*SD*	Range	Cronbach's α
CTS-2 Physical Assault Victimization	23.28	18.69	1–71	.93
CTS-2 Psychological Aggression	24.55	12.98	0–48	.88
CTS-2 Sexual Coercion	10.20	12.68	0–42	.92
CTS-2 Physical Assault Perpetration	6.11	10.00	0–47	.84
CTS-2 Injury	6.59	6.24	0–26	.76
Social Support total (ISEL)	25.42	9.43	5–39	.93
Daily Spiritual Experiences (DSE)	72.55	12.38	33–93	.89
Religious coping	13.89	2.67	6–16	.85
Religious involvement	38.03	7.36	26–51	.73
Depression (BDI)	17.45	12.30	0–42	.93
PTSD symptoms (PCL)	43.44	15.85	18–75	.94

Depression symptoms. With respect to depressive symptoms, higher levels of exposure to physical assault ($r = .41$, $p < .01$) and psychological abuse ($r = .33$, $p < .01$) were related to higher levels of depressive symptoms. Further, those who reported higher levels of PTSD symptoms reported higher levels of depressive symptoms ($r = .72$, $p < .01$). Also, higher levels of spirituality and religious involvement were related to lower levels of depressive symptoms ($r = -.28$, $p < .05$; $r = -.29$, $p < .05$).

Religious involvement. Religious involvement was related to other religious variables—spirituality and religious coping. Those who reported higher levels of spirituality reported higher levels of religious involvement ($r = .47$, $p < .01$), and those who reported higher levels of religious coping reported higher levels of religious involvement ($r = .33$, $p < .01$). Finally, religious involvement was positively related to levels of social support ($r = .28$, $p < .05$).

Spirituality. High levels of spirituality were found to be related to high levels of religious coping ($r = .41$, $p < .01$). Finally, high levels of spirituality were related to high levels of social support ($r = .32$, $p < .01$).

Table 4
Intercorrelations of Observed Measures (n = 65)

	1	2	3	4	5	6	7	8
1. Depression	—	.72**	−.28*	−.29*	.00	−.61**	.41**	.33**
2. PTSD		—	−.20	−.25*	.06	−.59**	.38**	.25*
3. Spirituality			—	.47**	.41**	.32**	−.05	.04
4. Religious involvement				—	.33**	.28*	−.09	−.04
5. Religious coping					—	−.10	.03	.09
6. Social support						—	−.37**	−.18
7. Physical assault victimization							—	.78**
8. Psychological abuse victimization								—

*$p < .05$. **$p < .01$.

Overview of Mediation Analyses

Two mediators were examined in the present study: religious coping and social support. To establish the significance of mediation, Baron and Kenny (1986) note that the following conditions must hold: (a) the independent variable (e.g., spirituality) must be associated with the outcome variable (e.g., depression); (b) the spirituality (the IV in this model) must be related to the hypothesized mediator (e.g., religious coping); (c) the hypothesized mediator must be associated with the dependent variable; and (d) when the mediator is statistically controlled, a previously significant relationship between the independent and dependent variables is no longer significant or is significantly reduced in effect size. Multiple regression analyses at each step were only conducted when simple bivariate correlations were found to be significant and covariates were deemed necessary.

Spirituality, Religious Coping, and Depression Relation

The results did not support the hypothesis that religious coping mediates the association between spirituality and depression. The first criterion for demonstrating mediation was supported, as spirituality was significantly related to depression symptoms (the DV in this model) ($r = -.28$, $p < .05$), such that those with high levels of spirituality reported less symptoms of depression. As shown in Table 5, this association remained significant after controlling for abuse characteristics (physical assault and psychological aggression and time since most recent episode of physical assault) and personal income. The second criterion for demonstrating mediation was also supported. As shown in Table 4, spirituality was positively related to religious coping (the hypothesized mediator), such that those who reported higher levels of spirituality reported higher levels of religious coping ($r = .41$, $p < .01$). However, the third criterion for demonstrating mediation was not supported, as bivariate analysis revealed that religious coping was not significantly related to depression ($r = .00$, $p > .05$).

Table 5
Summary of Stepwise Regression Analyses for Spirituality Predicting Depression Symptoms

Variable	B	*SE B*	β
Step 1			
Physical aggression	0.11	0.12	.29
Psychological aggression	0.01	0.21	.02
Income	−5.51	2.93	−.22
Episode of abuse	−5.41	3.33	−.19
Step 2			
Physical aggression	0.12	0.12	.32
Psychological aggression	−0.01	0.21	−.01
Income	−4.59	2.87	−.19
Episode of abuse	−5.72	3.23	−.21
Spirituality	−0.24	0.11	−.24*

Note. $R^2 = .28$ for Step 1; $\Delta R^2 = .06$ for Step 2; $F_{change} = 4.94$, $p < .05$.
*$p < .05$. **$p < .01$.

Table 6
Summary of Stepwise Regression Analyses for Religious Involvement Predicting Depression Symptoms

Variable	B	*SE B*	β
Step 1			
Physical aggression	0.11	0.12	.29
Psychological aggression	0.01	0.22	.02
Income	−5.51	2.93	−.22
Abuse	−5.41	3.33	−.19
Step 2			
Physical aggression	0.11	0.12	.29
Psychological aggression	0.02	0.21	.03
Income	−3.83	3.09	−.16
Abuse	−5.49	3.29	−.19
Religious involvement	−0.31	0.19	−.19

Note. $R^2 = .28$ for Step 1; $\Delta R^2 = .03$ for Step 2; $F_{change} = 2.50$, $p > .05$.
*$p < .05$. **$p < .01$.

Spirituality, Religious Coping, and Posttraumatic Stress Syndrome Relation

Once again, the results did not support the hypothesized model whereby religious coping mediates the association between spirituality and PTSD. As Table 4 illustrates, spirituality was not significantly related to PTSD symptoms ($r = -.20$, $p > .05$). Therefore, it was deemed unnecessary to enter the variables in a multiple regression equation. Because the criterion for testing mediation was not met, we did not proceed with testing mediation.

Religious Involvement, Social Support, and Depression Relation

For this model, the criteria for testing mediation were not met. As Table 4 illustrates, religious involvement was related to depression ($r = -.29$, $p < .05$), such that those who reported higher levels of religious involvement reported lower levels of depression.[4] However, as shown in Table 6, the association did not remain significant after controlling for abuse characteristics and personal income. Therefore, the first criterion for demonstrating mediation was not met and we did not proceed with testing mediation.

Religious Involvement, Social Support, and Posttraumatic Stress Syndrome Relation

Once again, the criteria for testing mediation were not supported. The first criterion for demonstrating mediation was not met. As Table 4 illustrates, higher religious involvement was significantly related to less posttraumatic stress symptoms ($r = -.25$, $p < .05$). However, the association did not remain significant after controlling for abuse characteristics and personal income (see Table 7). The criterion for testing mediation was not met; therefore, we did not proceed with testing mediation.

[4] Note that this relation failed to be significant when the two-item measure of religious involvement was used.

Table 7
Summary of Stepwise Regression Analyses for Religious Involvement Predicting Posttraumatic Stress Symptoms

Variable	B	*SE B*	β
Step 1			
Physical aggression	0.20	0.09	.43*
Psychological aggression	−0.21	0.22	−.18
Income	−6.82	3.84	−.18
Episode of abuse	−5.73	4.38	−.19
Step 2			
Physical aggression	0.19	0.08	.41
Psychological aggression	−0.19	0.22	−.15
Income	−3.92	4.07	−.12
Episode of abuse	−6.86	4.35	−.19
Religious involvement	−0.33	0.26	−.15

Note. $R^2 = .48$ for Step 1; $\Delta R^2 = .02$ for Step 2; $F_{change} = 1.59$, $p > .05$.
*$p < .05$. **$p < .01$.

Discussion

The present study sought to examine ways in which religious variables are associated with negative mental health outcomes among African American survivors of domestic violence. Study results indicated that African American women who reported higher levels of spirituality and greater religious involvement reported fewer depressive symptoms. Religious involvement was also found to be negatively associated with posttraumatic stress symptoms. The association between spirituality and depression remained significant after controlling for physical abuse characteristics and personal income. Consistent with hypotheses, findings further revealed that women who reported higher levels of spirituality reported utilizing higher levels of religious coping strategies and women who reported higher levels of religious involvement reported higher levels of social support. Finally, contrary to the hypotheses, social support did not mediate the relation between religious involvement and negative mental health outcomes; and religious coping did not mediate the relation between spirituality and negative mental health outcomes.

Religious Coping in the Spirituality–Mental Health Link

The significant association found between spirituality and depression provides evidence for the important role of spirituality in the lives of African American women. It is noteworthy to mention that the association between spirituality and depression remained significant after controlling for other variables that are theoretically related to depression—physical assault, psychological abuse, time since most recent episode of abuse, and personal income. Because this was quite a stringent test of the association, this finding provides strong empirical evidence that spiritual experiences such as connection with the transcendent, gratitude, compassion, and support from the transcendent, are associated with lower levels of depression symptoms (e.g., sadness, pessimism, worthlessness) even after accounting for severity of violence exposure, psychological aggression, time since last abusive episode, and personal income among African American women who experience physical abuse.

On the other hand, spirituality was not significantly associated with posttraumatic stress symptoms in this sample. This finding is contrary to research that has found that abused women who reported high levels of intrinsic religiosity suffer less-severe PTSD symptoms than women without a high level of intrinsic religiosity (Astin et al., 1993). Further, studies of other traumatized populations have found spirituality to be negatively correlated with trauma symptoms (e.g., Smith, Pargament, Brant, & Oliver, 2000). It is possible that unique features of traumatic exposure in the current sample account for these inconsistent findings. For example, perhaps the potential buffering effects of spirituality as an experiential process may have been outweighed by the severe, repetitive, and often chronic nature of spouse abuse victimization in this sample.

Although spirituality was found to be related to religious coping, religious coping could not explain the association between spirituality and depressive symptoms. In fact, religious coping was not related to depression ($r = .00$) and was only slightly related to posttraumatic stress symptoms in a positive direction ($r = .06$). This is counter to studies that have found religious coping measures to be stronger predictors of outcomes of stressful situations than generic measures of religiousness (e.g., frequency of prayer, frequency of attendance, etc.; Pargament, 1997). Pargament (1997) suggested that religious coping may account for the association between spirituality and mental health outcomes. Indeed, the failure to find a significant inverse association between religious coping and mental health outcomes of depression symptoms and posttraumatic stress symptoms is notable. It is possible that more specific forms of coping (i.e., positive and negative coping) may have stronger associations with mental health outcomes for this sample. Future studies should include measures of both positive and negative religious coping to understand how they may influence positive and negative mental health outcomes among domestic violence victims.

Finally, it is also possible to conceptualize religious coping as a moderating variable in these associations. This view suggests that the relationship between spirituality and mental health outcomes may differ depending upon one's degree of religious coping. For example, spirituality may be more negatively associated with negative mental health conditions for those with high levels of religious coping compared to those with low levels of religious coping. Future studies may consider the moderating role of religious coping in their theoretical models.

Social Support in the Religious Involvement–Mental Health Link

African Americans generally tend to report higher levels of religious involvement than other ethnic groups (Jang & Johnson, 2004). When examining the two-item measure of religious involvement,[5] over half the sample reported very high levels of religious attendance. The significant association found between the eight-item measure of religious involvement and the mental health outcomes of depression symptoms and posttraumatic stress symptoms provides evidence for the important role of this variable in the lives of African American women. Indeed, this finding is consistent with other studies finding a significant inverse association between religious involvement and negative mental health outcomes (Koenig & Larson, 2001), suggesting that the religiously active are less likely to become depressed and experience trauma symptoms. However, when more stringent tests (i.e., controlling for abuse characteristics and personal income) examining the

[5] The two-item measure is cited here because it specifically looked at religious attendance. The other questions looked at frequency of engaging in religious behaviors like prayer, meditation, etc.

association between religious involvement and depression were employed, the association failed to remain significant. Similarly, the association between religious involvement and posttraumatic stress symptoms failed to remain significant after more-stringent tests were employed. Past research has shown substantial downward adjustment in the association between religious involvement and depression when covariates are included in analyses (Ferraro, 1998). Further, the failure to find an association after controlling for abuse characteristics and personal income suggests that the association between religious involvement and mental health outcomes may involve processes associated with other variables such as socioeconomic factors.

The association between religious involvement and both mental health outcomes in this study is worth emphasizing. The other religious variable, spirituality, only had a significant inverse association with the measure of depression, and religious coping was not significantly associated with the negative mental health outcomes of posttraumatic stress symptoms and depression. Pargament (1997) has argued that spirituality and religious coping exert a stronger influence on health than more global measures of religiosity (e.g., frequency of prayer, church attendance, etc.). It would seem likely that the measures of religious coping and spirituality would be able to predict both mental health outcomes based on Pargament's argument. The contrary findings suggest that religious involvement has a notable influence on negative mental health outcomes among African American survivors of domestic violence, and warrants further examination in this population. However, it is worth noting that the effect sizes for the associations between religious variables and mental health outcomes were relatively small (correlations in the .00–.26 range).

Consistent with the hypothesis, social support was positively related to religious involvement. This confirms the theory that persons who actively involve themselves in religious communities are more likely to make supportive social contacts. Also consistent with the hypotheses, social support was significantly related to depression symptoms and posttraumatic stress, and the effect sizes were rather large (correlations $>$ .50). These findings provide further empirical evidence that social support is related to fewer depressive symptoms (e.g., sadness, pessimism, worthlessness) and trauma symptoms (e.g., trouble remembering important parts of the event, feeling emotionally numb). This association is in the expected direction and is consistent with prior research.

Contrary to our hypothesis, social support was not found to mediate the association between religious involvement and the negative mental health outcomes of posttraumatic stress and depressive symptoms. This finding is inconsistent with Jang and Johnson's (2004) findings among African Americans. Jang and Johnson (2004) found that the religious effects on distress are mediated by social support. However, it is important to note that the current study used a very stringent test of the hypothesized mediational effect. The failure to demonstrate social support mediation was a result of covariate adjustment with abuse exposure and income included in the statistical analyses. Therefore, it is best at the current state of knowledge to avoid strong conclusions with respect to the potential mediating influence of social support in the religious involvement–mental health link until more research can further examine these effects. It is possible that more stringent control of potential confounding variables would have likewise eliminated mediational effects in previous studies, or, conversely, that larger sample sizes or samples with fewer confounded variables would yield support for these mediational effects in future studies.

Limitations

Several limitations in the present study are worth addressing. First, the sample size in the study is relatively small. It is possible that nonsignificant associations between the

coping variables and mental health outcomes were due to the small sample size. For example, some correlations were in the expected direction but not quite significant, including the association between posttraumatic stress symptoms and spirituality ($r = -.20$). Further, the small sample size could have caused the failure of previously significant associations (e.g., religious involvement and mental health outcomes) to remain significant after controlling for abuse characteristics and personal income. Further research is needed with larger samples to determine if these findings would be significant if the study were replicated with greater statistical power.

However, it is also important to note that the effect sizes for the associations between mental health variables and religious variables were rather small ($r = .00$ to $.28$), whereas the effect sizes for the associations between social support and mental health outcomes were large ($>.50$).

A second concern warranting attention is the cross-sectional, correlational nature of the design. Based on such a design, the direction of effects is unclear. Several studies examining coping mechanisms in the lives of abused women have noted the limitations of cross-sectional studies (e.g., Kocot & Goodman, 2003). Cross-sectional studies make it difficult to untangle the direction of the effects. For example, it is difficult to ascertain if spirituality affects mental health or if mental health affects spirituality. Further, longitudinal data are needed to gain a more thorough, accurate understanding of the process and causal associations in stress and coping.

Sampling is a third issue of concern for this study. Most of the participants (90.8%) in this study were drawn from a help-seeking population. Waldrop and Resick (2004) have suggested that help-seeking participants may not reflect the population of domestic violence survivors as a whole. It is likely, for example, that help-seeking women can differ from community samples in the frequency and severity of abuse, their social support network, religious involvement, and their access to tangible forms of help. Indeed, the literature examining help seeking among African American victims has clearly indicated that this group is less likely to use formal services when compared to their European American counterparts. Therefore, this sample of African American women may be uniquely different from most African American survivors. Future studies should examine such coping mechanisms among community samples.

Fourth, another apparent limitation is that the generalizability of the study is confined to African American female victims of domestic violence. Although this is the purpose of the study, it is important to note that this study does not provide information on the role of such variables in the lives of non-African American women.

Fifth, the quantitative nature of the study prohibits women from speaking and defining the variables for themselves. Likewise, it is difficult to discern if the measures are adequately tapping into the constructs as defined by this population of abused women.

Finally, the data were based on self-report measures obtained from the women only. This is problematic as studies have revealed that agreement between spouses in their reporting of violence vary considerably (Jouriles & O'Leary, 1985). Typically, victims tend to report more violence than perpetrators and the victim reports are less associated with social desirability measures than the perpetrators. Future research would benefit from collateral reports from partners and the inclusion of social desirability measures.

Indeed, it is likely that the study would also benefit from other sources of data on social support. For instance, it would be interesting to measure the number of social transactions one has and their satisfaction with the support system provided. It might also be interesting to examine the agreement between women's perception of social support and the social support reported by a friend or relative.

Implications for Psychological Research and Practice

Although this study has some apparent shortcomings, there are some potential implications that make the present study an important contribution to the literature. Concerning research implications, very few studies have examined culturally relevant protective factors that may mitigate against the negative effects of violence among African American women. Further, there has been a lack of group-specific data on African American women's responses to intimate partner violence. In fact, Weaver et al. (2003) found that only 4.1% (15 of 366) of quantitative research articles published in the *Journal of Traumatic Stress* between 1990 and 1999 considered religious and spiritual variables. This study contributes to the literature by highlighting relevant coping mechanisms for this population. Indeed, spirituality and religious involvement emerged as important coping mechanisms for this sample. Traditionally, psychology has not paid much attention to religious and spiritual variables in research. The present study highlighted the role that these variables played for abused women and hopefully will serve to spark continued research in the area of religion/spirituality and domestic violence.

This study also has implications for clinical training and practice. Miller (1999) has noted that the historical underrepresentation of spiritual and religious issues in clinical training programs has resulted in a lack of sensitivity and clinicians, thus, may be unequipped to address such issues with their clients. Further, psychologists may inappropriately evaluate the role of religion in the lives of their clients, as psychologists tend to be much less religious than the general population (Pargament, 1997). Attending to client's spiritual and religious issues is an important aspect of being a multiculturally competent counselor and has vital implications for the delivery of mental health services. In fact, the American Psychological Association (1992) ethical principles underscore the importance of religion as an important aspect of human diversity that deserves appropriate attention when providing services (Standard 1.08). The findings from this study confirm that spirituality and religious involvement are culturally relevant coping mechanisms for this sample of African American women, suggesting that clinicians should consider ways in which they might use religion/spirituality as a therapeutic tool. Although there is no empirical evidence to determine the effectiveness of interventions targeting spiritual issues, several authors have written about techniques that one might consider when working with clients who consider religion/spirituality to be important (e.g., Drescher & Foy, 1995; Ganje-Fling & McCarthy, 1996). Future research should examine the effectiveness of interventions that incorporate spiritual/religious issues. Further, findings from this study should serve to encourage training programs to emphasize religious diversity so that future psychologists will be prepared to consider such issues to enhance treatment.

References

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed). Washington, DC: Author.

American Psychological Association. (1992). Ethical principles of psychologist and code of conduct. American Psychologist, 47, 1597–1611.

Anderson, N.C., & Black, D.W. (1995). Introductory textbook of psychiatry (2nd ed.). Washington, DC: American Psychiatric Press.

Aneshensel, C.S. (1992). Social distress: Theory and research. Annual Review of Sociology, 18, 15–38.

Astin, M.C., Lawrence, K.J., & Foy, D.W. (1993). Posttraumatic stress disorder among battered women: Risk and resiliency factors. Violence and Victims, 8, 17–28.

Baron, R.M., & Kenny, D.A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. Journal of Personality and Social Psychology, 51, 1173–1182.

Barrerra, M., Sandler, I.N., & Ramsay, T.B. (1981). Preliminary development of a scale of social support: Studies on college students. American Journal of Community Psychology, 9, 435–447.

Beck, A.T., Steer, R.A., & Garbin, M.G. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. Clinical Psychology Review, 8, 77–100.

Beck, A.T., Ward, C.H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. Archives of General Psychiatry, 4, 561–571.

Blanchard, E.B., Jones-Alexander, J., Buckley, T.C., & Forneris, C.A. (1996). Psychometric properties of the PTSD checklist (PCL). Behavior Research and Therapy, 34, 669–673.

Campbell, D.W., & Gary, F.A. (1998). Providing effective interventions for African American battered women: Afrocentric perspectives. In J.C. Campbell (Ed.), Empowering survivors of abuse: Healthcare for battered women and their children (pp. 229–240). Thousand Oaks, CA: Sage.

Campbell, J.C., & Belknap, R.A. (1997). Predictors of depression in battered women. Violence Against Women, 3, 271–294.

Campbell, J.C., & Soeken, K.L. (1999). Women's responses to battering over time: An analysis of change. Journal of Interpersonal Violence, 14, 21–39.

Carver, C.S., Scheier, M.F., & Weintraub, J.K. (1989). Assessing coping strategies: A theoretically based approach. Journal of Personality and Social Psychology, 56, 267–283.

Cohen, J. (1977). Statistical power analysis for the behavioral sciences (2nd ed.). New York: Academic Press.

Cohen, S., Mermelstein, R., Kamarck, T., & Hoberman, H.M. (1985). Measuring the functional components of social support. In I.G. Sarason & B.R. Sarason (Eds.), Social support: Theory, research and applications (pp. 73–94). The Hague, the Netherlands: Martinus, Nijhoff.

Cohen, S., & Wills, T.A. (1985). Stress, social support, and the buffering hypothesis. Psychological Bulletin, 98, 310–357.

Coker, A.L., Smith, P.H., Thompson, M.P., McKeown, R.E., Bethea, L., & Davis, K.E. (2002). Social support protects against the negative effects of partner violence on mental health. Journal of Women's Health and Gender-Based Medicine, 11, 465–475.

Connors, G.J., Tonigan, J.S., & Miller, W.R. (1996). A measure of religious background and behavior for use in behavior change research. Psychology of Addictive Behaviors, 10(2), 90–96.

Cunradi, C., Caetano, R., Clark, C., & Shafer, J. (1999). Alcohol-related problems and intimate partner violence among White, African American, and Hispanic couples in the U.S. Alcoholism: Clinical and Experimental Research, 23, 1492–1501.

Drescher, K.D., & Foy, D.W. (1995). Spirituality and trauma treatment: Suggestions for including spirituality as a coping resource. National Center for PTSD Clinical Quarterly, 5, 4–5.

Ellison, C.G. (1998). Religion, health and well-being among African Americans. African American Research Perspectives, 4, 65–84.

Fagan, J. (1996). The criminalization of domestic violence: Promises and limits. Washington, DC: U.S. Department of Justice.

Ferraro, K.F. (1998). Firm believers? Religion, body weight, and well-being. Review of Religious Research, 39, 224–244.

Gallup, G., Jr. (1984). The religion report: Religion in America. Princeton, NJ: Gallup Report.

Ganje-Fling, M.A., & McCarthy, P. (1996). Impact of childhood sexual abuse on client spiritual development: Counseling implications. Journal of Counseling and Development, 74, 253–258.

Hampton, R.L., & Gelles, R. (1994). Violence toward Black women in a nationally representative sample of Black families. Journal of Comparative Family Studies, 25, 115–119.

Hampton, R.L., & Yung, B.R. (1996). Violence within communities of color: Where we were, where we are, and where we need to be. In R.L. Hampton, P. Jenkins, & T.P. Gullotta (Eds.), Preventing violence in America (pp. 53–86). Thousand Oaks, CA: Sage.

Hill, H.M., Hawkins, S.R., Raposa, M., & Carr, P. (1995). Relationship between multiple exposures to violence and coping strategies among African American mothers. Violence and Victims, 10, 55–71.

Jang, S.J., & Johnson, B.R. (2004). Explaining religious effects on distress among African Americans. Journal for the Scientific Study of Religion, 43, 239–260.

Joseph, J. (1997). Woman battering: A comparative analysis of Black and White women. In G.K. Kantor & J.L. Jansinski (Eds.), Out of darkness: Contemporary perspectives on family violence (pp. 161–169). Thousand Oaks, CA: Sage.

Jouriles, E.N. & O'Leary, K.D. (1985). Interspousal reliability of reports of marital violence. Journal of Consulting and Clinical Psychology, 53, 419–421.

Kocot, G., & Goodman, L. (2003). The roles of coping and social support in battered women's mental health. Violence Against Women, 9, 323–346.

Koenig, H.G., & Larson, D.B. (2001). Religion and mental health: Evidence for an association. International Review of Psychiatry, 13, 67–78.

Miller, W.R. (1999). Diversity training in spiritual and religious issues. In W.R. Miller (Ed.), Integrating spirituality into treatment: Resources for practitioners (pp. 253–263). Washington, DC: American Psychological Association.

Moore, T. (1991). The African American church: A source of empowerment, mutual help, and social change. Prevention in Human Services, 10, 147–167.

Myers, L. (1987). Stress resolution among middle-aged black Americans. In R.L. Hampton (Ed.), Violence in the black family: Correlates and consequences (pp. 237–245). Lexington, MA: Lexington Books.

Negg, J., Halaman, B., & Schultzer, T. (1995). Spousal violence among Anglos, Blacks, and Mexican-Americans: The role of demographic variables, psychological predictors and alcohol consumption. Journal of Family Violence, 10, 1–21.

Neighbors, H., Jackson, J., Bowman, P., & Gurin, G. (1983). Stress, coping and Black mental health: Preliminary findings from a national study. In R. Hess & J. Hermalin (Eds.), Innovations and prevention (pp. 5–29). New York: Haworth Press.

Office of Justice Programs. (1998). Bureau of Justice statistics factbook: Violence by intimates—analysis of data on crime by current or former spouses, boyfriends, and girlfriends (NCJ No. 167237). Washington, DC: Department of Justice.

Pargament, K.J. (2002). The bitter and the sweet: An evaluation of the costs and benefits of religiousness. Psychological Inquiry, 13, 168–181.

Pargament, K.J. (1997). The psychology of religion and coping: Theory, research, practice. New York: Guilford.

Rennison, C.M., & Welchans, S. (2000, May). Intimate partner violence. Washington, DC: U.S. Department of Justice, Bureau of Statistics.

Schnittker, J. (2001). When is faith enough? The effects of religious involvement on depression. Journal of the Scientific Study of Religion, 3, 393–412.

Smith, B., Pargament, K., Brant, C., & Oliver, J. (2000). Noah revisited: Religious coping by church members and the impact of the 1993 Midwest flood. Journal of Community Psychology, 28, 169–186.

Stets, J.E., & Straus, M.A. (1990). Gender differences in reporting marital violence and its medical and social consequences. In M.A. Straus & R.J. Gelles (Eds.), Physical violence in American families (pp. 151–166). New Brunswick, NJ: Transaction.

Straus, M. (1979). Measuring intrafamily conflict and violence: The Conflict Tactics Scale. Journal of Marriage and the Family, 41, 75–88.

Straus, M.A., Hamby, S.L., Boney-McCoy, S., & Sugarman, D.B. (1996). The Revised Conflict Tactics Scales (CTS2). Journal of Family Issues, 17, 283–316.

Sullivan, W.P. (1993). It helps me to be a whole person: The role of spirituality among the mentally challenged. Psychosocial Rehabilitation Journal, 16, 125–134.

Taylor, R.J., & Chatters, L.M. (1991). Religious life. In J.S. Jackson (Ed.), Life in Black America (pp. 105–123). Newbory Park, CA: Sage.

Taylor, R.J., Ellison, L.M., Chatters, L.M., Levin, J.S., & Lincoln, K.D. (2000). Mental health services in faith communities: The role of clergy in black churches. Social Work, 45, 73–87.

Underwood, L.G., & Teresi, J.A. (2002). The Daily Spiritual Experience Scale: Development, theoretical description, reliability, exploratory factor analysis, and preliminary construct validity using health related data. Annals of Behavioral Medicine, 24, 22–33.

Waldrop, A.E., & Resick, P.A. (2004). Coping among adult female victims of domestic violence. Journal of Family Violence, 19, 291–302.

Weathers, F.W., Litz, B.T., Hermann, D.S., Huska, J.A., & Keane, T.M. (1993, October). The PTSD Checklist: Reliability, validity, and diagnostic utility. Paper presented at the Annual Meeting of the International Society for Traumatic Stress Studies, San Antonio, TX.

Weaver, A.J., Flannelly, L.T., Gabarino, J., Figley, C.R., & Flannelly, K.J. (2003). A systematic review of research on religion and spirituality in the Journal of Traumatic Stress: 1990–1999. Mental Health, Religion, & Culture, 6, 215–228.

Wingrove, C.R., & Alston, J.P. (1974). Cohort analysis of church attendance, 1989–69. Social Forces, 53, 324–331.

Wyatt, G.E., Axelrod, J., Chin, D., Carmona, J.V., & Loeb, T.B. (2000). Examining patterns of vulnerability to domestic violence among African American women. Violence Against Women, 6, 495–514.