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Predictive Relationships Between Cultural Coping Strategies, Intimate Partner Violence, and Depression in African American Women

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Walden University
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Abstract

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MEd, Troy State University, 2003

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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Abstract

Intimate partner violence (IPV) against women has been linked to long-term, negative health consequences such as depression, PTSD, and suicidal ideation. There is a growing perception that African American women are the most affected by IPV, but the current literature does not confirm this perception. The purpose of this nonexperimental, correlational study was to examine the predictive relationships between the independent variables (spiritual coping, religious coping, and levels of IPV) and the dependent variable (level of depression). The ecological systems theory provided the framework for the study. The research question addressed how well variables such as religious coping, spiritual coping, and level of IPV predicted levels of depression in African American women. Convenience sampling was used to recruit 63 participants. Data were collected using a survey methodology. Multiple linear regression was used to analyze the data. Results indicated a statistically significant negative correlation between spiritual coping and depression, as well as a statistically significant positive correlation between IPV scores and level of depression. No statistically relationship was found between religious coping and depression. Human services and other professionals could use the results to advocate for the development of educational and counseling programs that inform African American women of the benefits of culturally based coping strategies such as spiritual coping. Findings from the study could contribute to social change by adding information to the literature on coping strategies that can potentially improve negative outcomes such as levels of depression for female survivors of IPV, particularly African American Women.

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Dedication

It is with much respect, humility and honor to dedicate my dissertation to the memory of my maternal grandparents, who raised me, Robert Lee Parrish (1931-2015) and Irene Green Parrish (1935-2017). They taught me how to persevere and prepared me to embrace life challenges with faith, love, humility, strength, courage and excellence. They always believed in my ability to be successful at anything I desired to do. They allowed me to stand on their shoulders as I reached for the stars and chased my dreams. Due to the sacrifices they made for me, I'm unapologetically Ph.D. To my grandparents, who paved the way for me, I miss and love you both so much! Thank you for helping me create my life and live my purpose. The memories will be eternal, as I keep you both in my heart. Your oldest grandchild did it and I owe it all to you!

I'd also like to dedicate this study to my maternal uncle, Robert Lee Parrish, Jr. (1963-2012), who encouraged me to pursue my doctorate degree. He would always tell me the sky is just a view and I could do anything I prepared for. In fact, we pursued our undergraduate degree from the same university. I wish he was here to celebrate this major accomplishment with me. Although he is gone, he is never forgotten, truly loved and forever missed. To my favorite uncle, I kept my promise and this is also for you!

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First, I give honor to my God, who is the author of my life, for blessing me to finish this journey called, "Ph.D.!" I give Him all the glory for His unmerited favor, grace and for sustaining me. Finally and without hesitation I would like to thank my husband Christopher, for being my "biggest fan!" To my loving mother, Theresa, thank you for always believing in me and telling me that I can do anything I set my mind to do. To my dad, Jimmy, thank you for supporting me and telling me how proud I make you. To my brothers, Dexter and Justin, thank you for encouraging me when I felt discouraged. To my aunts Rosetta and Carolyn, thank you for all the late night conversations and support you have shown me during this process. To my extended family and friends, thanks for simply being there for me. I'm truly blessed to have each of you as my amazing circle of love and support group. I love you all beyond measure!

A debt of gratitude is also owed to my Dissertation Committee Members for their collegial guidance. The completion of my research could not have been possible without the expertise of Dr. Sandra Harris, my committee chairperson. I'm humbly grateful for the guidance and support that you have given me over the years, as I navigated through the dissertation process. You have exceeded the example of excellence as a researcher, mentor, instructor, and role model. To my committee member, Dr. Melinda Haley, thank you so much for helping me sharpen my skills. Your feedback was absolutely invaluable and it strengthen my manuscript. To Dr. Gregory Hickman, my URR, thank you for investing your time in reading my dissertation and offering your expertise through the process. Each of you have truly made a difference in my life and I'll never forget you.

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Chapter 1: Introduction to the Study

Researchers studying intimate partner violence (IPV) have shown that women are at a higher risk for being victims of IPV than their male counterparts (Mager, Bresin, & Verona, 2014). According to Wong and Mellor (2014), one in four women experience physical or sexual violence—or both—by an intimate partner at some point in their lives. Johnson, Giordano, Manning, and Longmore (2015) reported that in 2014, an estimated 7 million women reported IPV experiences that included acts of rape, physical violence, or stalking during the previous 12 months by an intimate partner. Those partners include current and former spouses, boyfriends, or girlfriends. Intimate partner violence is a major health concern for victims who are exposed to it (Modi, Palmer, & Armstrong, 2014).

Considering the documented harmful effects of IPV, I examined how culturally specific coping strategies are related to depression. It is my hope that the results will be used to promote coping strategies to improve the mental well-being of those victimized by IPV. Professionals may use the results to inform leaders of women shelters, medical professionals, and IPV victims or other individuals who closely interact with IPV victims about culturally effective coping strategies. Medical professionals may promote the use of effective coping strategies to improve the emotional well-being of IPV victims, specifically African American women. In this chapter, I present the following information: background information on IPV, the problem statement, the theoretical framework, the scope of the research, the nature of the study, and the assumptions, limitations, and delimitations of the study.

Background

Previous researchers have revealed that IPV is linked to poor mental health consequences, such as depression and PTSD (Salom, Williams, Najman, & Alati, 2015; Sugg, 2015; White & Satyen, 2015; Wong & Mellor, 2014). Researchers have also found that internalization or suffering as a result of IPV exposure is related to mental and emotional problems such as depression (Devries et al., 2014). Other researchers have shown that victims of IPV who reported the abuse had higher utilization rates of health care services compared to victims who did not report abuse (Sugg, 2015). Other researchers found that as a result of the stigmatization associated with IPV, victims may not seek care for their mental and emotional injuries (Cavanaugh, Messing, Eyzerovich, & Campbell, 2015). Exposure to IPV has been linked to nonfatal injuries of women in the United States, with approximately 35.6% of women reporting being injured as a result of IPV during their lifetime (Black et al., 2011). Individuals affected by IPV have reported experiencing pain, suffering, and loss of quality of life (H.D. Nelson, Bougatsos, & Blazina, 2012).

When examining IPV from a social-cultural perspective, several researchers found that African American women are at greater risk for negative outcomes and nonfatal injuries related to IPV compared to women from other racial or ethnic backgrounds (Cavanaugh et al, 2015; Graham-Bermann, Miller-Graff, Howell, & Grogan-Kaylo, 2015; Lacey, Sears, Matsuko, & Jackson, 2015). Wadsworth and Records (2013) found increased risks for dysthymia, alcohol dependence, drug abuse, and poor perceived health for African American female victims of IPV. Researchers revealed that

African American women have a higher risk of dying from intimate partner violence than women from other racial or ethnic backgrounds (Bagwell-Gray, Messing, & Baldwin-White, 2015). Researchers also indicated that African American women with a history of IPV exposure are at increased risk for suicidal ideation and suicide attempts (Devries et al., 2014; Karakurt, Smith, & Whiting, 2014). Researchers have examined the relationship between socioeconomic factors and African American women's exposure to IPV (Kiss, Schraiber, Hossain, Watts, & Zimmerman, 2015). Results from several studies revealed that IPV occurred more frequently among couples with low incomes and in relationships in which the male partner was underemployed or unemployed (Kiss et al., 2015).

Strategies for Coping With IPV

Although findings from earlier studies suggested that there are no statistically significant differences pertaining to the causation of IPV against women across different races and ethnicities, researchers have found that culturally specific interventions may be more effective in helping African American women victims cope with IPV (White & Satyen, 2015). The strategies that women use to cope with IPV play an important role in their health, safety, and well-being (Blair, McFarlane, Nava, Gilroy, & Maddoux, 2015). Victims of IPV may be better able to cope if they have access to sources of emotional support, such as culturally specific coping strategies (Foster et al., 2015). Effective coping strategies can impact a person's ability to psychologically adjust and endure stressful situations (Bryden, Field, & Francis, 2015; Shim, Mercer Kollar, & Roberts, 2015).

Africultural coping refers to a group of strategies that African Americans use to cope with stressful situations; these strategies are spiritual centered, collective, and ritual centered (Pargament, Feuille, & Burdzy, 2011). Africultural coping is defined as the extent to which individuals of African descent adopt coping behaviors specifically derived from African culture (Utsey, Adams, & Bolden, 2000). Africultural coping behaviors include four primary dimensions: (a) cognitive/emotional debriefing, which represents adaptive reactions by individuals of African descent as a result of efforts to manage stressors (e.g., hoping for things to get better); (b) spiritual centered coping, which refers to behaviors that reflect a spiritual sensibility (e.g., praying that things will work themselves out); (c) collective coping, which represents a reliance on in-group to manage stressful situations (e.g., resolution and comfort sought from others or a group); and (d) ritual centered coping, which involves African cultural practices (e.g., burning incense for strength or guidance in dealing with a problem) as stress responses. More specifically, scholars have provided evidence that African American women use spirituality, collective coping, and cognitive/emotional debriefing to overcome daily challenges (Brownley, Fallot, & Wolfson-Berley, 2015; Kremer et al., 2015; Zhang et al., 2015). African American women who utilize spirituality and collective coping during stressful events have a higher coping capacity for handling stress (Alamilla, Scott, & Hughes, 2016). The benefits of spiritual coping among African American women exposed to IPV include the enhancement of coping skills, ability to engage in treatment decisions, and inner strength (Schreiber & Brockopp, 2012). The spiritual activities that African American women use include prayer, meditation, and receiving instruction on

effective coping (Jim et al., 2015). Several researchers have revealed positive relationships between spirituality or spiritual coping and positive mental health outcomes such as lower levels of anxiety, depression, and hopelessness (Kremer et al., 2015).

Other researchers found that African American women use culturally relevant coping strategies, such as religious coping and spiritual coping, to manage life stressors (Ellison & Hummer, 2010; Jim et al., 2015). Religious coping refers to how individuals use the beliefs, values, practices, and rituals of a particular faith as coping strategies (Bryant-Davis et al., 2012). Spiritual coping pertains to the questions a person asks about life's meaning. Spiritual coping is more subjective than religious coping (Bryant-Davis et al., 2012). I used the terms *spiritual coping* and *religious coping* interchangeably because the meaning of spiritual coping incorporates the definition of spirituality. Spirituality includes beliefs that provide an individual with meaning or purpose in life, including belief in a higher power and a sense of connectedness with self, others, nature, and a higher being (Bryant-Davis et al., 2012). Both religious and spiritual coping have been associated with decreased negative psychological effects in survivors of child abuse, sexual violence, IPV, community violence, and war (Bryant-Davis et al., 2012). Although spiritual coping and religious coping have distinct characteristics, they are not separate; they are highly correlated with one another (Good, Willoughby, & Busseri, 2011).

Religion and spirituality have been identified as the preferred manner of coping for African Americans, and both are related to increased social support, improved quality of life, longevity of life, and decreased psychopathology (Bryden et al., 2015; Hirsch, Nsamenang, Chang, & Kaslow, 2014). Research pertaining to African American women

indicated that spiritual engagement may promote inter- and intrapersonal functioning, which can lead to improve family relationships (Bryant-Davis et al., 2012; Good et al., 2011). The coping strategies used by victims of IPV are critical in terms of their effectiveness in improving the victim's emotional well-being (Bryant-Davis et al., 2012).

Service providers should be aware of the coping strategies that may lead to negative outcomes associated with IPV. Understanding a victim's spiritual development process and assisting him or her in discovering his or her spiritual development process though both internal and external factors may be a form of effective treatment for depression (Hirsch et al., 2014). In this study, I examined how victims of IPV use religion or spirituality as a coping strategy. Although researchers have begun focusing on the cultural differences in perceptions of IPV (J. L. Austin & Falconier, 2013), major gaps exist in the literature. After an exhaustive literature review, I did not locate any researchers who had addressed the relationships between religiosity, spirituality, IPV, and depression in African American women.

Problem Statement

Interpersonal violence is a major social and public health problem that adversely and disproportionately affects African American women in the United States (Modi et al., 2014). Researchers have linked exposure to IPV to a number of poor mental health conditions, such as depressive symptoms, suicidal ideation, suicide attempts, anxiety, PTSD, feelings of hopelessness and helplessness, dissociation, social isolation, and substance abuse (Johnson et al., 2015; Modi et al., 2014). Researchers have revealed that African American women are at higher risk for IPV and its negative consequences

(Weiss, Dixon-Gordon, Duke, & Sullivan, 2015). Epidemiological data in the United States have indicated a lifetime prevalence rate of IPV at 29.1% among African American women, in comparison to 11.4% for Caucasian women, 7.7% for Latin women, and 4.8% for Asian women (Bagwell-Gray et al., 2015). Researchers have shown the rate of IPV for African American women to be 35% higher than the rate reported by European American women (White & Satyen, 2015). Intimate partner violence is a risk factor for suicidal behavior among African American women, even after controlling for mental health disorders (Devries et al., 2014; Stockman, Hayashi, & Campbell, 2015) and adjusting for sociodemographic variables and childhood sexual abuse. Afifi et al. (2009) found that women exposed to IPV were 7.5 times more likely than those not exposed to IPV to experience suicidal ideation.

Mitigating these problems, reducing negative health consequences, and decreasing the costs associated with IPV requires a multidisciplinary approach (Modi et al., 2014). The costs of IPV in the United States are more than $7.5 billion each year (Black et al., 2011; Johnson et al., 2015; Modi et al., 2014). The effects of IPV exposure have resulted in a variety of treatment expenses that researchers have linked to a number of mental health problems, such as depressive symptoms, suicidal ideation, anxiety, PTSD, feelings of hopelessness and helplessness, dissociation, social isolation, cognitive distortions, and substance abuse (Johnson et al., 2015; Modi et al., 2014).

Spiritual well-being and religious coping can be protective factors for survivors of IPV. The identification, development, and implementation of effective coping strategies for African American women who are victims of IPV can have a positive impact on their

psychological and emotional well-being (Arroyo, Lundahl, Butters, Vanderloo, & Wood, 2015; Lacey et al., 2015; Zhang et., 2015). Researchers have suggested that women of different cultures use varying methods for coping with or avoiding abuse in intimate partner relationships (Fischer et al., 2016; Ivan, Barnett-Queen, Messick, & Gurrola, 2015). Religious coping and spirituality are considered effective coping strategies for dealing with IPV because some women may report their victimization to a pastor or religious leader rather than to the police (Drumm et al., 2013). These religious organizations, however, may not be equipped to provide adequate resources in the form of counseling, health care, and shelter to these IPV victims.

Intimate partner violence is a major problem that affects the health and well-being of African American women (Devries et al., 2014; Weiss et al., 2015; White & Satyen, 2015). Although researchers have begun focusing on cultural differences in perceptions of IPV (J. L. Austin & Falconier, 2013), major gaps in the research exist regarding the strategies that African American women use to cope with problems associated with IPV. After an exhaustive literature review, I did not locate any researchers who had addressed the relationships between religiosity, spirituality, IPV, and depression in African American women.

Purpose Statement

The purpose of this quantitative study was to examine the predictive relationships between the independent variables of cultural coping strategies (spirituality and religious coping) and levels of IPV and the dependent variable of depression in African American women victimized by IPV. The target population was African American women ages 25

to 45 years. Participants were living in a shelter in downtown Atlanta and self-reported being victims of IPV. Hirsch et al. (2014) indicated that spirituality has frequently been used in the African American community as a tool for coping and healing. Hirsch et al. (2014) also posited that spirituality serves as a survival strategy for triumphing over adversity. The current study was an important step in investigating the spiritual and religions coping strategies that African American women in the United States use to cope with IPV exposure and how IPV affects their emotional well-being. Findings from this study may be used to advocate for the development of culturally specific treatment strategies and interventions for assisting African American women in coping with their exposure to IPV.

Research Question and Hypotheses

RQ: How well do variables such as religious coping, spiritual coping, and level of IPV predict depression in African American women?

H_0: The independent variables of religious coping (as measured by scores on the Brief RCOPE), spiritual coping (as measured by scores on the Africultural Coping System Inventory, ACSI), and level of IPV (as measured by scores on the Index of Spouse Abuse) are not statistically significant predictors of depression in African American women (as measured by scores on the Beck Depression Inventory).

H_a: The independent variables of religious coping (as measured by scores on the Brief RCOPE), spiritual coping (as measured by scores on the Africultural Coping System Inventory, ACSI), and level of IPV (as measured by scores on the Index of

Spouse Abuse) are statistically significant predictors of depression in African American women (as measured by scores on the Beck Depression Inventory).

The independent variables in the study were religious coping, spiritual coping, and level of IPV. I measured religious coping using scores on the Brief RCOPE and spiritual coping using scores on the Africultural Coping System Inventory (ACSI). I determined the participants' level of IPV from scores on the Index of Spouse Abuse. I measured the dependent variable, depression, using scores on the Beck Depression Inventory.

Theoretical Framework

The theoretical framework for this study was the ecological perspective, which Bronfenbrenner first published in 1979. The ecological systems theory is one of the most widely used frameworks for examining IPV (Bronfenbrenner, 1994). Bronfenbrenner's ecological model of human development was first introduced in the 1970s in reaction to researchers studying individual behavior within virtual social "vacuums" (Bronfenbrenner & Morris, 1998). Bronfenbrenner (1977) observed that most researchers in the field of human development conducted research in sterile, unnatural situations devoid of real-life consequences or contextual cues (i.e., the laboratory). Bronfenbrenner (1994) argued that the findings derived from those kinds of investigations had limited applicability to reality, and recommended that to understand human development, researchers must consider the entire ecological system in which growth occurs.

Use of the ecological theory in examining the issue of IPV allowed me to focus on the individual as the unit of analysis for investigating how African American women

cope with IPV. The ecological model offers a broad-based conceptualization that takes into account the complex interactions among individuals, family, community, and societal risk factors in the occurrence of IPV. The ecological theory suggests that people encounter different environments throughout their lifespans, which may influence their behavior to varying degrees (Boon, 2016).

By using surveys and self-report information from IPV victims, I examined how women use factors related to the macrosystem, such as spiritual and religious coping, which are related to African American women's experiences of IPV and emotional well-being. Asking participants specific demographic questions pertaining to their previous living environments, SES, and income allowed me to examine how elements of the microsystem are related to cultural coping strategies and the emotional well-being of African American women who are survivors of IPV.

Nature of the Study

Through this quantitative, nonexperimental, correlational study, I examined the predictive relationships between religious coping, spiritual coping, and level of IPV and depression in African American women. Using a correlational design, I transformed the data collected through the participant surveys into numerical data to conduct a multiple linear regression analysis (see Smith, Fisher, & Heath, 2011). Researchers use a quantitative methodology to investigate relationships between identified study variables (Yoshikawa, Weisner, Kalil, & Way, 2013) that are quantified or measured with numerical values (Ostlund, Kidd, Wengstrom, & Rowa-Dewar, 2011). Quantitative studies are deductive and confirmatory, originating from a theory or set of hypotheses

validated through statistical testing (Pulido-Martos, Augusto-Landa, & Lopez-Zafra, 2012). Using a quantitative approach, I was able to generalize my findings from a sample to a larger group. I collected data using the survey methodology. The use of surveys for data collection allows researchers to collect large amounts of information from a larger group in a short period of time (Salganik & Levy, 2015). In addition, researchers can quantify survey results quickly and easily, and can use the data to make comparisons among variables of interest (Madrigal & McClain, 2012).

I analyzed data using multiple linear regression to examine the predictive relationships between the variables of interest. I measured the participants' level of IPV on a ratio level because IPV exposure could have been 0. I used scores on the Beck Depression Inventory to measure participants' depression at the ratio level because the value for depression could have been 0 as well. The two primary coping strategies in this study, religious coping and spiritual coping, were organized as interval data. In Chapter 3, I present details regarding the scoring procedures.

Definitions

Some terms used in this study had interchangeable meanings. Other terms were unique to a type of coping strategy referred to in this study. I defined the following terms for the purposes of the study.

Coping: Coping describes the cognitive and behavioral efforts that individuals use to deal with or overcome stressful events (Black et al., 2011).

Coping strategies: This refers to the specific efforts, both behavioral and psychological, that people employ to master, tolerate, reduce, or minimize stressful events (Black et al., 2011).

Culture: Culture refers to the beliefs, values, practices, behaviors, and norms shared by members of a group (Creswell, 2013).

Intimate partner violence: IPV refers to acts such as physical violence, sexual violence, stalking, and psychological aggression (including coercive acts) perpetrated by a current or former intimate partner (Kuijpers, Van der Knaap, & Lodewijks, 2011).

Mental health/psychological health: This refers to a person's level of psychological well-being or the absence of a mental disorder; it is the psychological state of someone who is functioning at a satisfactory level of emotional and behavioral adjustment (Black et al., 2011).

Religion: Religion refers to an organized belief system. This includes belief in the transcendent, a longing for certain spiritual values, organized worship, and involvement in a faith community (Poirier, Cordero, & Sandi, 2013).

Social support: Social support refers to the social interactions and relationships that provide assistance, love, and a sense of attachment. Support can come from family, friends, churches, synagogues, mosques, and community resources (Gaston-Johannson, Haisfield-Wolfe, Reddick, Goldstein, & Lawal, 2013).

Socioeconomic status (SES): SES is based on the economic and sociological factors that are combined to determine a person's work experience and an individual's or

family's economic and social position in relation to others, based on income, education, and occupation (Galvez, Mankowski, & Glass, 2015).

Spirituality: Spirituality is broader than religion; it includes trust in a higher power, a need for meaning in life, a sense of inner strength in life, and a longing for connections with community (Poirier et al., 2013).

Victim: This term refers to a person who has experienced or is experiencing violence or abuse (Garcia-Moreno, Pallitto, Devries, Stöckl, & Watts, 2013).

Assumptions

One of the assumptions of this study was that associations exist between IPV, coping, and depression (see Turner, Spangler, & Brandl, 2010). This assumption was important because assisting in the effective treatment of IPV victims requires those offering treatment to have knowledge of how IPV exposure affects the victims they are treating. Another assumption was that African American women would want to participate in the study. I assumed that the participants would be able to read and understand the questions asked in the surveys. I also assumed that the participants would provide honest responses to survey questions.

Other assumptions included that the women who responded to the call to participate in the study self-identified as victims of IPV perpetrated by a male partner. I assumed that spirituality and religiosity were concepts that could be accurately measured using survey instruments. A final assumption was that the survey instruments of Brief RCOPE and ACSI would be valid and reliable measures for the variables of religious coping and spiritual coping, respectively.

Limitations

Like other quantitative inquiries, this quantitative study had inherent limitations. Data errors due to survey question nonresponses were a potential threat. The number of respondents who choose to respond to a survey question may be different from those who choose not to respond; therefore, discrepancies of responses may exist (Bilsborrow & Henry, 2012; Creswell, 2013). As a solution, I made the survey questions a forced choice in the online survey tool where the surveys were administered. If the respondent refused to answer a question, he or she would be ineligible to proceed to the next question. This enabled me to collect many survey responses and eliminate incomplete responses in the data set.

The use of survey research has certain disadvantages. The respondents of the survey may not feel encouraged to provide accurate and honest answers on the survey. In addition, surveys with closed questions may have a lower validity rate than other question types (Sue & Ritter, 2012). Additional limitations of this study were gaining access to domestic violence shelters to recruit participants because of policy-related issues or lack of support from shelter sites. This lack of access affected the data collection process. Shelter employees are protective of their residents for many different reasons, including concern for the residents' physical or emotional well-being. These employees, therefore, may not have been as helpful or accommodating to me as they could have been. Other limitations included difficulty in obtaining an adequate sample size, and unwillingness of African American women to participate in the study.

Scope and Delimitations

I examined the relationships between religious coping, spiritual well-being, emotional health, and depression among African American women exposed to IPV. To accomplish this objective, I gathered data from residents in local women's shelters in Atlanta, Georgia. The rationale for delimiting the sample to this group was for convenience of collecting the data. I recruited African American women exposed to IPV in shelters because prospective participants were already pooled in these locations. I used convenience sampling to recruit samples. Participants were required to be currently residing in a women's shelter and had to self-identify as being a victim of IPV perpetrated by a male partner. Victims of IPV perpetrated by same-sex partners were not included in the study. Additionally, participants were between the ages of 25 and 49 years. According to the National Crime Victimization Survey, women between these ages are most vulnerable to IPV exposure (Kiss et al., 2015).

The scope of this study limited the generalizability of the results. I investigated the predictive relationships between culturally relevant coping strategies, levels of abuse, and depression in African American women. Consequently, these results may not be generalizable to women in other ethnic groups. In addition, the results may not be generalizable to women living in other areas of the United States, to African American women with different socioeconomic characteristics, or to African American women who have not been in shelters.

The data from this study were from retrospective self-reports, which may have introduced potential response bias due to memory; participants may have responded to

survey questions in a way that supported the way they felt or thought to be normal, instead of the way that reflected their actual experience. The respondents may not have been able to accurately remember their past experiences (see Grove, Burns, & Gray, 2013). Although purposive sampling is appropriate for selecting individuals who can best inform the study, it does not allow for the selection of a sample representative of the population being studied (Creswell, 2013). The findings of this study, therefore, may not be applicable to all African American women victimized by IPV or other minority populations. The results of this study are applicable to African American women ages 25 to 45 years living in shelters in downtown Atlanta who had reported being victims of IPV perpetrated by a male partner.

Significance

Researchers have identified IPV as an area of study since the 1970s (Graham-Bermann et al., 2015). The topic of IPV is controversial due to the perception that studying those who have experienced IPV is victim blaming, which occurs by implying that those who experience IPV are responsible for the abuse (Lacey et al., 2015). This study was important because I gathered information about the potential relationships between depression, IPV, and the strategies that African American women use to cope after IPV exposure. Findings from the study provided information regarding the effectiveness of culturally specific coping strategies, such as religious and spiritual coping, in promoting the emotional health of African American women exposed to IPV.

The results of this study may be used to develop seminars and educational programs about the research topic. Health practitioners may use the information to assist

African American women who have been exposed to IPV to choose or develop strategies for coping with and surviving the abuse. Results also have implications for prevention and service provisions to African American woman coping with IPV by identifying the possible role of religion and spiritual coping in reducing the risk of depression of African American women. In addition, the results added to the current body of knowledge by addressing the predictive relationships between religious coping, spiritual coping, depression, and IPV among African American women.

Summary

Experiencing violence in a relationship with a spouse or significant other can have a significant impact on an individual's physical and mental health (Devries et al., 2014; Wathen, MacGregor, & MacQuarrie, 2016). In 2011, more than 1 in 5 women and 1 in 7 men reported experiencing severe physical violence by their intimate partner (Devries et al., 2014). Breiding, Basile, Smith, Black, and Mahendra (2015) found that approximately 1 in 10 women and 1 in 200 men had been raped by an intimate partner at some point in their lives. These statistics reveal important insights related to IPV. First, these statistics reveal the higher rate at which women are victims of IPV than men. Second, the findings illustrate that individuals exposed to IPV are vulnerable to a wide range of mental health problems, such as depression, anxiety, PTSD, and additional physical or mental pains, making IPV an important public health issue.

Davila (2014) indicated that IPV is multifaceted in nature, requiring a comprehensive, integrative approach to addressing it. The ecological model is one of the most widely used frameworks in examining IPV. I used premises from this theory to

explain the relationships between coping strategies, IPV, and depression by connecting the different levels of the ecological model to IPV victims, their demographic characteristics, their use of religious and spiritual coping strategies, and their emotional well-being.

Researchers have indicated that IPV is related to mental health outcomes such as depression, internalization, and PTSD (Salom et al., 2015; Sugg, 2015; White & Saten, 2015; Wong & Mellor, 2014). Other scholars have shown that victims of IPV who reported the abuse had higher utilization rates of health care services compared to victims who did not report abuse (Sugg, 2015; Wong & Mellor, 2014). Researchers have also shown that religious and spiritual coping strategies are positively and negatively associated with healthy outcomes (Bryant-Davis et al., 2012). The coping strategies used by victims of IPV are hypothesized to be critical in terms of their effectiveness in improving the victim's emotional well-being (Drumm et al., 2013). African American women who use spirituality and collective coping during stressful events demonstrate a higher capacity for handling stress (Alamilla et al., 2016; Schreiber & Brockopp, 2012). After an extensive literature search, however, I did not locate any studies that had addressed the relationships between coping strategies, level of IPV, and depressive symptoms of African American female survivors of IPV.

Much of the literature that I reviewed in this study was based on small sample sizes or focused on clinical subjects. Overall, the literature provided empirical support for the relationships between IPV exposure and depression and the effects of these two factors on an individual's emotional well-being, strengthening the case for the need of

effective coping strategies to be developed and implemented (Cho, 2012). The current study included African American women survivors of IPV who were between the ages of 25 and 49 years. I used survey methodology to examine the predictive relationships between religious coping, spiritual coping, levels of IPV, and depression among African American women exposed to IPV.

In Chapter 2, I describe the research on IPV and the characteristics of IPV victims. I also explain the known associated risk factors and consequences of IPV. In addition, I discuss the research on the effectiveness of culturally specific coping strategies. Further, I describe the depressive symptoms, associated risk factors, and adverse health behaviors related to IPV. Finally, I describe different culturally specific coping strategies and the effectiveness of using them.

Chapter 2: Literature Review

Researchers have revealed that IPV is particularly prevalent among African American women when compared to other ethno-cultural groups (Bryden et al., 2015; Shim et al., 2015). Intimate partner violence has also been shown to have deleterious effects among its victims (Cho, 2012; Salom et al., 2015). These negative effects adversely affect the victim's mental and physical health and sense of well-being (Sugg, 2015; White & Satyen, 2015; Wong & Mellor, 2014). A need exists to adopt effective coping strategies to alleviate IPV's detrimental consequences. African American women are disproportionally represented among IPV victims (Bryden et al., 2015; Shim et al., 2015). The purpose of this study was to evaluate the predictive relationships between cultural coping strategies (spirituality and religious coping), and levels of IPV, in relation to the psychological health or depression of African American women.

In this literature review, I expand on the background of the research problem identified in Chapter 1. In the first section of Chapter 2, I present the search strategy used to perform the literature review. The second section includes the ecological theory as the theoretical foundation for the study. In the third section, I define IPV and illustrate the different types and prevalence of IPV. In the fourth section, I integrate ecological theory, spirituality, and religiosity with the problem and the study purpose. This chapter ends with a summary and conclusion of the literature review.

Literature Search Strategy

I conducted an extensive literature search using journal articles, books, and Internet sources to examine the current level of research on IPV, effective coping

strategies, and the impact on IPV victims' emotional well-being. I gathered the literature from several online databases, including PubMed EBSCOhost Academic Search Premier, MasterFILE Premier, PsycINFO, PsycARTICLES, and MEDLINE. The search terms included the following: *intimate partner violence, domestic violence, interpersonal violence, dating violence, abuse, aggression, attitudes, disclosure, coping strategies, young adults, women, men, gender, culture, spirituality, religion, African American religion, African American religiosity,* and *ethnicity*. Most of the articles were from the PubMed and Academic Search Premier databases.

I cross-searched the key words *IPV, coping strategies, emotional well-being, and depression,* or a combination of these words with demographic characteristics such as *women, race/ethnicity, income, employment,* and/or *marital status*. These key words were also cross-searched by risk behavior search terms such as *alcohol, drugs, obesity,* and *health consequences*. These searches resulted in many different articles and published reports from which I drew information. The key word search also yielded additional sources that I accessed and drew articles from.

The sources used to obtain the information in this chapter were mostly from current peer-reviewed journals. The research was initially limited to articles published within the past 5 years, but I identified key foundational information from articles as far back as 1995. Most of the articles used in the review came from journals published in the United States. After an extensive search of the literature, I did not locate any articles that addressed the relationships between religion, spirituality, IPV, and depression in African American women ages 25 to 45 years.

Theoretical Framework

The ecological perspective was appropriate for conceptualizing intimate partner violence. The theory allows for the consideration of multiple, interdependent factors including, but not limited to, participants, culture, nationality, and society as a whole that relate to factors such as economics and political systems that have an influence at the personal, situational, sociostructural, and sociocultural levels (Bronfenbrenner, 1977). Understanding the individual is a complex process. Bronfenbrenner stated that to understand the individual, there must be an examination of where the individual lives, including the home, work-place, community, culture, and so on. Most people are likely familiar with the microsystem, mesosystem, exosystem, and macrosystem frameworks Bronfenbrenner established, but Bronfenbrenner later stressed "the person-context interrelatedness" (Ushioda, 2015).

Bronfenbrenner's (1977) ecological systems theory (EST) is among the most widely adopted theoretical frameworks for researchers studying individuals in ecological contexts (Burns et.al.,2015). In the traditional formulation of EST, different levels of ecological systems are viewed as nested within one another (Bronfenbrenner, 1977). Ecological systems theory underscores the importance of interdependent and multilevel systems on individual development, but the precise relationships of systems to one another remain elusive (Bronfenbrenner, 1977). Bronfenbrenner (1977) originally described ecological systems as different levels nested within one another, giving rise to EST's classic graphic portrayal of concentric circles. Bronfenbrenner described the topology of the ecological environment as a nested arrangement of structures, each

contained within the next, which must be examined as an interdependent whole to fully understand the forces surrounding a developing individual. Effects of IPV exposure most likely take place at the microsystem level of Bronfenbrenner's EST. At the lowest level of the nested hierarchy, microsystems are settings in which the individual plays a direct role, has direct experiences, and has direct social interactions with others, such as families of origin and people with whom the individual regularly interacts in close relationships (Barth, 2017). Social interactions are a key component of EST. Bronfenbrenner (1977) was a pioneer of social network research, and clearly defined the microsystem and mesosystem in terms of social interactions (Bronfenbrenner, 1977). As a theory, EST specifies constructs, but it does not specify how to operationalize the constructs. The traditional nested model relies on the construct of settings as the fundamental building blocks of ecological systems (Bronfenbrenner, 1977).

Use of the Ecological Model for IPV

Bronfenbrenner (1977) described the interplay among personal, situation, and social factors. Although not primarily designed as a domestic violence model, this theoretical model's constructs fit IPV models (Davila, 2014; R.J. Nelson & Lund, 2017). The ecological model's role in the study of domestic violence suggested that an opportunity exists for the development of multilevel interventions (Smith, Foran, Heyman, & United States Air Force Family Advocacy Research Program, 2014). Using an ecological approach to IPV conceptualizes violence as a multifaceted phenomenon that may be explained within personal, situational, and sociocultural dynamics (Smith et al., 2014). Ecological theory's broad-based conceptualization and its focus on complex

interactions is fitting in the investigation of family violence as a whole, and more specifically, intimate partner violence (Srinivas & DePrince, 2015). This theoretical approach lends itself to a more holistic approach to intimate partner violence. This type of approach was necessary due to the complexities of violence located within families and more specifically between intimate partners.

Application of Ecological Theory to IPV

The ecological theory proposes four levels of the environmental system. Those levels include the microsystem, mesosystem, exosystem, and macrosystem (Barth, 2017). At the center of the system are the individual and associated personal characteristics such as age, gender, and health. The microsystem consists of the immediate surrounding environment and associated relationships with others in that environment. The mesosystem consists of the interactions between the various relationships in the microsystem (Bronfenbrenner, 1994).

In the context of the current study, a component of an individual's immediate surrounding would be the intimate partner. These individuals have a direct and consistent interaction with the IPV victims. In IPV, the immediate environment consists of intimate partners, family members, and immediate groups with whom the victim has primary relationships. The microsystem is the immediate setting in which a person operates and participates in face-to-face interactions. Examples include intimate interactions between family and friends, children and parents, and children and teachers. Personal history is also included within the microsystem environment (Bryden et al., 2015).

The exosystem involves the community surrounding the individual, such as the school, the church, media, and other environments such as communities or organizations (Boon, 2016). Church-related variables such as religion and spirituality have an impact on how individuals react to elements of the environment. For instance, researchers have shown that African Americans use religion and spirituality as coping strategies to handle stress (Bryden et al., 2015; Hirsch et al., 2014). Researchers have also shown that spirituality and religion are related to increased social support, improved quality of life, longevity of life, and less psychopathology among African American IPV victims (Bryden et al., 2015; Hirsch et al., 2014). The interactions that African American IPV victims have with the church are, therefore, relevant to this research area (Bryden et al., 2015; Hirsch et al., 2014). Spirituality and religious coping appear to be especially important as coping strategies for African Americans compared to European Americans, as African American women, have a strong tradition of relying on spiritual and religious beliefs for strength and support when coping with oppression (Hayward & Krause, 2015; Johnson et al., 2015). Alamilla et al. (2015) indicated that spirituality and religious coping were culturally relevant factors that had a positive impact on the mental health outcomes of African American women who were exposed to IPV.

The exosystem is further relevant to the current study because researchers have found a relationship between the rate at which IPV occurs in certain communities, families, and homes (Cho, 2012). The victim's larger environment, the macrosystem, includes the culture, the government, and society as a whole, which can influence how IPV affects women (Beyer, Wallis, & Hamberger, 2015). Different laws and policies

have been developed to address the issue of IPV and the effects of IPV on women. In 22 states, mandatory arrest laws indicate that police officers responding to a call for help no longer need to determine whether one person was truly violent or out of control; every time someone reports abuse, the police are allowed to make an arrest. In some states, battered women are charged with "failure to protect" if a child is in a home where IPV occurs (Juby, Downs, & Rindels, 2014). In the presence of such laws, women could become victimized twice: once by the perpetrator and again by the legal system. Previous researchers on domestic violence have indicated that there is an increase of rates of intimate partner violence arrest due to mandatory arrest laws; however, there is no evidence suggesting that it helps IPV victims (Li, Levick, Eichman, & Chang, 2015; Sherman & Harris, 2015).

African American women experience IPV at disproportionately high rates (Perez, Johnson, & Wright, 2012). As such, African American women who are victims of IPV may need a comprehensive array of resources to help them develop strategies for cope with and recover from their victimization (Perez et al., 2012). I adopted the ecological theory as the foundational theory for this study to investigate the relationships between African American women's use of elements of the microsystem and macrosystem to cope with IPV are related to their depression.

Researchers have found a direct correlation between IPV and emotional well-being such that abused African American women exposed to IPV reported lower levels of spiritual wellness than their abused and nonabused counterparts (Dutton et al., 2014; Stockman et al., 2015). This relationship can be explained theoretically through the

ecological systems theory. Based on this theory, I hypothesized that the psychological effects of IPV exposure could be harmful regarding an individual's behavior. In examining this topic based on the ecological theory, the exposure to IPV in the victim's environment leads to cognitive schemas concerning the sense of worthlessness, pessimistic outlook on life and the future, and a sense of isolation and disconnect from God and others (Davila, 2014). Use of the ecological theory in terms of coping for African American women exposed to IPV focuses on stabilization, safety, and empowerment and teaches women skills to manage the impact of their IPV exposure symptoms, which may interfere with their ability to access essential community resources and establish safety for themselves (Davila, 2014).

Literature Review

In this section, I will review and synthesize the relevant themes in previous studies that aided the current research in understanding the research problem. There are eight subsections in this section. The first includes a definition of IPV followed by types of IPV. The discussion proceeds with IPV as a public health issue. The next subsections include spirituality and depression and religious coping and depression. I will present the surveys used in the current study in the following paragraph. I will conclude the review with a discussion of the gaps in the body of literature and the limitations of previous research.

Defining IPV

Intimate partner violence is a serious, preventable public health problem that affects millions of Americans (Modi et al., 2014; Smith et al., 2017; Spivak et al., 2014).

The CDC (2014) has reported that more than 12 million women and men become victims of rape, physical violence, or stalking by an intimate partner over the course of a year in the United States. Based on this figure, an average of 24 persons in the United States experience some form of IPV every minute (CDC, 2014). The term *intimate partner violence* describes physical, sexual, or psychological harm that is caused by a current or former partner or spouse (Shepherd-McMullen, Mearns, Stokes, & Mechanic, 2015). Several researchers have described IPV as physical assault (hitting, kicking, slapping, choking, etc.), sexual assault, and stalking by a current or former spouse or intimate partner (Overstreet, Willie, Hellmuth, & Sullivan, 2015; Shepherd-McMullen et al., 2015).

Many researchers have supported the idea that establishing a consistent definition of IPV is needed to enable professionals to monitor the incidence of IPV and examine trends over time (Bagwell-Gray et al., 2015; Robbins, Hurley, Liu, & Chao, 2015; Stockman et al., 2015). By establishing consistent definitions that can help determine the magnitude of IPV and comparing the problem across jurisdictions, researchers will be better able to evaluate the effectiveness of interventions or coping strategies. A consistent definition may also help such researchers measure the risk and protective factors for victimization in a uniform manner (Bagwell-Gray et al., 2015; Robbins et al., 2015; Stockman et al., 2015). For the purposes of this dissertation, IPV referred to actual or threatened physical, emotional, or sexual harm, including coercive/controlling behaviors experienced by women from their current or former partner, such as a husband, boyfriend, or dating partner (Brieding et al., 2015; Shepherd-McMullen et al., 2015).

Types of IPV

Interpersonal violence can occur on a continuum ranging from one single occurrence of violence to chronic, severe battering (Beydoun, Kaufman, Lo, & Zonderman, 2012). One of the more common forms of IPV is that which is perpetrated by a husband or intimate male partner (Beydoun et al., 2012). Although women can be violent in relationships with men, and IPV can occur in same-sex partnerships, the majority of IPV cases are borne by men against women (Singh, Tolman, Walton, Chermack, & Cunningham, 2014). The four main types of IPV include physical violence, sexual violence, threats of physical or sexual abuse, and psychological or emotional violence (Yalch, Levendosky, Bernard, & Bogat, 2015).

The first form of IPV is physical violence, which refers to the intentional use of physical force with the potential for causing bodily injury, disability, or death (Lacey et al., 2015). The purpose of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed, is aggressive behavior and is considered by the law as an act of IPV (Lacey et al., 2015). Some examples of physical violence can include acts scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, slapping, punching, and burning. Other forms of physical aggression may involve the use of a weapon and or the use of restraints or one's body to subdue another person (Nybergh, Enander, & Krantz, 2016).

I noted that there are several forms of IPV sexual violence explored in the literature (Argento et al., 2014). The first form of IPV is related to an attempted or completed sex act involving a person who is unable to understand the nature or condition

of the action, unable to decline participation, or unable to communicate unwillingness to engage in the sexual act. The victim of this type of IPV sexual violence lacks ability because of illness, disability, the influence of alcohol or other drugs, intimidation, or undue pressure (Argento et al., 2014).

Sexual violence as a form of IPV can be divided into the four categories of attempted/completed sex acts, abusive sexual contact, psychological/emotional abuse, and stalking (Argento et al., 2014). Intimate partner violence in the form of sexual abuse can be categorized as threats of violence or sexual contact (Argento et al., 2014). In the threats of violence or sexual contact category of IPV, the violent partner often gives threats of physical or sexual abuse towards his or her partner. The dangers of violence or sexual contact form of sexual IPV can involve the use of words, gestures, or weapons to communicate the intent to cause physical injury, disability, or death (Lacey et al., 2015). Another form of IPV, or psychological/emotional violence, is identified as either act, the threats of actions, or coercive tactics that may result in mental trauma to the victim (Overstreet et al., 2015).

Psychological/emotional abuse results from acts such as humiliating the victim, controlling what the victim can and cannot do, withholding information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends and family, and denying the victim access to money or other primary resources (Hellmuth, Jaquier, Overstreet, Swan, & Sullivan, 2015; Overstreet et al., 2015). Psychological/emotional violence has been associated with prior physical or sexual abuse. Even the previous threat of physical and sexual violence has a

more intense effect on IPV victims than on victims without the experience of any physical or sexual abuse before the IPV (Devries et al., 2014).

Researchers have found cases where women experienced verbal abuse but did not report having experienced any physical damage from the same partner (Miranda & Ross-Sheriff, 2008). Many scholars have demonstrated that emotional maltreatment exists within a pattern of other physical violence; however, few researchers have examined nonphysical harassment as a form of IPV (Karakurt et al., 2014). Such findings revealed that control and emotional abuse is highest in relationships in which one partner is employed, and the other partner is not employed (Hellmuth et al., 2015).

Stalking is a form of IPV (Kuijpers et al., 2011). Of the four categories of IPV, stalking falls under the psychological classification of IPV. Stalking can take many forms and includes repeated threatening and harassing behavior directed to another person. Covered under stalking are following a person, repeatedly appearing at an individual's job, home or place of business unannounced. Also involved with stalking behaviors are leaving threatening or harassing messages on the telephone, and vandalizing personal property (Hellmuth et al., 2015).

Prevalence of IPV

Intimate partner violence has become a significant public health problem. Based on data from 48 surveys, 10 to 69% of women reported being physically assaulted by an intimate male partner at some point in their lives (Dutton, James, Langhorne, & Kelley, 2014; Spivak et al., 2014). In 1975, the National Family Violence Survey was conducted as one of the initial representative studies that addressed the incidence and prevalence of

IPV in the United States (Katz, Snetter, Robinson, Hewitt, & Cojucar, 2008). At that time, IPV among women occurred at a rate of 3.9 per 1,000 women and 0.3 per 1,000 men (Katz et al., 2008). More recent findings from the 2010 National Intimate Partner and Sexual Violence Survey (NISVS) conducted by the Centers for Disease Control disclosed that of the 9,086 women who completed the survey, approximately 35.6% of the women indicated that a current or former spouse or cohabiting partner had raped, physically assaulted, or stalked them (Stockman et al., 2015).

The likelihood of an event occurring during the lifetime of an individual is referred to the lifetime prevalence (Stockman et al., 2015). Lifetime prevalence of IPV is calculated using a sample demographic and based on risk characteristics. In the United States in 2012, the lifetime prevalence of IPV for women ranged from 25% to 60%. Lifetime prevalence of 25% to 60% means that a woman is 25% to 60% likely to experience IPV during her lifetime. The annual incidence or the likely occurrence of IPV in a year for women ranged from 4% to 54% (Bundock et al., 2013). Researchers have reported the following regarding the prevalence of the various types of IPV: 61% physical IPV in the absence of sexual IPV, 11% sexual IPV in the lack of physical IPV, and 29% both physical and sexual IPV (Bundock et al., 2013).

Previous researchers have indicated that African American women are at a higher risk for experiencing IPV (Hurwitz, Gupta, Liu, Silverman, & Raj, 2006). Hurwitz et al (2006) used a quantitative research design to investigate the prevalence of IPV in the United States. Results from that study revealed that African American women were 1.23 times more likely to experience minor IPV and 2.36 times more likely to suffer severe

IPV than White women (Hurwitz et al., 2006). The researchers also concluded that even after controlling for income level, or in relationships where both partners were employed, there was no statistical difference in the prevalence rates of IPV in either White or African American women. Although IPV can be found across a range of demographic groups, I focused on the IPV of experiences of African American women residing in the United States who have reported physical or sexual IPV as adults.

IPV as a Public Health Issue

Researchers have labeled IPV as a significant public health issue that needs to be addressed (Dutton et al., 2014). IPV has been linked to an increased risk of sexually transmitted diseases (STDs; Stockman et al., 2015). IPV has been associated with sexual risk-taking among women including having multiple partners, not using a condom, and inconsistent condom use (Stockman et al., 2015). Psychological abuse often accompanies physical violence in intimate relationships, and there is a connection to IPV in one third to one half of cases by sexual violence (Durborow, Lizdas, Flaherty, & Marjavi, 2013).

Findings revealed a significant correlation between IPV and emotional well-being such that abused women reported lower levels of psychological well-being than their nonabused counterparts (Dutton et al., 2014; Stockman et al., 2015). Many researchers have linked IPV with mental illnesses such as depression, anxiety, suicidality, posttraumatic stress disorder, substance dependence, chronic pain, and somatic symptoms, among others (Adams, Tolman, Bybee, Sullivan, & Kennedy, 2012). Victimized women may view themselves as being less healthy and having more physical complaints and symptoms of emotional distress than women who have not been

victimized (Fischer et al., 2016). African American women continue to be at increased risk for mortality, sustain injuries that are more serious and have higher mortality rates than other groups (Weiss et al., 2015).

Consequences of IPV

Several scholars have revealed that IPV has long-term adverse health consequences for survivors even after the abuse has ended (Dillon, Hussain, Loxton, & Rahman, 2013). This can translate into poor health status, lower quality of life, and higher utilization of health services (Dillon et al., 2013). On average, victims of intimate partner violence experience more operative surgeries, more visits to doctors, and more hospital stays throughout their lives than for those without a history of abuse (Yalch et al., 2015).

Researchers have reported IPV to take both a short-term and long-term toll on victims' mental and physical health (Yalch et al., 2015). Violence by an intimate partner has been linked to many immediate and long-term health issues such as physical injuries, gastrointestinal disorders, chronic pain syndromes, depression, and suicidal behavior (Yalch et al., 2015). Abused women have a 50% to 70% increase in gynecological issues, central nervous system, and stress-related problems compared to women who do not experience IPV (Yalch et al., 2015).

IPV also affects women's reproductive health and can lead to unwanted pregnancy, premature labor, and premature births (Caldwell, Swan, & Woodbrown, 2012). Researchers have also found that battered women were more likely to have gynecological symptoms, such as sexually transmitted diseases, vaginal bleeding or

infection, fibroids, pelvic pain, HIV/AIDS, and urinary tract infections (Hindin, Btoush, Brown, & Munet-Vilaro, 2015). Other health issues found to occur in battered women include mental health problems such as anxiety, PTSD, and depression (Breiding et al., 2015).

Researchers stated that both African American and Caucasian women experienced significant depression, suicidal thoughts, and even some physical health issues (Beydoun et al., 2012). Beydoun et al. used a qualitative research design to identify the connection between IPV exposure and depressive symptoms. The researchers conducted a meta-analysis of 37 cross-sectional designed studies conducted in the United States, finding that 9% to 28% of the women exposed to IPV reported an increased risk of significant or elevated depressive symptoms (Beydoun et al., 2012).

Cerdá, DiGangi, Galea, and Koenen (2012) engaged in a systematic review of the literature on IPV. These authors expressed their concern about the high mortality rate among IPV victims. The researchers also noted that even when IPVs were nonfatal, there were considerable severe physical and mental health problems for IPV victims (Cerdá et al., 2012). The researchers justified this study by citing critical methodological issues that remained despite the proliferation of investigations into this phenomenon (Cerdá et al., 2012).

Cerdá et al. (2012) concluded that several limitations continue to plague studies that focused on IPV. Cerdá et al. noted that the most significant challenge when designing and researching IPV is the impossibility of randomizing exposure to violence. Cerdá et al. reported that based on national surveys of all children exposed to violence

before the age of 18, 14.0% is attributed to IPV and family violence. Further, women exposed to abuse in childhood were more likely to experience depression in adulthood. Cerdá et al. also reported that multiple exposures to violence increased the likelihood of psychopathy.

Lacey et al. (2015) engaged in a quantitative study to evaluate the association between mental and physical health and IPV among U.S. Caribbean and African American women. The researchers argued that researchers in past studies have not addressed the differences in these conditions for different categories of Black females. As such, these researchers aimed to examine the association between IPV and mental and physical health for Black women and to determine whether these outcomes were different for US Caribbean Black females and African- American females (Lacey et al., 2015).

Lacey et al. (2015) used cross-sectional data from a National Survey of American Life. The researchers interviewed 6,082 adult females. In-person and telephone interviews were the primary methods of data collection, with about 90% of the participants interviewed in person. The researchers reported a 72.3% response rate. Lacey et al. (2015) used bivariate correlations to analyze the data. The researchers found a close association between increased risk for dysthymia, alcohol, and substance abuse. Lacey et al. also reported differences in health outcomes between both groups, with African American women being at higher risk for adverse health outcomes when compared to their U.S. Caribbean counterparts. The data revealed that African American women who experienced IPV became more depressed. Moreover, African American women were

more likely to stay depressed after the violence or abuse ended unlike their Caucasian counterparts (Lacey et al., 2015).

Lacey et al. (2015) admitted shortcomings were associated with their study. The researchers noted that they were unable to control for mediating and moderating factors and that there might also be in-built selectivity based on their sample population. The researchers called for additional longitudinal and comparative studies that explored the phenomenon that they studied (Lacey et al., 2015). Despite these shortcomings, Lacey et al. contended that their research contributed to an increased understanding of IPV and its relationship to emotional, mental, and physical health outcomes.

Stockman et al. (2015) reported that both HIV and IPV continue to remain epidemics despite attempts to address these issues in the past two decades. Saying that African- American women and women of color are more highly represented among HIV population, the researchers further added that there is disproportionately high HIV and IPV comorbidity among African American population. Stockman et al. also reported that there is an overlapping risk between IPV and HIV.

Researchers have consistently shown that African American women are at higher risk for experiencing IPV when compared with women from other ethnic groups (Beydoun et al., 2012; Dutton et al., 2013). Additionally, IPV has long-term effects even after the abuse has ended. Research into factors such as gender or race that can have a moderating influence on the occurrence and outcome of IPV is also needed (Lacey et al., 2015).

Variables Linked to IPV

Lacey et al. (2015) suggested that there must be more studies about the factors linked to IPV. In this section, such variables are discussed. Specifically, I will present variables such as gender, race, age, and religious involvement.

Gender. Results from several studies have revealed that exposure to IPV varies according to the gender of the research participant, victim, and the perpetrator (Sylaska & Edwards, 2014). When the victim was a male, participants viewed the situation as less dangerous, and the victim as more responsible. Participants were more likely to ignore the case when the victim was male than when the victim was female (Sylaska & Edwards, 2014). Within studies of cross-gender couples, male victims are seen as more responsible or blameworthy for IPV than female victims (Sylaska & Edwards, 2014). Although this information is vital to contributing to the general understanding of IPV perceptions and the influence of gender and attitudes on responses to IPV, there are other variables and other research that needs to be considered and when discussing this issue of IPV. Among those variables are race, religion, age, and spiritual coping strategies.

Race. Cho (2012) conducted a study using the Collaborative Psychiatric Epidemiology Surveys (CPES) to examine differences in the prevalence of IPV among significant racial groups in the United States. Cho reported that IPV affects all populations, but that there are significant variations among the different groups of IPV victims. Cho used a quantitative methodology to study whether there were racial differences in the prevalence of IPV among different ethnic groups of Blacks, Hispanic, Asian, and Caucasian women. In this study, Cho used both descriptive statistics and

multivariate logistic regression to analyze the data collected. The variables investigated in the study included age, race, financial security, employment, education, social network, IPV perpetration and victimization, and severity of IPV. Findings from this survey indicated that African Americans experienced IPV with the highest prevalence, followed by Whites, Hispanics, and Asians. This information is essential to the current context because the focus of the present study was African American women.

Religion. Acevedo, Lowe, Griffin, and Botvin (2013) performed a quantitative study with 1,130 young adult women between the ages of 21 and 26 to identify predictors of IPV among young adults. The researchers collected data using a telephone-based survey and found that religious involvement had a mitigating effect on IPV risk. Participants who attended church services more regularly also reported lower incidents of IPV. The findings indicated a higher rate and prevalence of IPV among women when compared with men (Acevedo et al., 2013). Acevedo et al. cited limitations of their study due to sampling techniques and integrity of the participants. Noting that recall and the unwillingness to disclose may have had a limiting impact on the results, the researchers reported that the findings in this study were consistent with previous and similar studies involving at-risk populations and risk predictors of IPV. This information because the current research problem is about religion and spiritual coping strategies.

Age. Cho (2012) indicated that financial security and age affected IPV victimization. The findings revealed that women between the ages 25-49 experience significantly higher rates of IPV victimization. Previous researchers also had similar

results (Breiding et al., 2015). In general, younger women are at higher risk for IPV than older women.

Spirituality, IPV, and African Americans

Previous researchers have revealed a relationship between religion, spirituality, and the emotional health of women exposed to IPV. Researchers often use the terms spirituality, intrinsic religiosity, and religious coping interchangeably (Drumm et al., 2013; López-Fuentes & Calvete, 2015), but many have concurred that spirituality is different from religion. Religion is often synonymous with extrinsic religiosity, which can be described as accepting a codified set of beliefs that are a part of a particular form of religion of which one is a member (Drumm et al., 2013). On the other hand, spirituality is having a belief in a higher Being (Drumm et al., 2013).

Fischer et al. (2016) conducted a quantitative study into the efficacy of spirituality as a protective factor for IPV. In this study, the researchers examined the link between spirituality and religion among low-income African American females to determine the extent to which spirituality and religion promoted resilience and increased coping strategies for these victims to avoid suicide ideation. The researchers used cross-sectional data and conducted both descriptive and path statistical analysis of the data. The researchers reported a positive association between suicide ideation and IPV, meaning that IPV is more inclined to think of suicidal thoughts.

Religious coping refers to people's "use of religious beliefs or behaviors to facilitate problem-solving to prevent or alleviate the negative emotional consequences of stressful life circumstances" (Holt, Clark, Debnam, & Roth, 2014, p. 193). Positive

religious coping results in individuals were feeling more connected to God and to others. This increased sense of connectedness with God and others creates definite meaning in life (Drumm et al., 2013; Holt et al., 2014). Negative religious coping leads to disconnection from not only God but also others, and a sense of guilt and of being punished. Several researchers have investigated the relationship between religious coping and mental health outcomes, including depressive symptoms, among women who were exposed to IPV (Drumm et al., 2013; Holt et al., 2014). The existing empirical evidence suggests that when religious coping functions as a mediator, the link between stressors and mental health outcomes are impacted (Archibald, Dobson, Daniels, & Bronner, 2013; Drumm et al., 2013; Holt et al., 2015).

In another study, Archibald et al. (2013) used a quantitative, cross-sectional study to examine the role of spiritual coping in African American women about dealing with stress. Archibald et al. suggested that there might be cultural elements that help African American IPV victims build resilience. Archibald et al. concluded that spiritual coping gave the victims a sense of control, and thus that sense of control served as a mediator between the psychological stressors, depressive symptoms, and spirituality. However, statistical analysis of the data produced findings that confirmed the hypothesis that spirituality and religion were mitigating factors that increased resilience and reduced stress among low-income African American IPV victims (Fischer et al., 2016).

Spirituality and religious coping are universal concepts that are not unique to the African American culture (Gaston-Johannson et al., 2013; Holt et al., 2014). Although universal dimensions of spirituality exist across different cultures, researchers have

suggested that African Americans have historically turned to spirituality to help them cope with serious physical and mental damaging experiences (Fischer et al., 2016; Foster et al., 2015).

Researchers have shown that both spirituality and religious coping play particularly important roles for African Americans concerning their coping abilities, as compared to the majority racial group (Archibald et al., 2013; Holt et al. 2014). One major difference in the way African American women cope lies in the areas of spirituality and religious coping, where African American women report more significant interest in incorporating these aspects in their repertoire of coping strategies (Holt et al. 2014) revealed that African American women strongly endorsed 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.

Foster et al. (2015) used a qualitative approach to examine effective coping strategies based on the circumstances that caused the need to cope. In this study, Foster et al. screened 200 female patients that were exposed to IPV; a total of 42 participants completed the in-depth survey. Utilizing the Brief RCOPE as the data collection tool, the results indicated that 86% of the participants, of which 72% were African American, turned to religious coping to help improve their emotional well-being after IPV exposure (Foster et al., 2015). Drumm et al. (2013) engaged in qualitative research to study the religious and spiritual coping strategies used by victims of IPV. In this study, Drumm et al. used data from 42 interviews of survivors of IPV. Religious coping is an essential

component of the repertoire of coping strategies in the African American community (Drumm et al., 2013) that positively impacted the study participants' well-being.

Holt et al. (2014) used a quantitative methodology to examine the benefits of spiritual coping as a mediatory influence on psychological stressors and health outcomes to illustrate the harmful effects of IPV on victim's emotional well-being. Holt et al. analyzed data collected from 2,370 participants who completed a telephone survey. Holt et al. posited that religious coping is multidimensional and has been shown to have beneficial outcomes for persons that used religious coping strategies. Holt et al. found that relying on their spirituality was a coping strategy for IPV victims (Holt et al., 2014). Relying on their spirituality helped the victims concerning their emotional well-being and depressive symptoms (Archibald et al., 2013; Holt et al., 2014).

Jones, Simpson, Briggs, and Dorsett (2016) reviewed 28 studies to examine the implications of spirituality for patients with Spinal Cord Injury (SCI). Of the 28 studies reviewed, 26 studies focused on adjustments to SCI. The researchers supported the conclusion that spirituality is an important dimension of life satisfaction and QOL. Based on their findings, the researchers indicated that spirituality promoted resilience, which is an important indicator of how well individuals adjust to traumatic and stressful events (Jones et al., 2016).

Breitbart et al. (2012) ascertained that spirituality and well-being are important for patients with cancer. As such, the researchers developed and tested a therapy that they designed to increase the benefits of spiritual well-being for their patients. Results from this quantitative study indicated that interventions that included improving spiritual well-

being had clear benefits for enhancing patients' quality of life (Breitbart et al., 2012). Although this study targeted a different cohort of patients instead of IPV victims, the findings highlighted the benefits of spirituality in alleviating some of the psychological outcomes associated with stressful life events (Breitbart et al., 2012).

Religious Coping and Depression

Jim et al. (2015) conducted a meta-analytical review of the literature of religion, spirituality and physical health in cancer patients. Contending that religion and spirituality are important in its own right, Jim et al. sought to discover whether there was a relationship between religion, spirituality, and physical health. Based on their findings, the researchers reported there was an association between religion, spirituality, and physical health (Jim et al., 2015). These authors conducted a meta-analysis of the relationship between religion, spirituality, and physical health. The researchers concluded from a study consisting of 32,000 participants that overall religion and spirituality was positively correlated with good physical health. Jim et al. used the SWBS in an attempt to discover whether there was a relationship between religion and spirituality and physical health. Based on their findings, the scholars reported an association between religion and spirituality and physical health (Jim et al., 2015).

Schreiber and Brockopp (2012) conducted a systematic review of 18 quantitative studies to examine the associations between religion, spirituality, and emotional well-being among women with cancer. The researchers reported that their findings did not indicate a relationship between spirituality and religion and emotional well-being. In this study, religion and spirituality were conceptualized as a religious practice, religious

coping, and perception of God. The researchers argued that there is an absence of clarity when defining religion and spirituality and that this might account for their findings (Schreiber & Brockopp, 2012). In my study, the focus was on religious coping. Several studies have similar characteristics and demographics to the current research. Empirical evidence from these studies points to a significant correlation between IPV and spiritual well-being. A consensus among these studies is that abused women report lower levels of spiritual well-being than their nonabused counterparts do (Breitbart et al., 2012; Cummins, 2013; Whitford & Olver, 2012).

Whitford and Olver (2012) contended that religion and spirituality are multidimensional constructs. Faith, peace, and meaning, quality of life (QOL), and coping are among the dimensions of spirituality and religion. The researchers used multiple regression to analyze the data collected from 999 newly diagnosed cancer patients. Their findings support the importance of spirituality and religion to well-being and QOL. The researchers contended that a multidimensional approach to IPV that integrated spirituality and religion offers a better plan and conceptualization of the phenomenon that renders it more applicable for treating patients experiencing traumatic life stressors (Whitford & Olver, 2012).

The existing empirical evidence suggests that spiritual well-being functions as a mediator of the link between stressors and mental health outcomes. Earlier researchers have found 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 severe depressive symptoms (Breiding et al., 2015).

Surveys Used in the Study

I used the survey methodology to collect data for the variables in this study. I measured the independent variable, religious coping, based on scores from the Brief RCOPE Survey. I measured the independent variable, spiritual coping, based on scores on the Spiritual Well-Being Inventory. I measured the independent variable of the level of IPV based on scores from the Index of Spouse Abuse. I measured the dependent variable depression based on scores from the Beck Depression Inventory. I captured demographic data such as age, income, marital status, number of children, and education in the demographic survey that I developed. In the following section, I will provide a brief synopsis of how these instruments have been used in past research.

Brief RCOPE

The Brief RCOPE is the most widely used measure in studies regarding religious coping (Pargament et al., 2011). Traditionally, researchers have used two approaches to assess religiousness. The first approach measures global indices such as church attendance and involvement, and a second measure assesses religious attitudes and beliefs (Pargament et al., 2011). The Brief RCOPE is a different approach to the study of religious coping. The Brief RCOPE is grounded in theory and research (Pargament et al., 2011).

Earlier researchers have found that the Brief RCOPE offers an efficient, theoretically meaningful way to investigate religious dimensions in studies of stress,

coping, and health (Gerber, Boals, & Schuettler, 2011). One benefit of using the Brief RCOPE is that the items themselves were generated through interviews with people experiencing major life stressors. The Brief RCOPE was beneficial in measuring participants' use of religious coping for IPV.

There are two primary forms of religious coping: positive and negative. Positive religious coping methods reflect that a person has a secure relationship with a transcendent force, a sense of spiritual connectedness with others, and a benevolent worldview (Bowland, Edmond, & Fallot, 2013). On the other hand, negative religious coping methods reflect underlying spiritual tensions and struggles within oneself, with others, and with the divine (Bowland et al., 2013). In this study, I measured positive religious coping methods.

A review of the literature related to use of the Brief RCOPE yielded 22 studies. The search result did not generate studies that involved the scale in assessing religious coping among IPV victims. I identified only one study in which the researchers used the Brief RCOPE scale to evaluating religious coping among an African American population. In the majority of studies in which the researchers used the brief RCOPE, they used the scale to assess coping with psychological stress in the context of hospitals and medical settings. I will present a brief summary of some of that research in the following section.

Hvidtjørn, Hjelmborg, Skytthe, Christensen, and Hvidt (2014) studied religiousness and religious coping in a secular society from a gender perspective. These researchers examined the effect of religious coping in a gender-specific manner. The

researchers engaged in a quantitative study that comprised 3,000 Danish men and women between 20 and 40 years of age. The response rate for this study was 45%. The researchers used a web-based questionnaire to elicit information about demographics, religiousness, and religious coping. Religiousness was categorized using three constructs, cognition, practice and importance. Religious coping was assessed using the Brief RCOPE. The findings indicated that gender accounted for substantial differences in both religiousness and religious coping. Approximately 60% of the women stated that they used religion as a coping strategy, as compared to 40% of male participants. Nearly 60% of the women believed in some spirit or God, as compared to 40% of the men. The proportion of men who used negative religious coping strategies was higher than the percentage of women who used negative coping strategies.

Freitas et al. (2015) conducted a study on religious coping and its influence on psychological distress, medication adherence, and quality of life in inflammatory bowel disease. The researchers engaged in a cross-sectional quantitative study of 147 patients. Freitas et al. collected data on sociodemographic data and disease-related variables. These researchers collected data on psychological distress using the Hospital Anxiety and Depression Scale. The researchers used the Brief RCOPE Scale to assess religious coping. The results indicated that the use of religious coping mitigated anxiety and that religious struggle was significantly associated with depression (Freitas et al., 2015).

Stroppa and Moreira-Almeida (2013) used a cross-sectional quantitative study to address religiosity, mood symptoms, and quality of life in bipolar disorder among 168 outpatients with bipolar disorder. The researchers assessed religiosity using the Duke

Religious Index, and assessed religious coping using the Brief RCOPE. The authors used logistic and multiple linear regression to analyze the association between the religious indicators and clinical variables while controlling for sociodemographic variables such as age, gender, race, education, and employment status. Findings from this showed that positive religious coping strategies mitigated depressive symptoms, and positive religious coping was correlated with higher levels of the psychological and environmental quality-of-life domains. Conversely, negative religious coping was associated with lower scores on the psychological area of quality of life. The researchers concluded that intrinsic religiosity and positive religious coping were strongly associated with fewer depressive symptoms and improved quality of life, whereas negative religious coping was associated with worse quality of life.

Beck Depression Inventory (BDI)

The Beck Depression Inventory (BDI) is a 21-item self-report inventory developed by Aaron T. Beck (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961; Beck, Steer, & Garbin, 1988). Beck developed the BDI based on psychodynamic theory (Beck et al., 1961; 1988). Researchers have consistently shown that IPV and depressive symptoms in women are correlated (Archibald et al., 2015). The Beck Depression Inventory is frequently used as a tool to screen for depression (Beck et al., 1961; 1988). Pinna, Johnson, and Delahanty (2014) used the BDI to examine the impact of IPV exposure on the victims' emotional well-being. The researchers concluded that a direct correlation exists between exposure to IPV and the effect it has on emotional well-being (Archibald et al., 2013).

Researchers have revealed that African American women, in particular, experience higher exposure to IPV and related depressive symptoms than European American women, (Torres et al., 2013). Torres et al. administered participants' surveys including the BDI to investigate the relationship between IPV exposure, depression, and coping strategies. These researchers aimed to assess the link between IPV, and psychological and personality disorders. In their study, Torres et al. studied both abused and nonabused women, and they concluded from the results of the survey that there were significant correlations between IPV exposure and depression (Torres et al., 2013). The BDI scale appeared to be a useful assessment tool for social and clinical settings. I used the BDI in my study to show the correlations between IPV exposure and depression in the participants.

Africultural Coping Systems Inventory

Africultural coping is derived from an Africentric worldview that guides the values, beliefs, and behavior of individuals of African descent. The Africentric worldview also promotes harmony with nature, conversation, and sensitivity to emotions of other individuals. The Africultural Coping Systems Inventory is a 30-item measure of African Americans' culture specific coping strategies which is grounded in an African-centered conceptual framework. Utsey et al. (2000) conducted a principal components factor analysis with a sample of African American adults (n = 180) to support the contents of the ACSI. In a separate sample of African Americans (n = 220), Utsey et al. confirmed the adequate internal consistency and concurrent validity of the ACSI.

Summary

This literature review revealed a high prevalence of IPV among African American women (Kiss et al., 2015). Several scholars have acknowledged that when compared with women from other ethnic groups, the prevalence of IPV among African American women is consistently higher than other ethnic groups, the aftermath more prolonged, and the adverse impact more intense (Kiss et al., 2015). The results of this review emphasized the efficacy of religious strategies as a coping mechanism among IPV victims (Archibald et al., 2013; Holt et al., 2014). Further, religion plays a vital role as a source of strength among African Americans (Archibald et al., 2013; Holt et al., 2014). Nevertheless, a gap in the literature exists with concerning how African American women that are IPV victims employ religious coping as a strategy to mitigate the deleterious effects of IPV. Through this study, I filled a research gap regarding the coping strategies used by African Americans women IPV victims. In the next chapter, I will provide a detailed explanation of the methodological approach and processes that I used to conduct this study.

Chapter 3: Research Method

The purpose of this study was to examine the predictive relationships between cultural coping strategies (spirituality and religious coping), levels of IPV, and depression in African American women. Researchers have found religion and spirituality to preferred means of coping for African Americans, and both are related to increased social support, greater quality and longevity of life, and less psychopathology (Boyd-Franklin, 2010). Spirituality is common in the African American community, and it has often served as a survival strategy for triumphing over adversity (Hirsch et al., 2014). The current study was an important step in investigating the relationship between religious coping, spiritual coping, level of IPV, and depression among African American women in the United States coping with IPV exposure. Findings from this study may be used to advocate for the development of interventions for assisting African American women in coping with their exposure to IPV.

This chapter contains a description of the methodology I used to conduct this study. This chapter also includes a discussion and justification of the research method and design chosen for this study. In addition, I describe the participants and sampling procedure, the instruments used in the study, the research procedure, the data analysis process, and the threats to validity. I conclude with a discussion of the ethical considerations of the study.

Research Design and Rationale

I used a quantitative, nonexperimental, correlational design to examine the predictive relationships between the independent variables of religious coping, spiritual

coping, and level of IPV, and the dependent variable of depression in African American women. Using a quantitative design allowed me to transform the data collected through participant surveys to numbers to allow for a quantitative analysis (see Smith et al., 2011). Researchers use quantitative methodology when the purpose of the study is to investigate relationships between identified study variables that are quantified or measured with numerical values (Yoshikawa et al., 2013). Quantitative studies are deductive and confirmatory research, which originates from a theory or set of hypotheses that are validated through statistical testing (Pulido-Martos et al., 2012). Through a quantitative study, I was able to generalize my findings from a small sample to a larger group.

I used a nonexperimental design because the purpose of this study did not include manipulation of IPV exposure on the victims. The use of a nonexperimental study does not show a true cause-and-effect relationship between the variables, but rather allows for a high level of external validity. This design allowed me to apply the results to the representative sample of African women 25 to 45 years of age from women's shelters in Atlanta. I used a nonexperimental design because although there may be a correlation between IPV exposure and emotional well-being, there are other factors involved in the lives of people exposed to IPV that could be contributing to their emotional well-being. A quasi-experimental design was not appropriate for the purpose of this study, which was to examine possible correlation between variables in a setting that does not permit control and manipulation of relevant variables. The equivalency of the groups must be determined via a pretest to examine preexisting differences. To have a true experimental

study, the researcher needs to be able to manipulate the predictor variable. If I had a way to switch men exposed to IPV into women exposed to IPV and women exposed to IPV into men exposed to IPV to determine which gender is impacted more by IPV exposure, then it would have been possible to perform an experimental study. To study the effects of IPV exposure, a person should be able to manipulate his or her level of IPV exposure. If a researcher cannot manipulate a person's level of IPV exposure, then he or she cannot run an experimental study. A nonexperimental design involves using variables that cannot be manipulated and controlled (Babbie, 2012).

The quantitative design in this study was correlational. Researchers conduct a correlational study when the objective is to examine relationships among variables or predictive relationships between the independent variables and the dependent variables (Leedy & Omrod, 2010). A correlational design was appropriate because this study did not involve any manipulation of variables or the use of a controlled experimental research setting.

I collected data using the survey methodology. The use of surveys allowed me to collect large amounts of information from a larger group in a short period of time (see Salganik & Levy, 2015). In addition, this allowed me to quantify the survey results quickly and easily, as well as to use the data to make comparisons among the variables of interest (Madrigal & McClain, 2012).

The independent variables in the study were religious coping, spiritual coping, and level of IPV. I measured religious coping using scores from the Brief RCOPE, and I measured spiritual coping using scores from the Africultural Coping System Inventory. I

determined the participants' level of IPV using scores from the Index of Spouse Abuse. I operationalized the dependent variable of depression using scores from the Beck Depression Inventory.

Methodology

The methodology section includes a discussion of the population and sampling and sampling procedures. I also describe the procedures for recruitment, participation, and data collection, including details about recruiting procedures, demographic information collected, and how I provided participants with informed consent. Next I discuss the instrumentation and operationalization of constructs, including details about the instruments I used to measure the variables in the study. The last section includes a discussion of the data analysis plan.

Population

The targeted population was African American women ages 25 to 45 years. The sample population was African American women ages 25 to 45 years living in shelters in downtown Atlanta who had reported being victims of IPV. The participants were residents of Atlanta, GA, which is the 40th largest city in the United States. Atlanta is the sixth largest city in the Southeastern region; however, the city's population at the lowest point in 1990 was approximately 394,000. The population has been increasing every year since then, reaching 420,003 residents in 2010 (U.S. Census Bureau, 2010). In 2010, 54% of the population in Atlanta was African American women (U.S. Census Bureau, 2010). Approximately 54% of the 420,003 residents in Atlanta are African American women (U.S. Census Bureau, 2010). Participants were required to self-identify as being a victim

of IPV perpetrated by a male partner. I determined the eligibility of potential participants by asking questions in the demographic questionnaire regarding their characteristics and the inclusion criteria.

Sampling and Sampling Procedure

I used purposeful and convenience sampling to recruit a sample of African American women to participate in this study. The use of purposeful sampling involves recruiting targeted individuals with similar characteristics related to the objectives of the study (Yang & Banamah, 2014). The inclusion criteria were African American women ages 25 to 45 years living in shelters in downtown Atlanta who had reported being victims of IPV perpetrated by a male partner. I screened the participants to determine whether they met the inclusion criteria by checking the demographic information on their responses in the demographic questionnaire. I also used convenience sampling to increase the likelihood of achieving the required sample size. Convenience sampling is a nonprobability sampling technique in which the researcher selects participants because of their convenient accessibility and proximity to the researcher (Yang & Banamah, 2014). I selected the participants because they were the easiest sample to recruit for the study, and I did not consider selecting subjects representative of the entire population. I recruited participants through the use of advertisements, flyers, information sheets, notices, Internet postings, and social media announcements (see Appendix A). The recruitment materials specified the specific sample that I was recruiting for the study.

Gogtay (2010) recommended a medium effect in order not to be too lenient or strict, a level of significance of 0.05, and a power of 0.8 in the power analysis in order to

determine the required sample size for quantitative research. Researchers compute the minimum sample size for a multiple regression analysis using the following parameters in the power analysis using G*power sample size calculator: three predictors, power of 80%, a medium effect size of 0.15 for a regression analysis, and a significance level of 0.05. Researchers utilize a power of 80% in empirical studies to ensure the statistical validity of results by having an adequate statistical power in the analysis (Gogtay, 2010). The resulting computation showed that I should include a minimum of 55 participants (see Appendix B) in the data analysis for this study.

Sample

The sample of participants consisted of African American women ages 25-45 years; this age range of women has been found to be at a significantly higher risk for IPV exposure (Cho, 2012). The rationale for choosing this targeted age was because researchers have shown that there is a higher risk of IPV among younger women (Stockman et al., 2015). Participants were African American women living in shelters in downtown Atlanta who reported being victims of IPV perpetrated by a male partner. An exclusion criterion was those victims of IPV perpetrated by same-sex partners.

Procedures for Recruitment, Participation, and Data Collection

I used a variety of methods to recruit participants for this study. I used recruitment materials such as advertisements, flyers, internet postings, and social media to recruit participants (see Appendix A). I placed these announcements at different local women's centers and agencies that help African American women living in shelters in downtown Atlanta who have reported being victims of IPV perpetrated by a male partner. I included

the text of these advertisements with my IRB application. The advertisements included the inclusion criteria for the study. I obtained a letter of cooperation (see Appendix C) from each of these organizations when they provided approval to recruit through their organization. These letters were signed from the heads of the organizations. I posted the flyers on the bulletin boards in the recruitment areas of the local women's centers and agencies. In addition, I accepted participant referrals. Anyone who was aware of the study and knew African American women who fit the demographics and inclusion criteria could refer others who were in the same shelter to participate in the study.

In addition, I recruited participants from a local women's center that has a nonprofit network that offers comprehensive resources and counseling to women, men, and children who are affected by IPV. This organization provides confidential support, counseling, and emergency shelter. The center provides educational domestic violence programs to women who experienced IPV and other forms of sexual assault. Women involved in these programs participate in a battering program or are referred by other programs. Some of the programs the shelter offers to the women include direct services such as outreach, police-partnered programs, monitored visitation, and legal aid. The organization also hosts working groups such as a domestic task force and sexual assault response, as well as community education, which includes professional training and school-based programs. I contacted some of the local women centers and the representatives agreed to allow me to recruit participants. I obtained letters of cooperation from the administrators and responsible persons at these agencies, along with IRB approval, before beginning the study at these organizations (see Appendix C).

Participants completed the survey using the SurveyMonkey online survey tool. To ensure that the participants fit in the inclusion criteria of the study, they were first screened before undergoing the survey process. I screened participants to ensure that I did not collect many ineligible surveys. With Survey Monkey, I included a screening question asking whether the participant has been a victim of IPV perpetrated by male partners. If the respondents answered in the affirmative, they could proceed to the next step. If they answered that they had not, the site would take them to an exit page thanking them for their participation and letting them know they were ineligible to participate in the study. Other screening questions were if they are African American women, aged 25 to 45 years old, and living in shelters in downtown. If they answered in the negative then the respondents were considered ineligible samples.

Additionally, I stated in all study materials that participation was voluntary. Consent was required to participate in the study, and the participants indicated their consent by checking "yes" to a question on the consent form page prior to the presentation of the survey questions. In the consent form and upon completion of the study, I provided the participants with my contact information and instructions to contact me if they had experienced discomfort or distress as a result of participation. Data errors due to question nonresponses may have occurred. As a solution, I made the survey questions a forced choice in the online survey tool where the surveys were administered. If the respondent refused to answer a question, she was ineligible to proceed to the next question.

At the end of the study, I provide participants with information regarding mental health referrals (i.e., Counseling Centers, Georgia Crisis and Access Line) and informed them that there could be a cost to seeking mental health services. I kept research participants' names and e-mail addresses separate from their survey responses to ensure confidentiality. The entire survey took approximately 60 minutes to complete.

Instrumentation and Operationalization of Constructs

Religious coping. Religious coping was an independent variable that I measured using the two measures of the Brief RCOPE instrument of positive and negative coping. The scores were continuous measures. The Brief RCOPE is a 14-item measure of how individuals use religious coping to cope with major life stressors developed in 1997 from Kenneth I. Pargament's theory on religious coping. The Brief RCOPE is the most widely used measure used in studies that examine religious coping (Pargament et al., 2011); therefore, this instrument has contributed to the growth of knowledge about the roles religion serves in the process of dealing with crisis, trauma, and transition. I obtained approval to use the Brief RCOPE in my study.

The Brief RCOPE is comprised of two subscales that measure two patterns of religious coping methods, positive and negative coping. Seven items measure positive religious coping (items 1-7) and another seven items measure negative religious coping (items 8-14). Positive religious coping methods have been found to reflect a secure relationship with a transcendent force, a sense of spiritual connectedness with others, and a benevolent worldview (Paragament et.al, 2011). Sample questions of positive religious coping methods included "Looked for a stronger connection with God (Spiritual

Connection)" and "Sought God's love and care (Seeking Spiritual Support)." Negative religious coping methods have been found to reflect underlying spiritual tensions and struggles within oneself, with others, and with a divine source (Paragament et.al, 2011). Sample questions of negative religious coping methods included "Wondered whether God had abandoned me (Spiritual Discontent)" and "Felt punished by God for my lack of devotion (Punishing God Reappraisal)."

Items on the Brief RCOPE ask what part religion played in what the respondent did to cope with this negative experience. Each item represents a particular way of coping with an event. The respondents answer each question using a 4-point Likert scale ranging from 1 (*Not at all*) to 4 (*A great deal*). I summed the total scores of the seven items together to derive scores for the each of the two scales. Higher scores indicate a greater degree of use in both positive and negative religious coping.

The Brief RCOPE has demonstrated good internal consistency in many of studies across widely differing samples (Sherman & Harris, 2015). The Brief RCOPE has demonstrated good concurrent validity. As would be expected, the Brief RCOPE is most strongly and consistently related to measures of positive psychological constructs and spiritual well-being (Sherman & Harris, 2015). Researchers have also demonstrated the validity of the Brief RCOPE relative to psychological, physical, and social well-being constructs. Cotton et al. (2006) examined associations between the Brief RCOPE and quality of life, as measured by a single item asking participants to compare their experiences before a traumatic event to the present.

Spiritual coping. Spiritual coping was an independent variable, and I measured this variable using the score of the spiritual centered coping subscale of Africultural Coping System Inventory instrument. The score was a continuous measure. ACSI is a 30-item measure developed by Utsey et al. (2000) to evaluate culturally specific spiritual coping. Items on this measure are answered on a 4–point Likert scale where participants respond on a range of 0-3, with 0 being "does not apply or did not use" and three being "always apply or used a lot." The ACSI contains four subscales that measure the following: cognitive-emotional well-being (11 items), ritual centered coping (three items), collective centered coping (eight items), and spiritual centered coping (eight items; Utsey et al., 2000). The range of possible scores for cognitive-emotional well-being is 0 to 33, ritual centered coping is 0 to 9, collective centered coping is 0 to 24, and spiritual centered coping is 0 to 24.

The ACSI is scored by adding the items for each scale. High scores represent a persistent use of a specific Africentric coping strategy. For this study, I used only the eight items that measure spiritual centered coping to measure the independent variable of spiritual coping strategies. I used the total score of the eight items to measure spiritual coping strategies. The items included on the ACSI were developed from informal interviews with African American adults from a variety of backgrounds (i.e., socioeconomic, gender, educational), a review of related literature, and from personal observations made by the primary researcher (Utsey et al., 2000). To ensure the ACSI's content validity, I facilitated a focus group composed of seven African American and Afro-Caribbean adults. The focus group members completed the 74-item ACSI prototype

and then engaged in a discussion of the instrument. Some of the points discussed included the ACSI's structure, clarity of items, domain appropriateness of items, and the measure's comprehensiveness. The developers of the instrument evaluated the instrument's efficiency, clarity of instructions, and readability. Utsey et al. reported that the ACSI demonstrated adequate internal consistency reliability, with Cronbach's alphas ranging from 0.71 to 0.80 for the four subscales. For spiritual centered coping, the Cronbach's alpha value was 0.87. Constantine, Donnelly, and Myers (2002) determined that the collective self-esteem and Africultural coping styles in African American adolescents showed that the ACSI exhibited acceptable internal consistency reliability. The Cronbach's alpha ranged from 0.76 to .82 across the scores of the four subscales in the ACSI. I have also seen the instrument published in several journals, confirming that instrument complies with the fair use copyright rules (The Copyright Act of October 19, 1976).

Level of IPV. Level of IPV was an independent variable that I measured using the two measures of the Index of Spouse Abuse (ISA) instrument of physical and nonphysical abuse. The scores were continuous measures. The ISA is a 30-item self-report instrument that measures the severity and frequency of physical (P) and nonphysical (NP) abuse or relational violence (Castro, García, Ruíz, & Peek-Asa, 2006). The scale was developed using items from the Conflict Tactic Scale (CTS; Castro et al., 2006). The ISA was developed by Coker, Pope, Smith, Sanderson, and Hussey (2001). The instrument consists of the following two factors: physical abuse (11 items: 3, 4, 7, 13, 17, 22, 23, 24, 27, 28, and 30) and nonphysical abuse (19 items: 1, 2, 5, 6, 8, 9, 10,

11, 12, 14, 15, 16, 18, 19, 20, 21, 25, 26, and 29). The responses to each question is measured using a 5-point Likert scale of 1 (*never*) to 5 (*most of the time*). The suggested cutoff score is 10 for physical abuse and 25 for nonphysical abuse. Scores ranging from 10 and above for physical abuse scale are considered physical abuse. Scores ranging from 25 and above for nonphysical abuse scale are considered nonphysical abuse. The scores for physical and nonphysical abuse are interval measures. I used both subscale scores. Coefficient alpha estimates of reliability were over 0.90 for the original ISA subscales and with the African American sample, indicating acceptable internal consistency reliability (Coker et al., 2001). Campbell, Campbell, King, Parker, and Ryan (1994) investigated the reliability and validity of the ISA and showed that the ISA exhibited acceptable internal consistency reliability. The Cronbach's alpha coefficients estimating reliability were over 0.90 for the two ISA subscales and with the African American sample. The study involved 504 African American women.

Depression. Depression was a dependent variable, and I measured this variable using the overall or total score of the Beck Depression Inventory instrument. The score is a continuous measure. I used the BDI by Beck et al. (1961) to measure depression for participants in this research. The BDI assesses the severity of depression symptoms for descriptive purposes only (Pinna et al., 2014); the instrument is not used to diagnose depression. The BDI is a 21-item measure that researchers use to assess how the respondent has felt in the last week. Items on this measure are answered on a 4–point Likert scale style where participants respond using a range of 0-3. Each question has a set

of at least four possible responses, ranging in intensity to describe the respondent's feelings. Each question has different response scales.

Summing the responses in the 21 items yields depression scores, which range from 0 to 63. The standard cut-off scores are as follows and coding schemes are as follows: 0–9 indicates minimal depression, and I coded this as 1; 10–18 indicates mild depression, and I coded this as 2; 19–29 indicates moderate depression, and I coded this as 3; and 30–63 indicates severe depression, and I coded this as 4. The scores for depression are an interval measure.

Internal consistency for the BDI ranges from 0.73 to 0.92 with a mean of 0.86 (Beck et al., 1988; D. Nelson et al., 2012). Wang and Gorenstein (2013) reviewed the psychometric properties of the BDI as a self-report measure of depression in a variety of settings and populations showed that the BDI exhibited acceptable internal consistency reliability. The internal consistency was described as around 0.90, and the retest reliability ranged from 0.73 to 0.96. The criterion-based validity showed good sensitivity and specificity for detecting depression (Wang & Gorenstein, 2013). Factor analysis in the study by Wang and Gorestein showed a robust dimension of general depression composed of two constructs: cognitive-affective and somatic-vegetative. The results of the factor analysis showed that the BDI has a relevant psychometric instrument, showing a high reliability, acceptable concurrent, content, and structural validity (Wang & Gorestein, 2013). I have obtained permission to use this instrument.

Demographic information survey. I used a separate demographic questionnaire to gather data on age, family income, length of time in which a person was exposed to IPV, and frequency of attending church or other religious events.

Data Analysis Plan

I analyzed data using the statistical software of Statistical Package for the Social Sciences (SPSS). I investigated potential outliers in the data set by converting the variables to z scores. It is unusual for observation to fall more than three standard deviations from the mean (Tabachnick & Fidell, 2007). Thus, any observation with a z score less than -3 or greater than +3 is considered an outlier which should be removed from the data set. Outliers can have a substantial effect on the statistical results, leading to very difficult conclusions regarding the data.

I conducted an inferential statistical test of regression analysis to address the research question of the study. I tested the required assumptions of the regression analysis, the normality of residuals and homogeneity of variances. I conducted a test of normality by investigating the skewness and kurtosis statistics of the data of the study variables and also the investigation of the normality plots in the histograms. To determine whether the data follows a normal distribution, skewness statistics greater than three indicate strong nonnormality and kurtosis statistics between 10 and 20 also show nonnormality (Kline, 2005) while the histogram should exhibit a pattern of a bell-shaped curve. I tested the homogeneity of variances using Levene's test. The *p*-values of the Levene's test should be greater than the level of significance value of 0.05 to prove that

the variances of the dependent variable are equal or homogenous across the different categorical groups of the independent variable (Tabachnick & Fidell, 2007).

The following research question and hypothesis guided this research study.

RQ: How well do variables such as religious coping, spiritual coping, and level of IPV predict depression in African American women?

H_0: The independent variables of religious coping (as measured by scores on the Brief RCOPE), spiritual coping (as measured by scores on the Africultural Coping System Inventory, ACSI), and level of IPV (as measured by scores on the Index of Spouse Abuse), are not statistically significant predictors of depression in African American women (as measured by scores on the Beck Depression Inventory).

H_a: The independent variables of religious coping (as measured by scores on the Brief RCOPE), spiritual coping (as measured by scores on the Africultural Coping System Inventory, ACSI), and level of IPV (as measured by scores on the Index of Spouse Abuse), are statistically predictors of depression in African American women (as measured by scores on the Beck Depression Inventory).

Descriptive statistics. The demographic data included the age, family income level and the number of children, length of time in which person was exposed to IPV, and frequency of attending church or other religious events. The study variables included the independent variables of religious coping, spiritual coping, and level of IPV. The dependent variable was depression. I used frequencies and percentage tables to summarize data for categorical or nominal variables, and used descriptive statistic

measures of means and standard deviations to summarize the data for variables that are continuous.

Multiple linear regression analysis. I conducted a multiple linear regression analysis to test the null hypothesis. Specifically, a MLR determines whether the independent variables (religious coping, spiritual coping, and level of IPV) significantly predict the dependent variable (depression) in African American women. Through a multiple linear regression statistical test, I measured the size of the effect and determined whether the independent variables have positive or negative relationships with the dependent variable (Neuman, 2009). A multiple linear regression is used to determine the effects of two or more independent variables and if it predicts the value of a dependent variable (Allison, 1999).

In SPSS, the method of entry of the independent variables was the "enter" method. The regression model is used to predict the outcome by the independent variables to the dependent variable. The "entry" method is an appropriate analysis when dealing with a small set of predictors and when the researcher does not know which independent variables will create the best prediction equation (Leech, Barrett, & Morgan, 2008). Each predictor is assessed as though it were entered after all the other independent variables were entered, and assessed by what it offers to the prediction of the dependent variable that is different from the predictions offered by the other variables entered into the model. The independent variables of religious coping, spiritual coping, and level of IPV were added to the multiple linear regression to determine if it adds significantly to the model. This result identifies any statistical significance of additional variances

accounted for by the independent variables to the dependent variable. The result of the analysis determines the individual effects of each independent variable of interest to the dependent variable by examining the statistical significance of the change in the correlation coefficient R^2.

I used an alpha level or level of significance of 5% or 0.05 to determine the relevance of the effects of the independent variables in predicting the dependent variable in the regression analysis. The independent variable has a significant effect or a significant predictor of the dependent variable if the *p*-value of the regression is less than or equal to the value of the significance level. I examined the beta coefficient in the regression model to determine the degree of the effect of the independent variables on the dependent variable. A positive value of the beta coefficient indicates high scores on the independent variable has are related to high scores on the dependent variable. A negative value of the beta coefficient suggests that the independent variable has an inverse relationship with the dependent variable, which means that high scores on the dependent variable are associated with low scores on the dependent variable. I used the beta coefficient to measure the strength of the relationship and to determine whether any of the independent variables can predict the scores on the dependent variable.

Threats to Validity

The instruments used in this study rely on self-report. This presents a risk to validity in that the validity of the findings is determined by the measure of veracity of the participants (Ary, Jacobs, Sorensen, & Walker, 2014; Creswell, 2013). In this study, I engaged in a nonrandom sampling technique. As such, the findings cannot be generalized

to the general population. Additionally, there may have been unintended uncontrolled variables that could have been introduced into the study.

Statistical conclusion validity is the validity of which statements about the association of two variables can be made based on statistical tests (J. T. Austin, Boyle, & Lualhati, 1998). Threats to statistical conclusion validity include low statistical power, violated assumptions of statistical tests, and reliability of measures (Trochim & Donnelly, 2008). I took all of these factors into consideration in this study. I computed the required sample size for this study based on a power analysis considering the minimum required power needed for a quantitative analysis. I tested all the necessary assumptions of the regression analysis. All the survey instruments used to measure the study variables have more than acceptable reliabilities based on findings of previous studies.

As with any research study, there are specific threats to reliability and validity that must be considered. The survey questionnaires used in this current study have been tested for validity and reliability. Internal validity refers to the relative validity with which researchers infer that a relationship between two variables is causal (Campbell & Stanley, 1966). Causal relationships usually occur in experiments where treatment variables are manipulated to produce the desired outcome (Creswell, 2013). The current study did not involve any treatment variable, nor was I focused on laying claim to causality. Several other threats of validity do not apply to the study, such as the threat of history, maturation, the interaction effect of testing and instrumentation (Wisdom, Cavaleri, Onwuegbuzie, & Green, 2012). These internal threats to validity are relevant only to experimental studies and other studies that use pretest and posttest data, or longitudinal

studies (Mertens, 2014). These threats do not apply in this study because data collection occurred once, which removed chances that the results of the study were affected by changes that occurred in the participants or the instruments as a result of a gap between the pretest and the posttest.

The threat concerning the chosen research design has already been acknowledged, in that the findings of this study did not include conclusions regarding causal relationships between the variables, only significant associations to form the basis for further investigation. The nature of a correlative examination of isolated variables can reveal correlation but not causation. The inability to adjust the independent variable to determine the impact on the dependent variable means a cause and effect relationship cannot be established. Lastly, the implementation of the study within a specific population is also considered a threat to its generalizability. Results from this study, therefore, may not be generalized to other groups, but only to the specific sample of African American women ages 25-45 years old, living in shelters in downtown Atlanta, who have reported being victims of IPV perpetrated by a male partner.

Ethical Procedures

Human subjects were engaged in this study. As such, all measures that ensure the protection of human subjects involved in research were followed. This research had a minimal threat to the physical and emotional well-being of the participants; however, IPV is a traumatic experience, and involvement in this study may have affected some of the participants. The survey was administered online so that there was no direct contact with the researcher. Responses were kept anonymous and confidential. I advised the

participants of the minimal risks that involved before engaging in the study. Volunteers who expressed concern about the impact of their involvement on the emotional of emotional well-being were excluded from participating in the study. It is common practice to have referrals available where participants can go if they have an emotional or other reaction to the survey. It was possible that some questions may have triggered an emotional response. I provided at least three referrals, one of which was a low cost or sliding scale fee arrangement. Lastly, participants were asked to provide informed consent to get proof of approval to participate in the study before they administer the surveys. Electronic consent was obtained.

For this study, I adhered to the ethical standards put forth by the Belmont Report. Protocol, including respect for persons, beneficence, and justice (Sims, 2010). Respect for persons involves recognition of the personal dignity and autonomy of individuals and special protection of those persons with diminished autonomy. Beneficence entails the researcher's obligation to protect persons from harm by maximizing anticipated benefits and minimizing possible risks of harm. Justice requires the fair distribution of benefits and burdens of research.

I conducted this study in compliance with the ethical standards for human research. I underwent the process to obtain IRB approval for the procedures of this study to ensure that the rights of the study participants were protected and upheld through the course of conducting this study. I implemented specific policies and procedures to protect participant privacy and rights. I conducted all data collected procedures anonymously. Human participants were respondents to the survey conducted in this study; therefore, it

was important to consider their confidentiality and anonymity. I provided an informed consent form to all prospective participants. The participants were required to agree to participate in the study before they began by signing the informed consent form to prove they provided consent. This process ensured that the respondents were aware of their role as study participants. I stored all data collected in the study in a password-protected computer accessible only by me. The data will remain stored for the prescribed period of 5 years after the completion of the study. The survey did not include any identifiable information such as name, address, or phone number, to ensure that respondents cannot be located. I provided the potential participants with the relevant information they needed to make an informed decision whether or not to participate in the study. Furthermore, respondents were allowed to withdraw from the study at any point without consequences. If the participant needed more information about the study, I included my contact details in the invitation email and informed consent form.

Summary

In Chapter 3, I presented the research methods conducted for this quantitative study. I conducted a quantitative, nonexperimental, correlational study. This chapter included a discussion of the research design, population, sampling and sampling procedures, procedures for recruitment, participation, and data collection, instrumentation, data analysis, threats to validity, and ethical procedures. The population of the study included African American women aged 25-45 years old, living in shelters in downtown Atlanta, who reported being victims of IPV and have used culturally specific coping strategies in handling their experience. I collected the data for the study using

several survey instruments: the Brief RCOPE, the Africultural Coping System Inventor, the Index of Spouse Abuse, Beck Depression Inventory, and a demographic information survey. The survey was administered online via SurveyMonkey. Data analysis involved the use of multiple linear regression analysis to address the research question of the study. In Chapter 4, I will present the findings of the data analysis and specifically expose the data results. In Chapter 5, I will discuss the results and their implications for practice, research, and theory.

Chapter 4: Results

In this quantitative study, I examined the predictive relationships between the independent variables of cultural coping strategies (spirituality and religious coping) and levels of IPV and the dependent variable of depression in African American women victimized by IPV. I used the following research question and associated hypotheses to guide this study:

RQ: How well do variables such as religious coping, spiritual coping, and level of IPV predict level of depression in African American women?

H_0: The independent variables of religious coping (scores on the Brief RCOPE), spiritual coping (scores on the Africultural Coping System Inventory, ACSI), and level of IPV (scores on the Index of Spouse Abuse) are not statistically significant predictors of depression in African American women (scores on the Beck Depression Inventory).

H_a: The independent variables of religious coping (scores on the Brief RCOPE), spiritual coping (scores on the Africultural Coping System Inventory), and level of IPV (scores on the Index of Spouse Abuse) are statistically predictors of depression in African American women (scores on the Beck Depression Inventory).

In this chapter, I present the results of the data collection for my study. I provide demographic data for the participants and results of testing for the statistical assumptions in the first part of this chapter. I also address missing data, outliers, and the multicollinearity test. Next, I report the results of the analysis followed by a brief conclusion.

Data Collection

I received permission from Walden University's institutional review board (IRB) to conduct this study. My Walden IRB approval number for my study was 08-22-17-0341333. I also received permission from Dr. Shawn Utsey to use the Africultural Coping System Inventory, and from Dr. Kenneth I. Pargament to the use the Brief RCOPE. William H. Schryver, the senior legal licensing specialist for Pearson, granted me permission to use the BDI-II. I gained access to use the Index of Spousal Abuse instrument because it is covered under the fair use copyright law. After I received permission to use each instrument, I posted the surveys on Survey Monkey, a well-known online survey platform. SurveyMonkey simplified the data collection process and allowed me to export data into a statistical program for analysis.

I met with the director of the women's shelter, formally introduced myself, and described the purpose of the study. The director gave me permission to post flyers around the shelter to recruit participants. The flyers included information on how to access the survey link through SurveyMonkey. The flyers also had information on how participants could contact me, if needed. Participants had access to the survey after they gave their consent. I informed them that the survey was optional and that they could stop taking the survey at any time. Participants had the option to print a copy of their consent form for their records. Completing the online survey took approximately 20 to 30 minutes. After the participants completed the survey, I did not collect any additional data. I collected data for 8 weeks, and the final data set included 63 participants.

Demographics

I recruited African American women between the ages of 25 and 45 years who had experienced intimate partner violence by a male perpetrator. The participants lived in a women's shelter in downtown Atlanta, Georgia. Each participant reported her age, and I divided the age groups into 5-year increments. Table 1 presents a summary of the results. Most participants indicated they were 31 to 35 years of age (n = 39, 61.9%).

Table 1

Participant Demographic Information

Age	*N*	%
25-30	13	20.6
31-35	39	61.9
36-40	7	11.1
41-45	4	6.3

Results

Predata Screening

I conducted several predata screening procedures before running the descriptive statistics for the survey and testing the null hypothesis for the research question. Those procedures included examining the file for missing data, running a reliability analysis on items for each of the surveys, and testing the relevant statistical assumptions. I present the details and results of those procedures in the following paragraphs.

Missing Data

I downloaded an Excel spreadsheet from SurveyMonkey consisting of the data collected from 87 participants. I screened the data file for nonrandom patterns in missing data using the countblank function in Excel, which counts the number of blank entries in

each participant's response data. I removed cases with blank counts greater than 0 from the data set. There were 22 cases with missing data, and I removed them from the data set. I imported the final data file into SPSS Version 24 for data management and analysis. I used a total of 63 cases in the analysis.

Reliability Analysis

Before performing statistical analyses of the data, I assessed the reliability of the data collected with each of the instruments by checking the internal consistency of the scales used to assess religious coping, spiritual coping, IPV, and depression. I calculated the Cronbach's alpha coefficient to assess the mean correlation between the individual pairs of items and the total number of questions on the scales (Brace, Kemp, & Snelgar, 2012). I evaluated the reliability of the data, as indicated by the Cronbach alpha coefficients, according to the guidelines established by George and Mallery (2010) in which coefficients greater than .9 indicate excellent reliability, .8 and above indicate good reliability, .7 and above indicate acceptable reliability, .6 and above indicate questionable reliability, .5 and above indicate poor reliability, and less than .5 indicate unacceptable reliability.

The results revealed that the data collected by the Religious Coping Scale exhibited acceptable reliability ($\alpha = .72$). Pargament et al. (2011) performed a reliability analysis of the Brief RCOPE and found similar results with alpha values of at least 0.80, indicating good reliability. Data from the Spiritual Coping Scale exhibited good reliability ($\alpha = .88$). The Cronbach's alpha exceeded the values established by Utsey et al. (2000), which ranged from .71 to .80. Results from the Index Spousal Abuse Scale ($\alpha =$

.97) yielded excellent results. Reliability estimates exceeded the previously reported value of .90 reported by Campbell et al. (1994). Data for the Beck Depression Inventory exhibited excellent reliability estimates ($\alpha = .93$). Wang and Gorenstein's (2013) reliability analysis indicated that the BDI exhibited acceptable reliability. Overall, the results indicated that the instruments were reliable measures of the variables of interest. Table 2 presents a summary of the results of the reliability analysis.

Table 2

Reliability Analysis Results for Spiritual Coping, Religious Coping, IPV, and Beck Depression Inventory Scores

Variable	No. of items	A
Religious coping	14	.72
Spiritual coping	8	.88
IPV	15	.97
BDI	21	.93

Descriptive Statistics for Independent Variables

I calculated means, standard deviations, skewness, and kurtosis for the independent variables. Table 3 presents the results of these analyses. The mean score for religious coping was 40.32 (*SD* = 6.69). The mean spiritual coping score was 26.89 (*SD* = 5.28). The mean IPV score was 63.27 (*SD* = 24.98). Finally, the mean depression score was 29.41 (*SD* = 13.96).

Table 3

Descriptive Statistics for the Independent Variables

	N	Minimum	Maximum	*M*	*SD*
Religious coping	63.00	27.00	56.00	40.32	6.69
Spiritual coping	63.00	10.00	32.00	26.89	5.28
IPV	63.00	15.00	105.00	63.27	24.98
BDI	63.00	0.00	56.00	29.41	13.96

Dependent Variable

I computed the participants' scores for the level of depression variable within SPSS using participants' scores on the BDI. I recoded the continuous BDI scores into ranges that represented minimal to severe depression, in alignment with the coding scheme for depression presented in Chapter 3. I coded these ranges with values of 1 to 4, which corresponded to the minimal to severe depression categories. Most of the participants' BDI scores fell into the severe depression category (75%). Table 4 presents the frequencies and percentages for level of depression.

Table 4

Descriptive Statistics for Beck Depression Inventory

	Code	*N*	%
Minimal depression	1	9	14.3
Mild depression	2	1	1.6
Moderate depression	3	6	9.5
Severe depression	4	47	74.6

Testing Statistical Assumptions

Prior to conducting the multiple linear regression analysis, I assessed the assumptions for linear regression. I assessed the assumptions of linearity, normality,

multicollinearity, homogeneity of variance, and absence of outliers. I present the findings of the assumption testing below.

Linearity

I assessed the assumption of linearity through an examination of scatterplots. I constructed scatterplots to illustrate the linear relationship between each predictor variable and the dependent variable. Figures 1 through 3 present the scatterplots for each predictor variable. I screened each scatterplot to ensure that a roughly linear relationship existed between each predictor variable and the dependent variable (see Tabachnick & Fidell, 2007). I assumed that the assumption of linearity was met if there was no curvature in the plot and the values for the predictor and dependent variables appeared to vary together. The scatterplot for religious coping (see Figure 1) revealed that only a slight linear relationship existed between religious coping and level of depression as assessed by the BDI. The presence of a slight curvature and the apparent lack of relationship between the two variables indicated that linearity was not met.

The scatterplot for spiritual coping (Figure 2) indicated that a slight linear relationship existed between spiritual coping and level of depression. I observed a more distinct relationship between IPV and level of depression as assessed by the BDI (see Figure 3). Both plots lacked a distinct curvature, and the variables appeared to vary together.

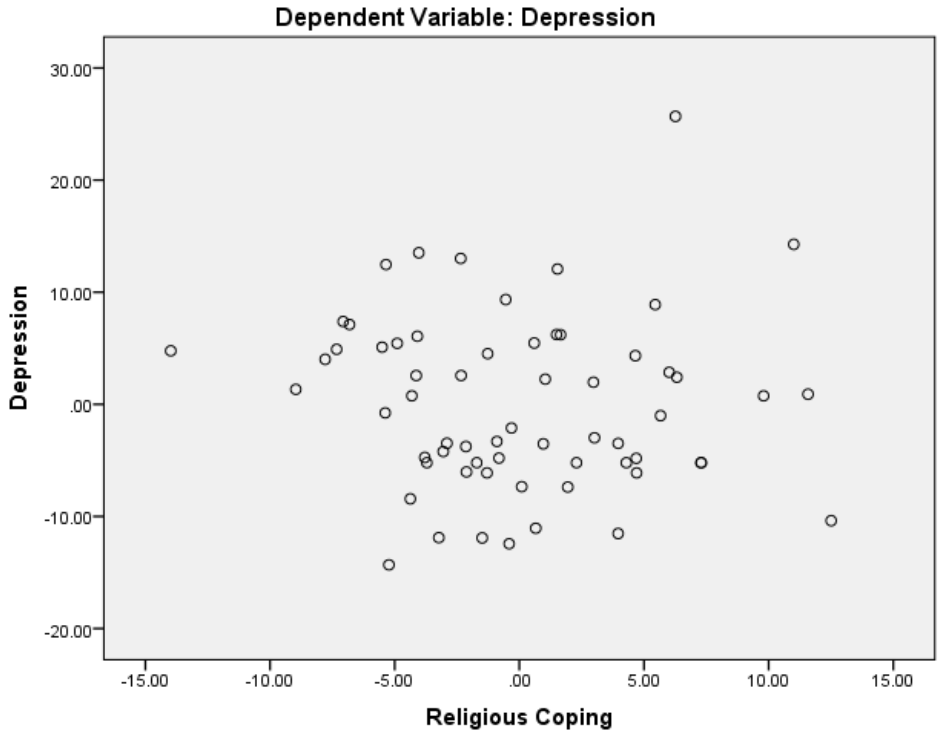

Figure 1. Scatterplot for religious coping and depression.

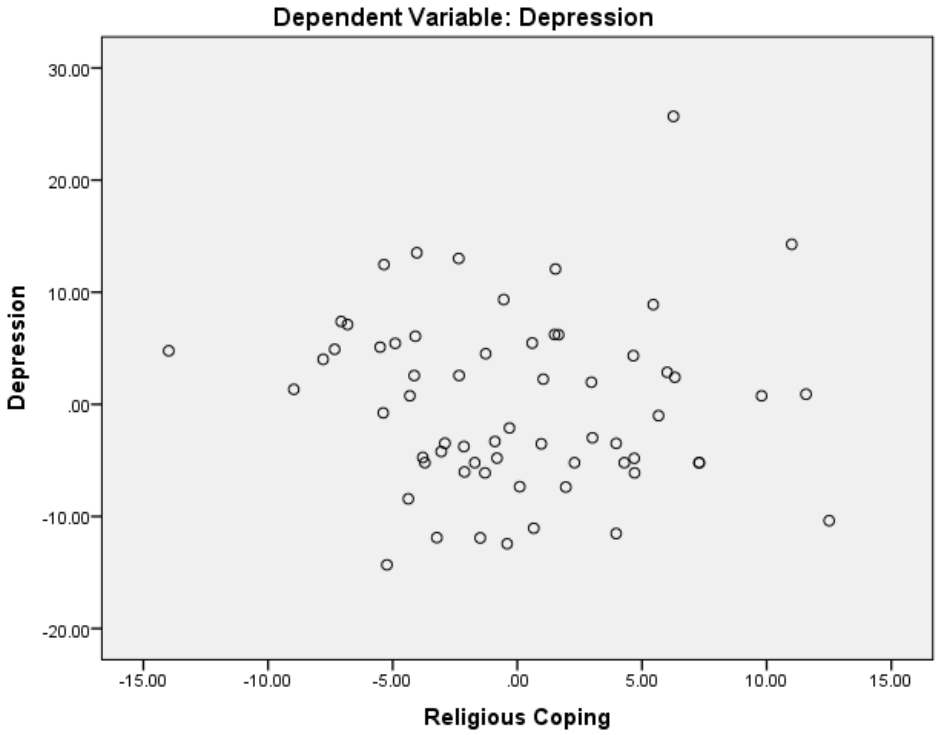

Figure 2. Scatterplot for spiritual coping and depression.

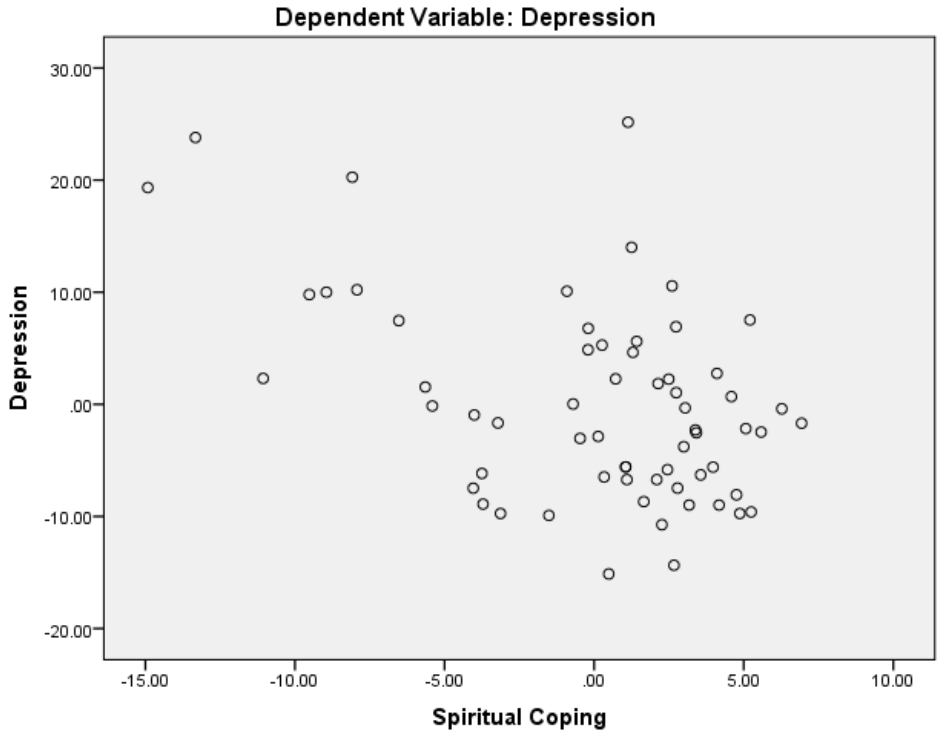

Figure 3. Scatterplot for IPV and depression.

Normality

I used skewness and kurtosis values to assess normality of the data distribution. Skewness statistics greater than three indicate strong nonnormality, and kurtosis statistics between 10 and 20 also indicate nonnormality (Kline, 2005). None of the skewness and kurtosis values exceeded the indicated cut off values. Table 5 illustrates that the calculated skewness and kurtosis values do not indicate nonnormality of the data.

Table 5

Skewness and Kurtosis Values for Religious Coping, Spiritual Coping, IPV, and BDI

	Skewness	Kurtosis
Religious coping	0.60	-0.41
Spiritual coping	-1.34	1.48
IPV	-0.65	-0.25
BDI	-0.98	0.77

To further assess the data for normality, I screened histograms for religious coping, spiritual coping, IPV, and depression scores. I used the histograms to visually screen for extreme values in the dataset. I plotted the frequency distributions for the data against the normal curve. with a normal distribution line. I examined this plot to assess whether the data distribution followed a normal distribution as indicated by the normal distribution line. The examination of the histograms indicated that across the four continuous independent variables the assumption of normality appeared to be violated because the data points followed a nonnormal distribution (Figures 4 – 7). The IPV (Figure 6) and level of depression (Figure 7) histograms revealed data points on the lower end of the score distribution. These values represented the six participants who scored a 15 on the IPV scale and a 0 on the BDI-II scale. Although these values appeared to be extreme values based upon screening the histograms, an analysis of standardized values did not indicate that these values were outliers. Additionally, with a sample size of greater than 50, a multiple linear regression analysis can be considered robust to a slight violation of normality (Kline, 2005). There were 63 cases in the data set, and I deemed that the slight departures from normality were acceptable.

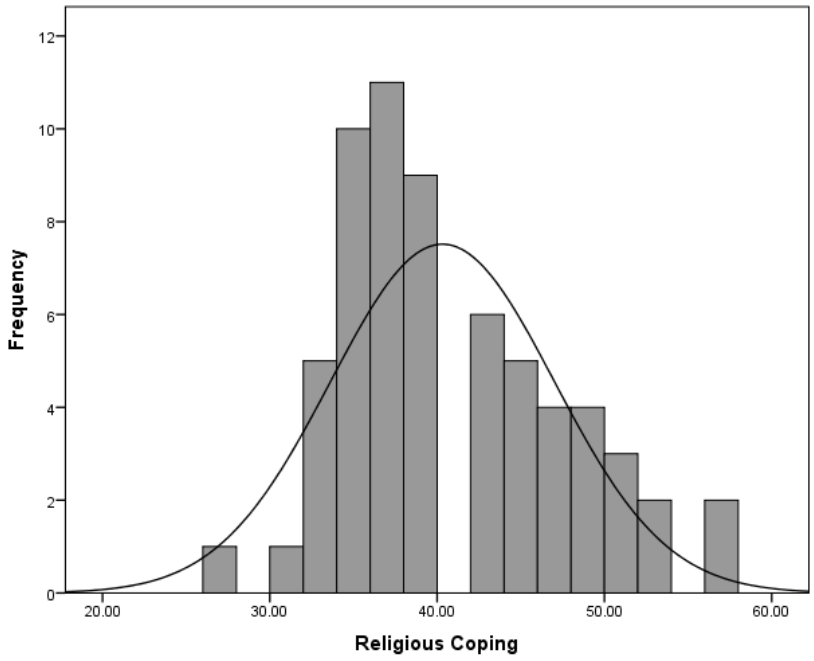

Figure 4. Histogram for religious coping.

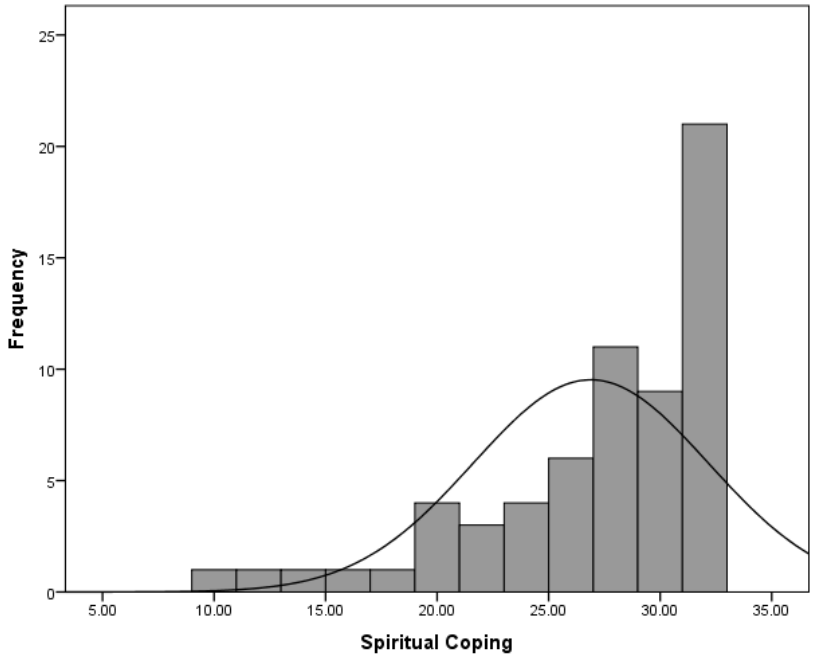

Figure 5. Histogram for spiritual coping.

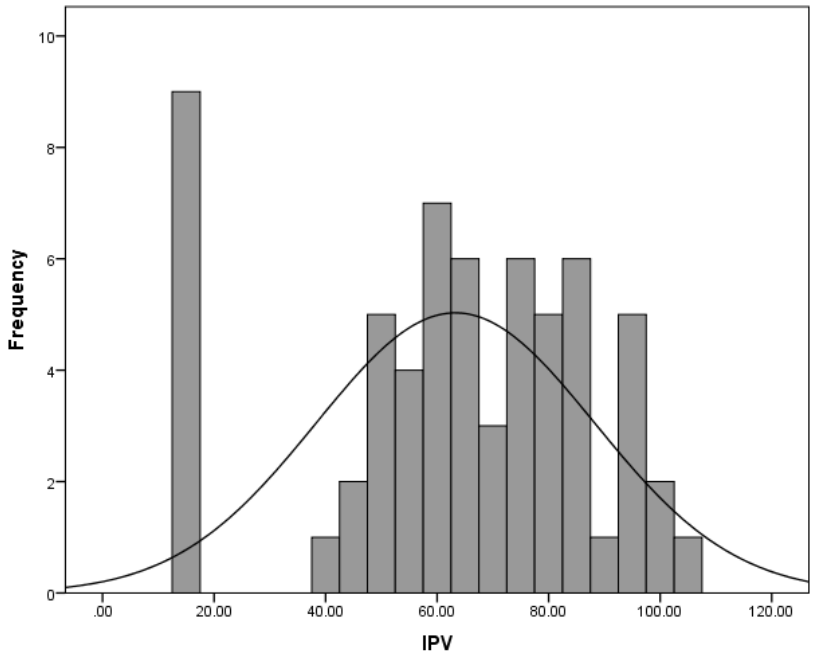

Figure 6. Histogram for IPV.

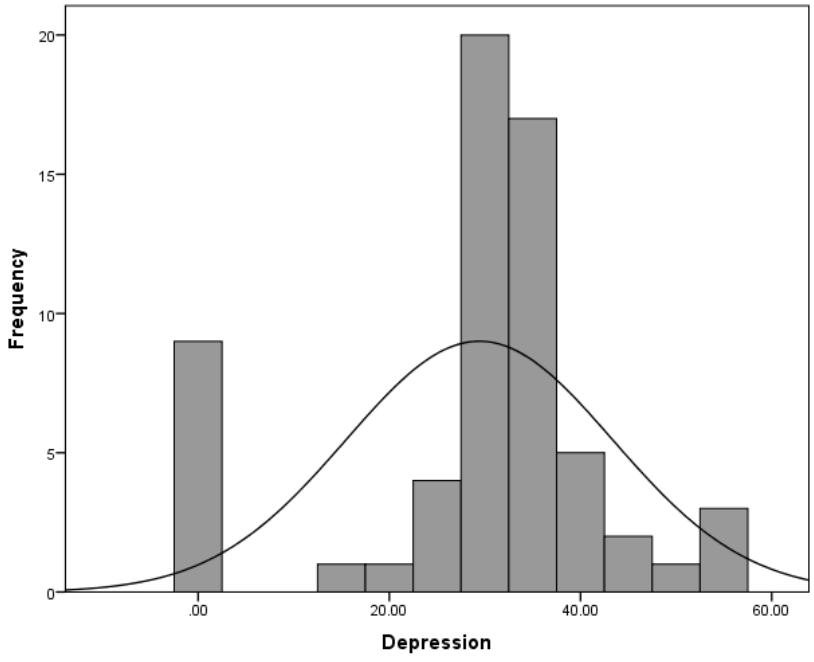

Figure 7. Histogram for depression.

Multicollinearity

I assessed multicollinearity using Variance Inflation Factors (VIFs) calculated using SPSS (Kline, 2005). VIF values greater than ten were considered evidence of multicollinearity between the predictor variables (Kline, 2005). I calculated these VIF values using the collinearity diagnostics function from SPSS (Kline, 2005). The VIF values are presented in Table 6. None of the VIF values exceeded 10; therefore, the assumption of multicollinearity was met.

Table 6

VIF Values for Spiritual Coping, Religious Coping, and IPV

Variable	VIF
Religious coping	1.59
Spiritual coping	1.18
IPV	1.38

Homogeneity of Variance

I assessed the assumption of homogeneity of variance using the Levene's test. I conducted this analysis to ensure that the variance for the values of the predictors were the same about the regression line. The Levene's test results indicated that the assumption of homogeneity of variance was met for religious coping ($p = .416$) and spiritual coping ($p = .055$). This assumption was not met for IPV ($p < .001$). Researchers may opt to transform the data when the assumption of homogeneity of variance is violated in regression analysis; however, interpretation of the data is then limited to an interpretation of the transformed data (Tabachnick & Fidell, 2007). Interpretation of the transformed variable may not be beneficial to the study. Additionally, the analysis is considered

robust to a violation of the assumption of homogeneity of variance (Tabachnick & Fidell, 2007). Because the assumption was considered robust to the violation, I opted not to transform the variable and instead advise caution in interpreting the results of IPV.

Outliers

Additionally, I examined the dataset for the presence of outliers using standardized scores generated within SPSS. I calculated standardized scores using the descriptive statistics option in SPSS (Tabachnick & Fidell, 2007). This function provides a standardized score (*z* score) for each score in the data set. *Z* scores can be used to assess the distance of a data point from the sample mean (Tabachnick & Fidell, 2007). Standardized scores greater than ±3.29 were considered evidence of outliers (Tabachnick & Fidell, 2007). There was one standardized score that exceeded the cutoff value, indicating that the value was more than 3.29 standard deviations from the sample mean. The final dataset consisted of data from 63 participants.

Results

The results of the multiple linear regression analysis were statistically significant ($F(3,59) = 44.20$, $p < .001$, $R^2 = 0.69$). This finding indicated that the regression model consisting of religious coping, spiritual coping, and IPV accounted for 69% of the variation in level of depression. Because the model was statistically significant, I rejected the null hypothesis. I assessed the contribution of each predictor on the depression as a post hoc analysis because the regression model was statistically significant. I developed the following regression equation for the model:

$$\text{Level of depression} = 3.71-0.04*SCS+0.03*IPV$$

Table 7 presents the results of the regression analysis with religious coping, spiritual coping, and IPV as predictors for level of depression as indicated by BDI scores. The findings indicated that of the three predictors, only spiritual coping and IPV were statistically significant predictors of depression. The results indicated that religious coping was not a statistically significant predictor (B = -0.03, p = .065). I found that the IPV variable contributed to the change in depression score (B = 0.03, p < .001). These findings indicated that on average, for each one-unit increase in IPV score, the level of depression increased by 0.03 units. I found spiritual coping to contribute to the change in depression score (B = -0.04, p = .022). The findings indicated that on average, the level of depression decreased by 0.04 units for each one-unit increase in spiritual coping score.

Table 7

Results of the Regression Analysis for Depression Scores

	B	*SE*	*β*	*T*	*p*
Religious coping	-0.03	0.02	-0.17	-1.88	.065
Spiritual coping	-0.04	0.02	-0.18	-2.35	.022
IPV	0.03	0.00	0.68	8.00	.000

Note. $F(3,59) = 44.20$, $p < .001$, $R^2 = 0.69$.

Conclusion

The purpose of this quantitative study was to assess the predictive relationships between religious coping, spiritual coping, and levels of IPV with the dependent variable of depression in African American women victimized by IPV. I conducted a multiple linear regression analysis to address the research question. The results of the multiple linear regression were statistically significant. As spiritual coping scores increased, depression scores were found to decrease. As IPV scores increased, depression scores

also increased. I found that religious coping did not contribute to the change in depression score, as assessed using the BDI.

In this chapter, I presented the results of the data collection and analysis for the current study. I provided descriptive statistics for the sample and the results of the assumption testing for multiple linear regression. This chapter included the results of the multiple linear regression analysis conducted to address the research question. In the next chapter, I will present a summary of the results, an interpretation of the results, recommendations for future research, and implications for positive social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Researchers have revealed that African American women are at a higher risk for experiencing IPV than women of other races or ethnicities (Modi et al., 2014). IPV is a major health concern for victims because it increases the likelihood of poor mental health consequences such as depression and PTSD (Devries et al., 2014; Modi et al., 2014; Salom et al., 2015; Sugg, 2015; White & Satyen, 2015; Wong & Mellor, 2014). Several researchers have shown that women employ different coping strategies unique to their sociocultural backgrounds (Fischer et al., 2016; Ivan et al., 2015); however, few scholars have examined the coping strategies of African American women suffering from IPV. The purpose of this study was to examine how religious coping, spiritual coping, and level of IPV related to the levels of depression in African American women.

In this quantitative, nonexperimental, correlational study, I sought to answer the following research question: How well do variables such as religious coping, spiritual coping, and level of IPV predict level of depression in African American women? I found that spiritual coping was associated with lower levels of depression in participants. I also found that more incidents of IPV correlated to higher levels of depression in participants. Based on previous research, I expected both of these results; however, I also found that religious coping did not correlate to depression, meaning that religious coping was not associated with higher or lower levels of depression in the participants. This result was not expected. I had assumed that higher levels of religious coping would be related to lower levels of depression, as was found with spiritual coping. In this chapter, I discuss the results of the study by interpreting the findings in the context of other studies and the

theoretical framework. I also discuss the limitations of the study, recommendations for future research, and implications. I end the chapter with a conclusion of the study.

Interpretation of Findings

Interpersonal violence is a major health and societal problem (Modi et al., 2014). Not only are there serious consequence for the victim of IPV, but there is also a societal cost because victims are more likely to require health services including more operative surgeries, visits to doctors, and hospital stays throughout their lives than for those without a history of abuse (Yalch et al., 2015). African American women are at higher risk of experiencing IPV than women from other racial and ethnic groups (Modi et al., 2014). It is therefore important to understand the relationship between IPV, depression, and coping strategies that African American women use to cope with the adverse experiences. In the following sections, I discuss each of the independent variables (religious coping, spiritual coping, and IPV) as they related to the dependent variable of depression by comparing my findings to those from other studies.

IPV and Mental Health Outcomes

In the current study, I measured IPV based on scores from the Index of Spouse Abuse. I found that as incidents and severity of IPV increased, so did levels of depression among participants. These findings indicated that higher levels of IPV were associated with higher levels of depression in participants. Results from this study are consistent with findings from previous studies that have linked IPV to poor mental health outcomes for women, such as depression (Devries et al., 2014; Modi et al., 2014; Salom et al., 2015; Sugg, 2015; White & Satyen, 2015; Wong & Mellor, 2014). Other researchers

have reported strong associations between IPV and other mental illnesses such as anxiety, suicidality, PTSD, and substance dependence (Adams et al., 2012).

Researchers have also shown that depression related to IPV appears to be worse and lasts longer in African American women compared to their Caucasian counterparts (Jones et al., 2016; Weiss et al., 2015). Depression is a dangerous and prevalent consequence of IPV among victims of IPV, especially African American women (Stockman et al., 2015; Weiss et al., 2015). Lacey et al. (2015) found that African American women who experienced IPV became more depressed than other women. In fact, African American women were more likely to stay depressed even after the violence or abuse ended, whereas their Caucasian counterparts often regained a balanced mental health state after the abuse ended (Lacey et al., 2015). The results of the current study were consistent with findings from previous research, as they showed that over three quarters of the participants reported high levels of depression.

IPV and Depression

In the current study, I found that as incidents and severity of IPV increased, so did depression among participants. This suggests that the longer a victim remains in an abusive situation, the higher risk he or she has of suffering mental health issues such as depression. Furthermore, the results suggest that removing a victim from an abusive relationship as early as possible could help reduce the severity of the victim's mental health consequences. This was an important contribution to the literature because previous scholars had not examined the relationship between frequency of IPV and levels of depression.

Spiritual Coping

Researchers have shown that spiritual coping can help to buffer the negative consequences of stress and traumatic events such as IPV (Breitbart et al., 2012; Holt et al., 2014; Jones et al., 2016). Researchers have also shown that religious and spiritual coping can have a mitigating effect on a person's ability to cope with stress and traumatic events such as IPV (Archibald et al., 2013; Foster et al., 2015; Holt et al., 2014). Based on the findings from previous research, I anticipated that spiritual coping would decrease the level of depression in participants. Results from the data analysis supported the alternative hypothesis because scores on spiritual coping were negatively correlated to levels of depression in African American women. This indicated that the more spiritual coping a participant reported, the lower her level of self-reported depression would be.

The relationship between spiritual coping and depression in African American women who have experienced IPV is well documented (Archibald et al., 2013; Foster et al., 2015; Holt et al., 2014). Findings from the current study were consistent with findings reported in the literature; the results revealed that as spiritual coping increased, levels of depression decreased among the African American women who participated in this research. This finding suggests that spiritual coping could possibly be used to mitigate the harmful effects of depression among African American women who have been victims of IPV.

Religious Coping

Researchers have shown that religious coping has a positive effect on the well-being and mental health of victims of IPV (Archibald et al., 2013; Drumm et al., 2013;

Holt et al., 2015). Based on findings from previous research, I anticipated that use of religious coping would be related to lower levels of depression in participants. The findings from the current study supported the null hypotheses, meaning that scores of religious coping for the participants were not statistically significant predictors of levels of depression. This was an unexpected result of the study and may indicate that more research is needed to understand the relationship between religious coping and depression in African American women who have experienced IPV.

Discussion of Findings

Although I found a statistically significant negative correlation between spiritual coping and levels of depression, the findings did not reveal a relationship between religious coping and levels of depression among participants. Researchers have suggested that there is a difference between spirituality and religion—despite the fact that these terms are often used interchangeably (Drumm et al., 2013; López-Fuentes & Calvete, 2015). Religion is an extrinsic factor, something outside of the individual, while spirituality can be more intrinsic and personal (Drumm et al., 2013). The ecological systems theory could provide an explanation. It is possible that the intrinsic nature of spirituality is located within the microsystem and operates in closer proximity to the individual. The institution of religion is located in the exosystem and may have less influence on individuals' coping mechanisms. I recommend that future researchers explore this possibility in more depth using qualitative methods. The results of the current study added interesting data regarding the need for clearer definitions of the two concepts. It is possible that the more intrinsic and personal nature of spirituality creates

more meaning for an individual than does the extrinsic factor of religion (Drumm et al., 2013; López-Fuentes & Calvete, 2015). The more meaningful connection of spirituality may offer more coping benefits than religion. The results of the current study indicated that more research is needed to understand the difference between religious and spiritual coping methods.

Limitations of the Study

Every decision made in designing a research study comes with inherent strengths and weaknesses. Although I strove for generalizable results in the current study, it still had limitations that need to be discussed. Each limitation resulted from design and execution elements including population sampling, instrumentation, time and resource constraints, and generalizability.

Previous researchers indicated that population sampling can potentially limit the generalizability of results (Yang & Banamah, 2014). In the current study, I recruited 63 African American women living in a shelter in Atlanta, GA. Several limitations stemmed from this population sample. First, I only looked at African American women, so the results cannot be generalized to women of other ethnicities, and the results cannot be generalized to men. Second, the relatively small sample from Atlanta, GA means that the results may not be generalizable to the larger population of African American women. Third, the participants all lived in a shelter at the time of the study; therefore, other factors related to shelter life may have affected the levels of depression in participants. Fourth, participants had to self-identify as being a victim of IPV perpetrated by a male partner; victims of IPV perpetrated by same-sex partners were not included in the study.

The results, therefore, cannot be generalized to incidents of same-sex IPV. I recommend that future researchers increase the sample size and diversity of participants to increase external validity (see Mertens, 2014; Yang & Banamah, 2014).

Another major limitation of the research was a lack of more demographic information from participants such as their education level, number of children, length of time in the abusive relationship, occupational status, length of time at the shelter, etc. All of those are variables that could have affected the participants' level of depression. Without that information, I cannot say conclusively that the findings were totally related to the effects of IPV. The very fact of being in a shelter was sure to have some negative impact on the participants' emotional state. The only information that I gathered was their age in 5-year increments. For future research, I recommend that scholars incorporate these demographic factors for potential consideration.

Despite these limitations, the rationale for utilizing this sample for the study was the convenience of collecting the data. It was easier to recruit African American women exposed to IPV in shelters because there are higher concentrations of African American women with IPV in shelters. Because I used convenience sampling to recruit participants, the results of this are not generalizable and may have been subject to sampling bias.

The instrumentation used also comes with various consequences in research design. I relied on self-report measures, which can limit both objectivity and honesty (Bilsborrow & Henry, 2012; Creswell, 2013; Wisdom et al., 2012). The use of close-ended surveys for quantitative data does not allow for explanation or added details thus may limit validity (Creswell, 2013; Sue & Ritter, 2012). Researchers have suggested that

without the ability to provide explanation or reasoning, participants may not answer as truthfully (Creswell, 2013). I recommend that future studies consider other methods beyond self-report measures.

Response bias is another limitation that can occur with survey measurements (Creswell, 2013). The respondents may have responded to the survey questions based on the assumption of how the researcher wanted them to respond. This is known as *social desirability* and is a specific type of response bias (Creswell, 2013). Social desirability occurs when respondents tend to conform to the actual or perceived social norms in terms of certain values, traits, attitudes, interests, opinions, and behaviors (Creswell, 2013). This could have occurred in the current study if respondents believed they should or should not behave a certain way and so skewed their answers. For example, it is possible that cultural norms around mental illness among African American women could have prevented some participants from admitting the severity or presence of their depression.

Another design element limited the current study. The study design was nonexperimental; thus, the results cannot show causality. They can show correlation, but cannot state that one variable determined another. Other researchers have come across similar limitations. For example, Cerdá et al. (2012) concluded that several limitations continue to plague studies that focused on IPV. Specifically, Cerdá et al. found that it is impossible to design a study around IPV with random exposure to violence. Based on limitations discussed, I have generated several recommendations for future research, which I will discuss in more detail in the following section.

Recommendations for Further Research

The findings of this dissertation support and extend previous research on the complex relationship between IPV, mental health symptoms, and preferred coping mechanisms among African American women. The results of the current study also revealed that future research is needed to understand these relationships better.

While previous researchers have suggested that both religious and spiritual coping were frequently utilized and beneficial to African American women (Archibald et al., 2013; Holt et al., 2014), the findings of the current study had mixed results. On the one hand, spiritual coping was negatively correlated to depression, while religious coping had no relationship. This finding suggests a need to explore the differences between religious and spiritual coping (Drumm et al., 2013; López-Fuentes & Calvete, 2015). I therefore recommend that future researchers seek to better define the two methods of coping through qualitative research, because it is more exploratory in nature.

Qualitative methods might add insight into the ways that African American women perceive spiritual coping versus religious coping, which could be achieved through semi-structured, open-ended interviews. Furthermore, utilizing the ecological systems theory could have many advantages for future research. For example, the ecological systems theory offers a more rounded approach to human behavior because it takes into consideration the many factors that contribute to an individual's actions and reactions (Bronfenbrenner, 1994). Ecological theory's broad-based focus can be applied to the complexity of interactions and relationships found in IPV (Srinivas & DePrince,

2015). Furthermore, investigators could use the ecological systems theory to explain the coping strategies of the victims (Bronfenbrenner, 1994).

Considering that there were different results for spiritual coping verses religious coping, an ecological perspective may help to explain this reason according to which system the coping mechanism lies. For example, the current study assumes that spirituality may reside in the microsystem with religious coping in the exosystem. This could account for the increased influence and effectiveness of spirituality vs. religious coping. However, other potential explanations could stem from a multitude of different factors, including personal, situational, and sociocultural dynamics (Bronfenbrenner, 1977). To better understand the specific causality of why spiritual coping was associated with decreased depression and religious coping had no effect on depression, I recommend employing the ecological perspective in future research. Determining whether there is a difference of extrinsic versus intrinsic motivation could be particularly important for learning how to foster a spiritual connection that improves mental health vs. a religious connection that is inconsequential. Using the ecological systems theory is useful when investigating personal and sociocultural factors, and religion and spirituality are both personal and cultural developments (Drumm et al., 2013; López-Fuentes & Calvete, 2015). Based on the limitations of the current study, I recommend that future researchers include larger sample sizes from a more diverse population to generalize the findings better.

Implications

Considering the documented harmful effects of IPV, identifying how culturally specific coping strategies are related to the depression levels of African American female victims of IPV has a potential impact on improving outcomes for victims of IPV and for promoting positive social change. Positive social change refers to actions designed to improve the well-being of individuals, communities, and society. In this study, I found that spiritual coping had a negative correlation with depression in participants. This implies that spiritual coping could be used to lessen the depressive symptoms of victims of IPV; therefore, promoting spiritual coping could be used as an intervention that increases the well-being of individuals who have experienced IPV. By decreasing depressive symptoms, spiritual coping has the potential to help victims improve their well-being. IPV has severe costs for the individual level as well as the societal level through the costs of services for helping victims. Mitigating the problems, adverse health consequences, and reducing costs associated with IPV could have a positive effect on society (Modi et al., 2014). The effects of IPV exposure have resulted in a variety of treatment expenses, and researchers have estimated that it costs more than $7 billion a year in the United States alone (Black et al., 2011; Johnson et al., 2015; Modi et al., 2014). If spiritual coping can help alleviate depressive symptoms, it is possible that it could help alleviate some of the societal costs associated with treating victims of IPV.

The results from this study also have implications for practice and could be used to inform leaders of women shelters, social workers, human services professionals, medical professionals, IPV victims, or other individuals who closely interact with IPV

victims about spiritual coping as a potentially effective and expensive strategy for coping with IPV. This means that the results of the study could help those in a position of practical application as well as future researchers in evaluating the potential use of spiritual coping methods when culturally appropriate for African American women. Those victimized by IPV could become aware of spiritual coping strategies that could be used to improve their emotional well-being.

Conclusion

Intimate partner violence occurs frequently and comes with serious consequences for the victim, the community, and for all of society (Modi et al., 2014). IPV is a subset of interpersonal violence that affects women more frequently than men (Overstreet et al., 2015; Shepherd-McMullen et al., 2015). African American women appear to be at a higher risk for IPV than Caucasian women (Modi et al., 2014). Furthermore, the consequences of IPV include decreased physical and mental health for the victims and a financial cost to the community and society. The body of previous literature on this topic contains a gap in understanding specific cultural coping strategies for African American women such as spiritual and religious coping. Through the current study, I attempted to address the gap in the literature by investigating the relationship between spiritual coping and religious coping with depression in African American women who have experienced IPV.

I found that spiritual coping was negatively correlated to depression among participants, suggesting that it may be an effective and positive coping strategy for African American women. Interestingly, religious coping was not found to have a

relationship with depression among participants. This suggests that more research is needed to understand and facilitate the best coping strategies for African American women who have experienced IPV. This suggests that a clearer understanding of the differences between religious and spiritual coping is needed because they did not appear to be utilized equally by the participants of the current study. This is significant because helping women cope with the negative consequences of IPV is paramount for improving their well-being and health.

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Appendix A: Recruitment Materials

RESEARCH PARTICIPANTS NEEDED

Intimate partner violence is a major problem that affects the health and well-being of African American women. Are you an African American female between the ages of 25-45 and have experienced Intimate Partner Violence (IPV) by a male perpetrator?

If you answered yes, I would like to invite you to participate in a research study focused on the "Predictive Relationships Between Cultural Coping Strategies, Intimate Partner Violence, and Depression in African American Women." As a participant in this study you will take an online survey that will last no more than 25-30 minutes.

The purpose of this study is to examine the connection between cultural coping strategies (spirituality and religious coping) and levels of IPV with levels of depression in African American women victimized by IPV.

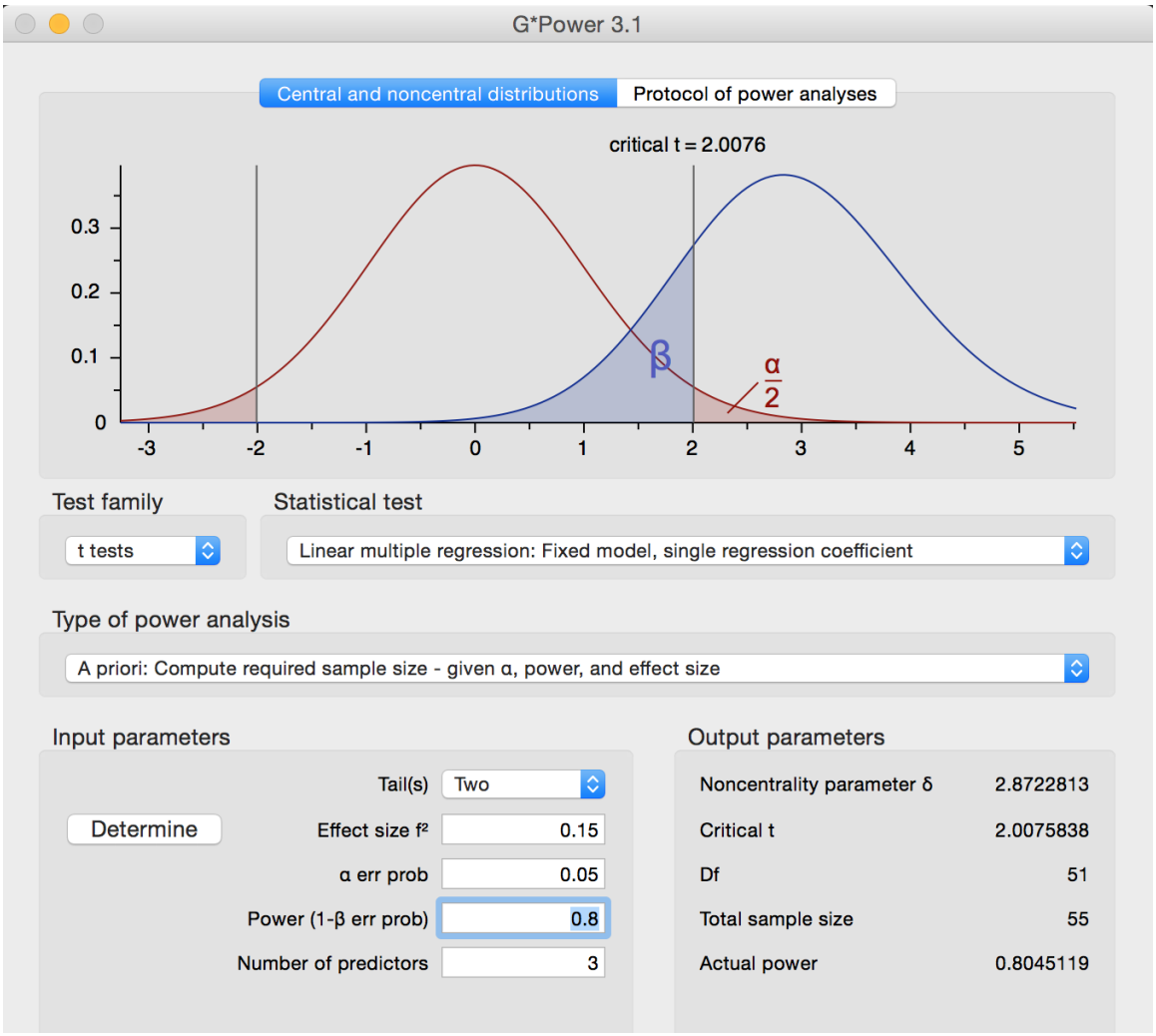
Your participation in this study is completely voluntary and your responses and information will remain private and secure at all times. If you think you are eligible and interested in participating in the study, please contact me via email at tiffany.wiggins@waldenu.edu or phone at 404-313-7729.

You can access the survey and informed consent form at www.surveymonkey.com

Thanks and I look forward to hearing from you,

Tiffany Wiggins

Appendix B: Results of G*Power Sample Size Computation



Appendix C: Letter of Cooperation

April 5, 2017

Dear Tiffany Wiggins,

I will provide my fullest support for your research. "Predictive Relationships Between Cultural Coping Strategies, Intimate Partner Violence and Depression in African American Women" is a great topic to explore and I look for to reading your dissertation. Our organization, Atlanta Consulting/Psychological Services and Women's Shelter is willing to support you on this venture by allowing you to post flyers to recruit participants for your study.

I am aware that neither participants nor I will be compensated for participating in this research. Administering surveys at the venue via computers enhances the likelihood of accurate participation. So, please feel free to utilize our computer room. I recognize the importance of this kind of research and its potential positive impact on women exposed to IPV.

Best Wishes,

Dr. Smith

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