ABSTRACT

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RELIGIOUSITY AND SPIRITUALITY AS COPING STRATEGIES AMONG

SUICIDAL AFRICAN AMERICAN WOMEN

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African American women traditionally have lower rates of suicide than women of

other races; however, over the past 20 years the rates of suicide have increased in the

African American community. The purpose of this paper was to examine the effects of

religiosity and spirituality as coping strategies for African American women. Findings

show that there is a correlation between higher levels of religiosity and spirituality and

lower levels of suicidal ideation, hopelessness and depression. It was hypothesized that

higher levels of religiosity would be more positively correlated with lower levels of

suicidal ideation, hopelessness and depression than spirituality. Conversely, it was found

that spirituality accounts for more of the variance associated with lower levels of suicidal

ideation, hopelessness and depression.

RELIGIOUSITY AND SPIRITUALITY AS COPING STRATEGIES AMONG

SUICIDAL AFRICAN AMERICAN WOMEN

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CHAPTER I

INTRODUCTION

Statement of the Problem

Suicide is the eight leading cause of death in the United States and the twelfth

leading cause of death for African Americans ages 18-64 (American Association of

Suicidology, 2008; Joe, S., Baser, R. E., Breeden, G., Neighbors, H. W., & Jackson, J. S.

, 2006). In addition, if the number of deaths that were misclassified as homicide or

accidents were taken into account this number may actually be higher (Poussaint, A. F.,

& Alexander, A. , 2000; Satcher, D., 1998). Younger, less educated, previously or never

married individuals with low social support have been reported to have higher suicidal

behavior. It has also been reported that individuals with significant psychological distress

are at higher risk for suicide attempts (Kaslow, N. J., Price, A. W., Wyckoff, S., & Grall,

M. B., Sherry, A. & Young, S., 2004; Kessler, R. C., Bergulund, P., Borges, G., Nock,

M., & Wang, P. S., 2005; Kessler, R. C., Borges, G., & Walters, E. E., 1999; Willis, L.

A., Coombs, D. W., Drentea, P. & Cockerham, W. C., 2003).

Traditionally, African Americans have lower rates of suicide than other racial

groups in the United States (Bingham, C., Bennion, L., Openshaw, D., & Adams, G.,

1994; CDC, 1998; Kachur, S., Potter, L. B., James, S. P., & Powell, K. E., 1995; Willis,

L. A., Coombs, D. W., Drentea, P., Cockerham, W. C., & Frison, S. L., 2002) However,

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over the past 20 years the rates in suicide in the African American community has

increased significantly (CDC, 1998). Yet, in the face of this increase in numbers there

is still limited research and few prevention programs devoted to addressing suicide in the

African-American community(CDC, 1998; Gibbs, J. T., 1997).

One of the leading risk factors for suicide completion is suicide attempts (Tejedor,

M. C., Diaz, A., Castillon, J. J., & Pericay, J. N., 1999) and while men complete suicide

more often than women, women are three times more likely to make an attempt (Kahn, J.,

Kehle, T., Jenson, W., & Clarke, E., 1990; Kessler, R. C., Borges, G., & Walters, E. E.,

1999). This is true for women of all ages and races including African-American women

(Juon, H. S., & Ensminger, M. E., 1997). Researchers found that African-American

women who attempt suicide are likely to have maladaptive coping strategies (Kaslow, N.

J., Thompson, M., Meadows, L., Jacobs, D., Chance, S., Gibb, B., et. al., 1998; Kaslow,

N. J., Thompson, M., Meadows, L., Chance, S., Puett, R., Hollins, L., et. al., 2000).

Research suggest that spirituality if incorporated into treatment can reduce

problems (Cowger, C. D., 1994) but there are few assessment tools that can be used to

identify individuals spiritual strengths (Bullis, R. K., 1996; Mattaini, M. A., & Kirk, S.

A., 1991; Sherwood, D. A., 1998) and therefore spirituality is not addressed during the

helping process. It is reported that a Gallup poll conducted in 1998 showed that

approximately 81% of the public would like to have their spiritual beliefs incorporated

into their counseling process yet social workers are rarely trained in the area of

spirituality (Hodge, D. R., & Williams, T. R., 2002).

Examinations of religious variables are of particular importance when looking at African-American women since these variables are used as coping mechanism more often than traditional mental health services (Meyers, L., 1987). In effect, it has been found to be the preferred way to deal with difficulties in the African American community (Boyd-Franklin, N., 1991; Mattis, J. S., 2000; Thomas, A. J., 2001), yet, many professionals in mental health services overlook the cultural relevance of spirituality as a coping mechanism for psychosocial problems (Fowler, D. N., & Hill, H. M., 2004).

Purpose of the Study

The purpose of this study is to add to the literature on religiosity and spirituality as coping strategies in the African American community by examining the correlation between religiosity and spirituality on levels of depression, suicidal ideation and hopelessness. In addition the wellness theory, strengths perspective and ecological perspective will be reviewed to see how mind, body and spirit, strength and environment can have an effect on an individual's life. There is not a consensus in regards to the definition of religiosity or spirituality. For this paper religiosity is defined as religious attendance, practice and activities at a place of worship. Spirituality is defined as an inner belief of a connection to a higher power and the world as a whole, and private worship activities such as prayer, reading the bible and meditating.

Research Questions

The questions the researcher have chosen for study are; (1) does higher levels of religiously and spirituality correlate with lower levels of suicidal ideation, hopelessness and depression, and (2) is there a difference between the effects of religiosity (going to church, talking to religious leaders) and the effects of spirituality (prayer, meditation, personal faith) on suicidal ideation, hopelessness and depression?

Hypotheses

It is the researcher's hypothesis that (1) higher levels of religiosity and spirituality are positively correlated with lower levels of depression, suicidal ideation and hopelessness and (2) religiosity will account for a greater proportion of the variance on suicidal ideation, hopelessness and depression than spirituality.

Significance of the Study

It is essential to examine factors that will assist African American women in decreasing suicidality in their lives. The development of culturally informed services that build upon protective factors, such as, religiosity and spirituality and incorporation of these components into treatment will assist in lowering the levels of depression, hopelessness and suicidal ideation within this population. Broadly, the clinical and research implications of this study include informing standards of clinical practice for working with suicidal, African-American women.

CHAPTER II

REVIEW OF THE LITERATURE

Historical Perspective

A major component of African-American culture is spirituality. Traditionally, it

has been an individual and collective source of meaning, hope, comfort and deliverance.

Furthermore, in regards to health, spirituality and religiosity has shown to influence

beliefs, practices and outcomes (Dash, M., Jackson, J., & Rasor, S., 1997; Newlin, K.,

Knafl, K. & Melkus, G. D., 2002).

Specifically, religion and spirituality have long been documented as coping

strategies for African Americans (Mattis, J. S., 2002; McAdoo, H. P., 1995; Neighbors,

H. W., Musick, M A., & Williams, D. R., 1998). Compared to their Caucasian

counterparts, African Americans tend to be more religious, attend religious services more

often and consider religion to be personally significant

(Ellison, C. G., 1998). African Americans spiritual connection play a important part in

their individual and collective well-being (Boyd-Franklin, N., 1991).

For African American women in particular, religion plays an important role.

African-American women are introduced to the church at a younger age than that of

African-American men and they tend to use prayer more as a means of coping when

stressors are introduced in their lives (Taylor, R. J., & Chatters, L. M., 1991). Compared

to African American women who are not religious, it was found that religious African

American women tend to have higher familial support and social support from friends and tend to be less distressed (Jang, S. J., & Johnson, B. R., 2004).

<center>Religiosity, Spirituality and Coping</center>

The church has been one resource that has been a constant in African Americans lives. They have used the church during the difficulties experienced by African Americans throughout history (Cook, D., & Wiley, C., 2000; Smith, A., 1981). African Americans tend to turn to religion as a coping mechanism when faced with health related challenges. They report that their involvement in their religious practices have a positive influence on their health (Ferraro, K. F., & Koch, J. R., 1994).

Chiefly, for African American women religion and spirituality holds a vital place in their coping repertoires. They use traditional and private religious activities to negotiate many adversities they face in their life (Haigginbotham, E., 1997; Mattis, J., 2001; McKay, N., 1989). Contrary to some perspectives that state people use religion and spirituality to protect them from their realities of their situation, African American women report that religion and spirituality assist them to confront and accept the reality of their lives (Mattis, J. S., 2002).

Different to the above findings, Chatters (2000) reports that religious role identities could include negative attitudes and beliefs such as retribution and original sin that may worsen personal issues and increase negative psychological states (Chatters, L. M., 2000). For some individuals the thought that we are born from sin and therefore sinners may cause feelings of hopelessness about gaining favor with their higher power

and thus lead to feelings of depression. Also, when it comes to retribution, believing that one will be punished by their higher power for their sins can be too much to bear for some.

<div align="center">Religiosity, Spirituality and Suicide</div>

Dervic and colleagues found that religious affiliation served as a protective factor against suicide attempts and it is also pertinent in decreasing pro-suicide ideology (Dervic, K., Oquendo, M. A., Grunebaum, M. F., Ellis, S., Burke, A. K. & Mnn, J. J., 2004; Stack, S., & Wasserman, I. , 1995). Superior moral objections to suicide and lower levels of aggression in religious individuals functions as a buffer against suicide as well. African American individuals who endorse religiosity have lower levels of suicidal ideation and increased psychological well-being (Kimbroug, R. M., Molock, S. D., & Walton, K., 1996). This may be in part due to the fact that the African-American church condemns suicide (Early, K. E., 1992).

In addition, suicidal African-American women who report high levels of spiritual well-being have a lower risk of attempting suicide (Kaslow, N. J., Thompson, M. P., Okun, A., Price, A., Young, S., Bender, M. , et. al., 2002) and among African American women, religiosity is linked to lower levels of suicide acceptability (Marion, M. S., & Ranger, L. M., 2003). When looking at African American suicide attempters versus African American non attempters of suicide, non-attempters of suicide endorsed higher levels of religiosity and/or spirituality (Kaslow, N. J., Price, A. W., Wyckoff, S., & Grall, M. B., Sherry, A. & Young, S., 2004).

However, in comparison to these findings Willis and colleagues reported that engaging in religious activities actually were more associated with African American suicides than Whites suicides(Willis, L. A., Coombs, D. W., Drentea, P. & Cockerham, W. C., 2003). This is not to say that these activities are not protective factors but it indicates that they are less of a protective factor for African Americans than their White counterparts.

Religiosity, Spirituality and Depression/Hopelessness

Literature on religious coping has shown that there is a link between religiosity and spirituality and lower levels of depression and anxiety (Koenig, H. G., & Larson, D. B., 2001; Pargament, K. J., 2002; Schnittker, J., 2001). It has also been found that religious participation, higher levels of spirituality and social support for African Americans buffer the negative effects of stressful life events on depression (Jesse, D. E., Walcott-McQuigg, J., Marietta, A. & Swanson, M. S., 2005)

Research done by Cooper and colleagues (2001) found that African Americans rated having faith in God and prayer as one of the top 10 important aspects of care for depression and another study showed that they are more likely to believe that prayer can help to heal depression (Cooper, L. A., Brown, C., Vu, H. T., Ford, D. E. & Powe, N. R., 2001; Cooper, L. A., Gonzales, J. J., Gallo, J. L., Rost, K. M., Meredith, L. S., Rubenstein, L. V., Wang, N., & Ford, D. E., 2002)

In contrast Ellison and Gay (1990) reports that religious participation only provide positive outcome for African Americans not living in the south. Of particular

interest, the findings of one study suggest that different religious activities may in fact intensify the harmful impact of incessant poverty on depression. These findings question whether or not the protective factors of religious involvement are dependent upon various demographic characteristics such as race, age or socioeconomic status (Brown, D. R., Gary, L. E., Greene, A. D., & Milburn, N. G. , 1992; Dressler, W., 1991; Ellison, C. G., & Gay, D. A., 1990).

Afrocentric Perspective

The Afrocentric perspective is a worldview based on the traditions from West African societies that have been preserved by their descendents, African Americans. Its premise is that African people should research and describe their own circumstances and challenge the distortions that have been disseminated through European scholarship.

From an Afrocentric perspective spirituality is a universal essence that interconnects human beings and the creator. It negates individual identity with an identity of collectiveness. We are bound together through spiritual and social connections (Schiele, J. H., 2000). Spirituality is both important and valid. By developing an understanding of spirituality and the connectedness created from it, spiritual development and growth can be incorporated into practice (Schiele, J. H., 1997).

The Afrocentric perspective promotes a human and societal transformation of spiritual, moral and humanistic growth, which will show people of different cultures that they have similar interest (Schiele, J. H., 1996). The perspective incorporates many

concepts which apply to religiosity and spirituality as coping strategies for African American women.

First, the perspective encompasses the strengths perspective which identifies the client system as the authority over their issues and the solutions to them. By identifying the clients spiritual and religious beliefs as strength for them and allowing them to use that and incorporate it into treatment best serves the client.

There is also the concept of spiritual balance which explores the effects of religious and spiritual beliefs, including superstition on the client systems perception of the issues and the selected treatment. Social workers must use these concepts to help the client system through their human transformation in their personal and environmental surroundings.

In addition, there is an incorporation of the collective view of self. The collective view of self is the clients connections with their family (blood and fictive), friends, neighbors, church members, colleagues, etc. It examines how these individuals view the problem the client is experiencing and what solutions they feel will work. This integrates the solution ideas of the clients' support system and promotes the strength that is found in collective environments.

Lastly, the Afrocentric perspectives of significance of self knowledge and personal experience, validation of circular and linear knowledge and intuitive feelings tie into religiosity and spirituality as coping strategies. These concepts support viewing problems as a challenge or opportunity for growth. They also support seeing how change will impact the past, present and future relationships. Spirituality is often viewed as a

process of growth and often this growth has an effect on relationships with the client's environment. The concept of intuitive speaks to the feelings the client has about their transformation process. The client's feelings must be taken into account in order to create a rapport and be able to help them move through the process.

<div align="center">Theoretical Framework</div>

This research is based upon the wellness theory, strengths perspective and ecological perspective.

The wellness theory is holistic approach based upon the premise that wellness, which is defined as a harmonious balance between individuals mind, body, and spirit, comes from congruency between ones interpersonal relationships, the environment in which one functions and intrapersonal body systems. Any interruptions in this balance can interfere with an individual's wellness and therefore it is imperative that these areas are explored during the therapeutic process. The key concepts of this theory are constructivism, psychoneuroimmunology and social development theory (Jones, G. C., & Kilpatrick, A. C., 1996; Schriver, J. M., 2003).

Constructivism states that for any single event there are multiple perceptions of reality and all of these perceptions have validity (Schriver, J. M., 2003). These perceptions are explored through dialogue and change can take place during therapy.

Psychoneuroimmunology is the relationship between the mind and body. The bases of psychoneuroimmunology is that the mind and body have a continuous reciprocal relationship and are inseparable (Saleebey, D., 1994).

Social development theory has a long history in social work. This theory recognizes the societal and political aspects of the human functioning. It attempts to address the injustices caused by oppression and/or discrimination towards out-groups (Billups, J., O., & Julia, M. O., 1991; Schriver, J. M., 2003).

This holistic approach is applicable to use with oppressed groups such as minorities, women, the poor and the homeless. It uses a collaborative framework for understanding the client and meeting their needs using the strengths perspective. Religiosity and spirituality is an important concept in the African American community. Without addressing the spiritual needs of the client then the harmony becomes unbalanced making it difficult to achieved complete wellness for the client.

As mentioned above the strengths perspective is another base for this research. The strengths perspective rest on the following five assumption: (1) despite problems in life, every person and environment has strengths that can be tapped into to improve the situation, (2) constantly emphasizing client strengths as defined by the client provides motivation, (3) exploring the strengths is a collaborative effort between the client and practitioner, (4) focusing on these strengths emphasizes the resilience and minimizes the potential for blame being placed on the client and (5) all environments contain resources (Saleeby, D., 1992).

If through collaboration between the client and the practitioner, religiosity and spirituality is identified as strength then the concepts that provide support and resilience must be constantly emphasized and discussed. The clients meaning of religiosity and spirituality is important and has to be integrated into the transforming process. By

respecting the client's world view and beliefs the helping process is strengthened.

Finally, the ecological perspective states that an individual is constantly creating, restructuring and adapting to the environment as the environment is affecting them. It looks at the interaction between systems and it stresses that all elements within an ecosystem play an equal part in maintaining the balance of the whole. For social work in particular, this means looking at the individual, families, cultures and communities and identifying the strengths and challenges within the transactional process between these systems. In this current research the connection between the individual and the culture of religion and spirituality and the helping process is explored. By understanding the experiences the individual has within this cultural context of religion and spirituality provides insight into proper assessment and intervention (Turner, F. J., 1996; Ungar, M., 2002).

CHAPTER III

METHODOLOGY

Research Design

The data set comes from pre-existing data obtained from a study entitled "Group

Intervention for Suicidal Black Females," authored by Drs. Nadine J. Kaslow and Sheryl

Heron. The study was funded by the Centers for Disease Control. The Principal

Investigator (PI) is Nadine Kaslow, Ph.D., Professor and Chief Psychologist, Emory

Department of Psychiatry and Behavioral Sciences at Grady Health System (an Emory

University affiliated, large, urban, public health system). Given the large scope of the

parent project mentioned above, description of its design and method will be limited to

those aspects that are central to the proposed thesis study.

The study will use a quantitative, cross-sectional, descriptive design to measure

the levels of religiosity and spirituality as it correlates with the levels of depression,

hopelessness and suicidal ideation.

Description of the Site

The research study was conducted at a large, level 1 trauma center, public

metropolitan hospital located in a southeastern area of the United States, which serves a

predominantly indigent and African American population.

Sample and Population

All African American women between the ages of 18-64 (M = 35.84, SD = 11.35) who reported a suicide attempt within the last 12 months were eligible for the study. Participants (n = 146) were recruited in two ways. First, the research team was available to hospital staff 24 hours a day, 7 days a week via pager. Whenever an African American woman between the ages of 18-64 presented in the medical or psychiatric emergency room after making a suicide attempt the research team member on call would be contacted by hospital personnel. Once the patient was medically stable, the team member would approach and screen the potential participant immediately. Second, research team members recruited women from hospital clinic waiting rooms. The women were approached and informed briefly about the study. Those individuals who were interested were taken to a private, confidential area to be screened for study criteria (i.e., women needed to have attempted suicide in the prior year). Women were excluded from the study if (a) they refused to participate, (b) the attempt did not occur within the last 12 months, (c) they had an imminent life threatening condition, (d) they were not cognitively functional or literate, or (e) they were unable to complete the protocol because of psychosis.

Women who were eligible and agreed to participate were scheduled an assessment date and time, as well as asked to give written informed consent. Once consent was obtained, an assessment interview was conducted. During this assessment questions were asked about the participant's beliefs, values and life experiences. Some

areas discussed included; domestic violence, depression, hopelessness, ways of coping, daily hassles, suicidal ideation, spiritual well-being, religious involvement and social support. The interview lasted approximately 2 ½ -3 hours and was conducted in a private interview room. After completing the interview the participants received $20.00 as compensation. Participants also received tokens for public transportation.

Instrumentation

Since the hypotheses for this study will require utilization of only a subset of the entire battery of measures administered in the parent investigation, only the hypotheses relevant measures are described.

Demographic Data Questionnaire. This questionnaire was developed for use in previous studies by Dr. Nadine J. Kaslow and was conducted on low-income African American women who experienced abuse and have made a suicide attempt (Appendix A). This comprehensive tool includes questions about demographics (age, sex, education, religion, socioeconomic status); family composition (presence of dependent children, marital status, sex of partner); living situation (including if the individual is homeless); and personal and family psychiatric, medical, and substance abuse history.

The *Beck Depression Inventory II* (BDI-II) (Beck, A. T., Steer, R., 7 Brown, G. K., 1996) has 21 items that measure severity of depressive symptoms (Appendix B). The measure has high internal consistency and reliability (α = .93). It consists of 4 statements reflecting increasing levels of severity for each symptom. Item scores range from 0-3 and total scores range from 0-63. Scores ranging from 29-63 reflect severe depressive

symptomatology, 20-28 reflect moderate depressive symptomatology, 14-19 reflect mild

depressive symptomatology and 0-13 reflect minimal depressive symptomatology. Items

consist of four statements reflecting increasing levels of severity for each depressive

symptom. It also includes thinking and behavior patterns associated with six of the

diagnostic criteria for depression (Dozois, D. J. A., Dobson, K. S. & Ahnberg, J. L.,

1998).

The *Beck Hopelessness Scale* (BHS) (Beck, A. T., Weissman, A., Lester, D., &

Trexler, L., 1974) is a 20 item true/false measure that assesses negative expectations

about the future (Appendix C). The internal reliability for this scale is moderate ($\alpha =$

.70). Scores range from 0-20 with higher scores indicating more hopelessness. Items

reflect negative attitudes about the future such as, "All I can see ahead of me is

unpleasantness rather than pleasantness", that seem to occur frequently in hopeless

individuals.

The *Beck Scale for Suicide Ideation* (BSS) (Beck, A. T., & Steer, R., 1991; Beck,

A. T., Kovacs, M. & Weissman, A., 1979) is a 19 item measure that gathers data on an

individual's specific attitudes, behaviors, and plans to commit suicide (Appendix D). It is

reliable and valid with high internal consistency reliability ($\alpha = .92$). The measure uses a

3 point Likert scale with items ranging from 0 (not present) to 2 (maximum severity of

suicidal ideation) and scores range from 0-38. There is no specific cutoff score with the

BSS however; higher scores indicate greater levels of suicidal ideation and risk. The list

includes thinking and behavior patterns, preoccupations, concerns, and wishes often

expressed by suicidal patients.

The *Multidimensional Measure of Religious Involvement* (MMRI) (Levin, J. S., Taylor, R. J., & Chatters, L M., 1995) is a 12 item measure of organizational, non-organizational and subjective religiosity (Appendix E). The internal consistency reliability is moderate on this scale ($\alpha = .78$). It uses a 5 point Likert scale for questions 1-9, ranging from 1 (nearly every day) to 5 (never) and a 4 point Liker scare for questions 10–12 ranging from 1 (very important) to 4 (not important at all). The measure asks questions about frequency of attendance at place of worship as well as involvement with committees and organizations within the church.

The *Spiritual Well-Being Scale* (SWBS) (Ellison, C. W., 1983) is a 20 item measure that requires participants to rate their religious and existential well-being (Appendix F). There is internal consistency reliability ($\alpha = .91$). It uses a 6 point Likert scale ranging from 1 (strongly agree) to 6 (strongly disagree). Questions are asked about private prayer, beliefs about Gods concern for an individual and the perception about personal strength and support received from God.

Treatment of Data

Bivariate correlations were used to assess the relation between religiosity and spirituality and suicidal ideation, hopelessness and depression. Next, simple linear regressions will be used to determine which independent variable, religiosity or spirituality is more positively associated with lower levels of suicidal ideation, hopelessness and depression.

Limitations of the Study

This study was conducted on low-income African American women residing in the southeast; therefore, the findings are not generalizable to a broader population. There is also possible low internal validity. Also, since there is not a consensus in regard to the definition of religiosity or spirituality it is hard to say for certain that these variables will have a significant effect on an individual unless the definitions given in this study are agreed upon.

CHAPTER IV

PRESENTATION OF FINDINGS

Demographic Data

Preliminary analyses were run to examine the demographic profile of the population studied; including age, relationship status, , parental status, homelessness, education, employment, socioeconomic status and religious affiliation (see Table 1).

Table 1

Demographic Characteristics of the Total Sample (N=146)

	M (SD)	Range
Age	35.84 (11.35)	18-61

	N	%
Relationship Status		
Single/Never married	63	40.4
Partner, Not Living Together	13	8.3
Partner, Living Together, Not Married	17	10.9
Married	9	5.8
Divorced/Separated	38	24.4
Widowed	5	3.2
Children		
Yes	115	73.7
No	29	18.6
Homeless		
Yes	76	48.7
No	70	44.9

Table 1 (Continued)

Education		
Less than 12th Grade	57	36.5
High School Diploma/GED	54	34.6
Some College/Tech Diploma	27	17.3
College Graduate/Grad School	8	5.1

Employment		
Employed	18	11.5
Not Employed	127	81.4

Monthly Individual Income		
Less than $500 per month	97	62.2
$500 to $999 per month	32	20.5
$1000 per month and up	14	9.0

Monthly Household Income		
Less than $500 per month	60	38.8
$500 to $999 per month	30	19.2
$1000 per month and up	31	19.8

Religious Affiliation		
Baptist	74	47.4
Jehovah Witness	5	3.2
Catholic	5	3.2
Holiness	8	5.1
Muslim	3	1.9
Methodist	2	1.3
Christian/Non-denominational	22	14.1
Other	6	3.8

A vast number of the participants are single/never married (40%), have children (74%), are homeless (49%), have less than a 12th grade education (37%), are unemployed (81%), have a monthly individual income less than $500 (62%), have a monthly

household income less than $500 (39%) and identified their religious affiliation as Baptist (47%).

Descriptive statistics for all relevant study variables, including means, standard deviations, and ranges are presented in Table 2 below.

Table 2

Descriptive Statistics

	Mean	SD	Min	Max
MMRI	18.08	8.17	1	39
SWBS	42.24	16.34	22	100
BSS	14.12	10.38	0	38
BHS	11.44	5.54	0	19
BDI-II	31.71	14.41	0	61

Bivariate Correlations

To answer the first study question, bivariate corellations were conducted to assess the associations that exist between religiousity and spiritualty and the outcome variables being examined.

Question #1: Does higher levels of religiousity and spirituality correlate with lower levels of depression, suicidal ideation and hopelessness?

The hypothessis associated with question was, higher levels of

religiousity and spirituality are negatively correlated with lower levels of

suicidal ideation, hopelessness and depression.

To test this hypothesis a series of bivariate correlations were conducted

using the data. Consistant with predictions, higher levels of religiousity were

associated with lower levels of suicidal ideation (r (84) =   -.283, p <.01),

hopelessness (r (85) = .259, p <.01) and depression (r (84) =   -.213, p <.05).

In addition, higher levels of spirituality were associated with lower levels of

suicidal ideation (r (86) = .555, p <.01), hopelessness (r (86) =   -.417, p <.01)

and depression (r (85) = .472, p <.01) (see Table 3).

Thus, African American women who endorse higher levels of

religiousity and spirituality appear to have lower levels of suicidal ideation,

hopelessness and depression.

Table 3

Correlations between Religiosity and Spirituality and Beck Scale for Suicide Ideation
(BSS), Beck Hopelessness Scale (BHS) and Beck Depression Inventory II (BDI-II)

	BSS	BHS	BDI-II
Religiosity	-.283**	.259**	-.213*
Spirituality	.555**	-.417**	.472**

Note; Religiosity is measured by the Multidimensional Measure of Religious
Involvement. Spirituality is measured by the Spiritual Well-Being Scale.
** Correlation is significant at the 0.01 level
* Correlation is significant at the 0.05 level

Simple Regressions

Question # 2: Is there a difference between the effects of religiousity and the effects of spirituality on suicidal ideation, hopelessness and depression?

The hypothesis associated with this question is, religiosity accounts for a greater portion of the variance on suicidal ideation, hopelessness and depression than spirituality.

Simple linear regression was used to address question #2. Contrary to the hypothesis, the findings show that spirituality accounted for a significantly greater portion of the variance on suicidal ideation (R^2 = .320, F = 19.29, p <.01), hopelessness (R^2 = .189, F = 9.52, p <.01) and depression (R^2 = .229, F = 12.02, p<.01). These results reveal that sprituality accounted for 32% of the variance of suicidal ideation, 19% of the variance of hopelessness and 23% of the variance of depression whereas religiousity only accounted for only 8%, 7% and 5% of the variance repectfully (see Table 4).

In other words, the levels of suicidal ideation, hopelessness and depression are largely accounted for by spirituality with a smaller portion of the variance accounted for by religiosity. From these findings we can predict that African American women who endores high levels of spirituality have more of a protective factor than those who only endores high levels of religiosity. In addition, if both sprituality and religiosity are endorsed at high levels than the protective factor increases.

Table 4

Simple Linear Regression Analyses Predicting Suicidal Ideation, Hopelessness and Depression Based on Endorsement of High Levels of Religiosity and/or Spirituality

Predictors	Dependent Variable	F	ΔR^2
Religiosity			
	BSS	19.29**	.32
	BHS	9.52**	.19
	BDI-II	12.02**	.23
	Table 4 (Continued)		
Spirituality			
	BSS	7.24*	.08
	BHS	5.97*	.07
	BDI-II	3.88*	.05

Note; Religiosity is measured by the Multidimensional Measure of Religious Involvement. Spirituality is measured by the Spiritual Well-Being Scale.
**Significant at the 0.01 level
* Significant at the 0.05 level

CHAPTER V

DISCUSSION OF FINDINGS

Summary of the Study

Results of the study confirm that there is an association between higher

levels of spirituaily and religiosity and lower levels of suicidal ideation,

hopelessness and depression. Consistant with the prediciton the women in the

study who enodresed higher levels of spirituality and religoisity endorsed lower

levels of suicidal ideation, hopelessness and depression. This is consisted with

the literature that states African American individuals who endorse religiousity

have lower levels of suicidal ideation, increased psychological well-being, and

lower levels of depression (Kimbroug, R. M., Molock, S. D., & Walton, K.,

1996; Koenig, H. G., & Larson, D. B., 2001; Pargament, K. J., 2002;

Schnittker, J., 2001). This also validates the usefulness of the wellness theory in

practice. We cannot ignore the spiritual health of the client. There has to be a

balance between the mind body and spirit for there to be harmoniusy balance in

individuals lives(Jones, G. C., & Kilpatrick, A. C., 1996; Schriver, J. M.,

2003).

However, contray to the hypothesis that higher levels of religiosity

would account for a greater preportion of the variance on the levels of suicidal

ideation, hopelessness and depression than spiruality it was found that spirituality accounted for a siginificantly greater preportion of the variance on the levels of suicidal ideation, hopelessness and depression. This may be explained by the findings reported by Chatters (2000) that stated that religious role identities such as being a sinner could be negative and include ideas about retribution and sin and these ideas could worsen personal distress and increase malpsychological states.

When looking at sprituality there is a connection between an individual and their higher power, universe and those around them as describe in the Afrocentric perspective. Spirituality does not include the above mentioned beliefs that are found in religion that may cause internal stress. Thus it makse sense that spirituality would account for more of that variance on suicidal ideation, hopelessness and depression.

What is even more important is the amount of variance that is accounted for by both spirituality and religiosity. Combined they account for 40% of the variance of suicidal ideation, 26% of the variance for hopelessness and 28% of the variance of depression.

These finding highlights the importance of religiosity and spirituality in the lives of suicidal African American women and how they serve as protect factors in this population.

Limitations

As mentioned before the sample is drawn from a low-income African American population. In addition many of the participants were single and had never been married, had dependent children, unemployed and low education levels, therefore the findings are not generalizable. Another limitation involves the use of self-report measures. The information that was collected was sensitive in nauture and consequently difficult for many women to talk about and report candidly with someone they are not familiar or close with. Also, the length of the interview was very long. The interview lasted approximately 2 ½ - 3 hours. This length of time could cause participants to become tired and they may start to rush through the questions to finish quickly causing some question as to the reliabilty of their answers.

Implications for Social Work

In order to be truly culturally competent as social workers we must address the religious and spiritual beliefs of our client systems. It is imparitive to acertain if this is an important part of the clients belief system and to be able to appropriately incorporate it into treatment. Sensitive incorporation of religious and spiritual concepts may enrich the client-worker relationship. We must use the wellness theory, strengths, ecological and Afrocentric perspectives when working with our clients and developing treatment plans. These

perspectives and theories are of great importance when working with socially and economically oppressed individuals. They provide the framework for utilizing the strengths of the clients and their environment and using them to build a strength drive, inclusive and harmonious theraputic atmosphere.

In addition, the findings from this study support evidence that there is a correlation between religion and spirituality and better mental health so it is a protective factor that should be addressed when working with depressed and/or suicidal clients. Social workers should consider ways they might use religoisity and /or spirituality as a therpeutic tool including incorporating sensitive religious leaders into the treatment plan.

In regards to policy, spirituality and religiosity training should be incoprorated in social work programs. If 81% of people are saying they would like to have their spiritual beliefs incorporated into their treatment process yet social workers are rarely trained in this area (Hodge, D. R., & Williams, T. R., 2002) then there is a fairly large gap in competency training that needs to be filled.

Lastly, futhur research needs to be conducted on the protective factors of religiousty and spirituality in the lives of African American women. There needs to more idepth study on the extrinsic and intrinsic beliefs that provide support and comfort and how they can be integrated into practice. In addition,

there should be implemetation and examination of the effectiveness of

treatment programs that incorporate religious and spirital concepts.

APPENDICES

APPENDIX A: DEMOGRAPHIC DATA QUESTIONNAIRE

Age:_____

DEMOGRAPHIC DATA

1. Do you consider yourself African American or Black   (0) No   (1) Yes

2. What is your current relationship status? (Circle all that apply)

(1) Single, never married   (2) Partner not living together   (3) Partner living together but not married

(4) Married   (5) Divorced (6) Separated   (7) Widowed

3. If you are currently involved in a relationship, is your partner
  (0) Male   (1) Female

4. Do you have children?   (0) No (1) Yes   If yes, list below.

Name	Age	Do they live with you	If no, where do they live

5. Do you consider yourself homeless?   (0) No (1) Yes

If no..
6. Do you own or rent your residence?   (0) Own (1) Rent

7. How many people live in your home/household (including you)?_____
(List all members in the household by name, age, relationship)

<u>Name</u>	<u>Age</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. What was the highest grade you completed in school?

(1) less than 12th   (2) 12th Grade (HS graduate)   (3) GED   (4) Some college or technical school

(5) Technical school graduate   (6) College graduate   (7) Graduate school

9. Are you currently employed?   (0) No   (1) Yes

10. If unemployed, have you ever had a job?   (0) No   (1) Yes

11. What kind of work do you or did you last do? (categorize response)_____

8. Not applicable/ never employed

7. Unskilled (attendant, janitor, construction, unspecified labor).

6. Semiskilled - Machine Operator (hospital aide, painter, bartender, bus driver, cutter, cook, drill press, garage, guard, watchman, checker, waiter, spot welder, cashier).

5. Skilled Manual (baker, barber, brakeman, chef, electrician, fireman, machinist, mechanic, paperhanger, painter, repairman, tailor, welder).

4. Clerical and Sales, Technician, Little Businesses (bank teller, bookkeeper, clerk, draftsman, timekeeper).

3. Administrative Personnel, Small Businesses, Minor Professionals (art gallery, decorator, plumber, actor, reporter, travel agent).

2. Business Manager, Medium Businesses, Lesser Professionals (sales people, policemen, managers, nurses, pharmacist, social workers, teachers).

1. Higher Executives, Major Professionals, Owners of Larger Business (post grads).

12. Do you own a car?   (0) No   (1) Yes

13. What are your current sources of income?   (Circle all that apply)

(1) Job   (2) TANF   (3) Food-stamps   (4) Social Security/SSI/Disability

(5) Partner (6) Child Support   (7) Parents   (8) Family member - other than parent

(9) Other

14. What is your approximate individual monthly income?

(1) $0 - 249   (2) $250 - 499   (3) $500 - 999   (4) $1,000 - 1,999   (5) $2,000 - +

15. What is your approximate household monthly income?

(1) $0 - 249   (2) $250 - 499   (3) $500 - 999   (4) $1,000 - 1,999   (5) $2,000 - +

16. What form of health insurance do you have?
____ None
____ Medicaid/Medicare
____ Private insurance

17. Have you ever been hospitalized or in a treatment program for psychiatric or substance abuse
       treatment?   (0) No   (1) Yes

18. Have you been diagnosed with any of the following?
____ Schizophrenia Spectrum Disorders (schizophrenia, schizoaffective disorder)
____ Depressive Disorders
____ Bipolar Disorder (manic depression)
____ Anxiety Disorders (generalized anxiety disorder, panic disorder, PTSD, OCD)
____ Personality Disorders
____ Other (please describe)

19. Are you currently taking any of the following medications? (Check all that apply)

Antipsychotics

___ Haldol	___ Loxitane	___ Zyprexa
___ Prolixin	___ Thorazine	___ Topomax
___ Navane	___ Mellaril	___ Geodone
___ Stelazine	___ Seroquel	___ Abilify
___ Trilafon	___ Risperdal	

Anticholinergics
    ___Benadryl   ___ Artane   ___ Cogentin

Antidepressants
    ___ Zoloft   ___Paxil   ___ Prozac   ___ Serzone
    ___ Effexor   ___ Wellbutrin ___ Trazadone ___ Celexa

Mood Stabalizers
___ Lithium   ___ Tegretol   ___ Depakote   ___ Valproic Acid

Antianxiety
    ___ Librium   ___ Valium
    ___ Tranxene ___ Ativan   ___ Xanax
    ___ Klonopin ___Vistaril   ___ Inderal
    ___ BuSpar

Other (list medication and reason)

_____

_____

20. Do you have any other medical problems?

_____

_____

21. What religion, if any, are you a part of or believe in?

    (1) Baptist   (2) Jehovah's Witness   (3) Catholic   (4) Holiness

    (5) 7th Day Adventist (6) Muslim   (7) Methodist

    (8) Christian/Non-denominational   (9) Other_____

    (10) None

22. Have you had any involvement with the legal system? (0) No   (1) Yes

23. If yes, have you ever been in jail or prison? (0) No   (1) Yes

24. If yes, what was the charge? _____

APPENDIX B: BECK DEPRESSION INVENTORY-II (BDI-II)

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

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

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

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

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

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

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

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

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

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

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

11. Agitation
    0   I am no more restless or wound up than usual.
    1   I feel more restless or wound up than usual.
    2   I am so restless or itated d to stay still.
    3   I am so restless or gitated to keep moving or doing

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

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

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

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

3   I don't have enough
energy to do anything.

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

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

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

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

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

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

APPENDIX C: BECK HOPELESSNESS SCALE (BHS)

This questionnaire consists of a list of twenty statements (sentences). Please read the statements carefully one by one. If the statement describes your attitude <u>for the past week, including today,</u> write down TRUE next to it. If the statement is false for <u>you,</u> write FALSE next to it. You may simply write T for TRUE and F for FALSE. Please be sure to read each sentence.

_____ A.   I look forward to the future with hope and enthusiasm.

_____ B.   I might as well give up because there's nothing I can do about making things better myself.

_____ C.   When things are going badly, I am helped by knowing that they can't stay that way forever.

_____ D.   I can't imagine (think of) what my life would be like in ten years.

_____ E.   I have enough time to accomplish (do) the things I most want to do.

_____ F.   In the future I expect to succeed in what concerns me (matters to me) most.

_____ G.   My future seems dark to me.

_____ H.   I happen to be particularly (really) lucky and I expect to get more of the good things in life than the average person (than most people).

_____ I.   I just don't get the breaks (I don't feel I have good luck), and there's no reason to believe I will in the future.

_____ J.   My past experiences have prepared me well for my future.

_____ K.   All I can see ahead of me is unpleasantness rather than pleasantness.

_____ L.   I don't expect to get what I really want.

_____ M.   When I look ahead to the future I expect I will be happier than I am now.

_____ N.   Things just won't work out the way I want them to.

_____ O.   I have great faith in the future.

_____ P.   I never get what I want so it's foolish (stupid) to want anything.

_____ Q.   It is very unlikely that I will get any real satisfaction in the future.

_____ R.   The future seems vague (unclear) and uncertain to me.

_____ S.   I can look forward to more good times than bad times.

_____ T.   There's no use in really trying to get something I want because I probably won't get it.

APPENDIX D: BECK SCALE FOR SUICIDE IDEATION (BSS)

Directions: Please carefully read each group of statements below. Circle the one statement in each group that best describes how you have been feeling for the past week, including today. Be sure to read all of the statements in each group before making a choice.

Part 1

1. 0 I have a moderate (medium) to strong wish to live.
1 I have a weak wish to live.
2 I have no wish to live.

2. 0 I have no wish to die.
1 I have a weak wish to die.
2 I have a moderate (medium) to strong wish to die.

3. 0 My reason for living outweigh my reasons for dying.
1 My reasons for living or dying are about equal.
2 My reasons for dying outweigh my reasons for living.

4. 0 I have no desire to kill myself.
1 I have a weak desire to kill myself.
2 I have a moderate (medium) to strong desire to kill myself.

5. 0 I would try to save my life if I found myself in a life-threatening situation.
1 I would take a chance on life or death if I found myself in a life- threatening situation.
2 I would not take the steps necessary to avoid death if I found myself in a life-threatening situation.

Subtotal Part 1 _____

If you have circled the zero statements in both groups 4 and 5, then skip down to group 20. If you have marked a 1 or 2 in either group 4 or 5, then go to group 6.

Part 2

6. 0 I have brief periods of thinking about killing myself which pass quickly.
1 I have periods of thinking about killing myself which last for moderate (medium) amounts of time.
2 I have long periods of thinking about killing myself.

7. 0 I rarely or only occasionally think about killing myself.
1 I have frequent (often) thoughts about killing myself.
2 I continuously (all the time) think about killing myself.

8. 0 I do not accept the idea of killing myself.
1 I neither accept nor reject the idea of killing myself.
2 I accept the idea of killing myself.

9. 0 I can keep myself from
    committing suicide.
    1 I am unsure that I can keep
    myself from committing
    suicide.
    2 I cannot keep myself from
    committing suicide.

10. 0 I would not kill myself because
    of my family, friends, religion,
    possible injury from an
    unsuccessful attempt, ect.
    1 I am somewhat concerned
    about killing myself because of
    my family, friends, religion,
    possible
    injury from an unsuccessful
    attempt, etc.
    2 I am not or only a little
    concerned about killing myself
    because of my family, friends,
    religion, possible injury from
    an unsuccessful attempt, ect.

11. 0 My reasons for wanting to
    commit suicide are primarily
    aimed at influencing other
    people, such as getting even
    with people, making people
    happier, making people pay
    attention to me, ect.
    1 My reasons for wanting to
    commit suicide are not only
    aimed at influencing other
    people, but also represent
    (are) a way of solving my
    problems.
    2 My reasons for wanting to
    commit suicide are primarily
    based upon escaping from my
    problems.

12. 0 I have no specific plan to kill
    myself.
    1 I have considered ways of
    killing myself, but have not

worked out the details.
    2 I have a specific plan for
    killing myself.

13. 0 I do not have access to a
    method or an opportunity to
    kill myself.
    1 The method that I would use
    for committing suicide takes
    time, and I really do not have a
    good opportunity to use this
    method.
    2 I have access to or anticipate
    having access to the method
    that I would choose for killing
    myself and also have or shall
    have the opportunity to use
    it.

14. 0 I do not have the courage or the
    ability to commit suicide.
    1 I am unsure that I have the
    courage or the ability to
    commit suicide.
    2 I have the courage and the
    ability to commit suicide.

15. 0 I do not expect to make a
    suicide attempt.
    1 I am unsure that I shall make a
    suicide attempt.
    2 I am sure that I shall make a
    suicide attempt.

16. 0 I have made no preparations for
    committing suicide.
    1 I have made some preparations
    for committing suicide.
    2 I have almost finished or
    completed my preparations for
    committing suicide.

17. 0 I have not written a suicide
        note.
     1 I have thought about writing a
        suicide note or have started to
        write one, but have not
        completed it yet.
     2 I have completed a suicide
        note.

18. 0 I have made no arrangements
        for what will happen after I
        have committed suicide.
     1 I have thought about making
        some arrangements for what
        will happen after I have
        committed suicide.
     2 I have made definite
        arrangements for what will
        happen after I have committed
        suicide.

19. 0 I have not hidden my desire to
        kill myself from people.
     1 I have held back telling people
        about wanting to kill myself.
     2 I have attempted to hide,
        conceal, or lie about wanting to
        commit suicide.

20. 0 I have never attempted suicide.
     1 I have attempted suicide once.
     2 I have attempted suicide two or
        more times.

21. 0 My wish to die during the last
        suicide attempt was low.
     1 My wish to die during the last
        suicide attempt was moderate
        (medium).
     2 My wish to die during the last
        suicide attempt was high.

Subtotal Part 2 _____

Total Score _____

APPENDIX E: MULTIDIMENSIONAL MEASURE OF RELIGIOUS INVOLVEMENT (MMRI)

1. How often do you usually attend religious services?

| 1. Nearly Everyday- 4 or More Times a Week | 2. At Least Once a Week- 1 to 3 Times | 3. A Few Times a Month- 1 to 3 Times | 4. A Few Times a Year | 5. Never |

2. Are you an official member of a church or other place of worship?

   Yes(1)   No(0)

3. How many church clubs or organizations do you belong to or participate in?

   Number: _____   None

4. Besides regular service, how often do you take part in other activities at your place of worship?

| 1. Nearly Everyday- 4 or More Times a Week | 2. At Least Once a Week- 1 to 3 Times | 3. A Few Times a Month- 1 to 3 Times | 4. A Few Times a Year | 5. Never |

5. Do you hold any positions or offices in your church or place of worship?

   Yes(1)   No(0)

6. How often do you read religious books or other religious materials?

| 1. Nearly Everyday- 4 or More Times a Week | 2. At Least Once a Week- 1 to 3 Times | 3. A Few Times a Month- 1 to 3 Times | 4. A Few Times a Year | 5. Never |

7. How often do you watch or listen to religious programs on TV or radio?

| 1. Nearly Everyday- 4 or More Times a Week | 2. At Least Once a Week- 1 to 3 Times | 3. A Few Times a Month- 1 to 3 Times | 4. A Few Times a Year | 5. Never |

8. How often do you pray?

| 1. Nearly Everyday- 4 or More Times a Week | 2. At Least Once a Week- 1 to 3 Times | 3. A Few Times a Month- 1 to 3 Times | 4. A Few Times a Year | 5. Never |

9. How often do you ask someone to pray for you?

| 1. Nearly Everyday- 4 or More Times a Week | 2. At Least Once a Week- 1 to 3 Times | 3. A Few Times a Month- 1 to 3 Times | 4. A Few Times a Year | 5. Never |

10. How religious would you say you are?

| 1. Very Religious | 2. Fairly Religious | 3. Not Too Religious | 4. Not Religious At All |

11. How important was religion in your home when you were growing up?

| 1. Very Important | 2. Fairly Important | 3. Not Too Important | 4. Not Important At All |

12. How important is it for Black parents to send or take their children to religious services?

| 1. Very Important | 2. Fairly Important | 3. Not Too Important | 4. Not Important At All |

APPENDIX F: SPIRITUAL WELL-BEING SCALE (SWBS)

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

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

1 2 3 4 5 6   1. I don't find much satisfaction in private prayer with God. (I don't find comfort in prayer alone with God.)

1 2 3 4 5 6   2. I don't know who I am, where I came from, or, where I am going. (I don't know where I belong in this world)

1 2 3 4 5 6   3. I believe that God loves me and cares about me.

1 2 3 4 5 6   4. I feel that life is a positive experience. (I believe that life is a good thing.)

1 2 3 4 5 6   5. I believe that God is impersonal and not interested in my daily situations.(I believe that God is distant and could care less about what happens to me.)

1 2 3 4 5 6   6. I feel unsettled about my future. (I feel unsure about my future.)

1 2 3 4 5 6   7. I have a personally meaningful relationship with God.(I have a close relationship with God.)

1 2 3 4 5 6   8. I feel very fulfilled and satisfied with life. (I feel good about what I have done with my life.)

1 2 3 4 5 6   9. I don't get much personal strength and support from my God. (I don't feel like God is there for me when I really need it.)

1 2 3 4 5 6   10. I feel a sense of well being about the direction my life is headed in. (I feel good about the direction my life is headed in.)

1 2 3 4 5 6   11. I believe that God is concerned (cares) about my problems.

1 2 3 4 5 6   12. I don't enjoy much about my life.

1 2 3 4 5 6   13. I don't have a personally satisfying relationship with God. (I am not happy with my relationship with God.)

1 2 3 4 5 6   14. I feel good about my future.

1 2 3 4 5 6   15. My relationship with God helps me not to feel lonely.

1 2 3 4 5 6   16. I feel that life is full of conflict (problems) and unhappiness.

1 2 3 4 5 6   17. I feel most fulfilled when I am in close communication with God. (I feel full of happiness when I talk to God.)

1 2 3 4 5 6   18. Life doesn't have much meaning.

1 2 3 4 5 6   19. My relationship with God contributes to my sense of well being. (My relationship with God helps me feel at peace.)

1 2 3 4 5 6   20. I believe there is some real purpose for my life.

APPENDIX G: LETTER OF CONSENT

EMORY
UNIVERSITY
SCHOOL OF
MEDICINE

Department of Psychiatry and Behavioral Sciences

Nadine J. Kaslow, Ph.D., ABPP
Professor and Chief Psychologist

October 27, 2008

To Whom It May Concern:

I am writing this letter to certify that Miesha Rhodes has my permission to use data obtained from the Grady Nia Project study entitled "Group Intervention for Suicidal Black Females" funded by the Centers for Disease Control and Prevention. I understand that Miesha will use a portion of this data to complete her master's thesis, and will ensure that the writing of this thesis does not conflict with topics selected by others students using this same data. If I can provide additional information, please contact me at (404)616-4757 or nkaslow@emory.edu

Sincerely,

Nadine J. Kaslow, Ph.D., ABPP
Professor and Chief Psychologist

CLARK ATLANTA UNIVERSITY
Institutional Review Board
Office of Sponsored Programs

November 6, 2008

Miesha N. Rhodes <mnrhode@yahoo.com>
School of Social Works
Clark Atlanta University
Atlanta, GA 30314

RE: Religiousity and Spirituality as Coping Strategies Among Suicidal African American Women.

Principal Investigator(s): Miesha N. Rhodes

Human Subjects Code Number: HR2008-11-283-1

Dear Ms. Rhodes:

The Human Subjects Committee of the Institutional Review Board (IRB) has reviewed your study protocol as an expedited (45 CFR 46.116(c) review and approved of it in accordance with 45 CFR 46.101b.5.

Your Protocol Approval Code is HR2008-11-283-1/A

Please note the new approval code for your study. This permit will therefore expire on November 5, 2009. Thereafter, continued approval is contingent upon the annual submission of a renewal form to this office. Any reaction or problems resulting from this investigation should be reported immediately to the IRB, the Department Chairperson and any sponsoring agency. If you have any questions, please contact Dr. Georgianna Bolden at the Office of Sponsored Programs (404) 880-6979 or Dr. Paul I. Musey, (404) 880-6829.

Sincerely:

Paul I. Musey, Ph.D.
Chair
IRB: Human Subjects Committee

cc.   "Dr. Mary Curtis Ashong" <mashong@cau.edu>
        Office of Sponsored Programs, "Dr. Georgianna Bolden" <gbolden@cau.edu>

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