

## ABSTRACT

Title of Thesis: THE ROLE OF PARENTING SOCIAL SUPPORT, RELIGIOUS COPING, AND RELIGIOUS PRACTICES IN MODERATING EFFECTS OF FINANCIAL POVERTY ON SYMPTOMS OF DEPRESSION AMONG RURAL, LOW-INCOME MOTHERS

Degree Candidate: Jamie Rose Marghi  
Degree and year: Master of Science, 2004  
Thesis Directed By: Associate Professor Bonnie Braun  
Department of Family Studies

This study explored relationships between financial poverty, social support, religious coping, religious practices, and symptoms of depression among rural, low-income mothers. Given the higher incidence of depression in these impoverished mothers and the limited mental health services in rural areas, this study sought to identify factors that are protective against depression. While research suggests that social support, religious coping, and religious practices are protective against depression, there has been little research exploring these relationships among rural, low-income mothers.

Correlations, *t*-tests, and hierarchical multiple regressions were utilized. The findings did not support the hypotheses that social support, religious coping, and religious practices functioned as moderators. However, for all mothers the higher the perception of economic situation and income adequacy, parenting social support, and religious practices, the lower the symptoms of depression. Additionally, for minority mothers the higher the religious coping, the lower the symptoms of depression. Recommendations for future research and psychotherapy are discussed.

THE ROLE OF PARENTING SOCIAL SUPPORT, RELIGIOUS COPING, AND  
RELIGIOUS PRACTICES IN MODERATING EFFECTS OF FINANCIAL  
POVERTY ON SYMPTOMS OF DEPRESSION AMONG RURAL, LOW-  
INCOME MOTHERS

By

Jamie Rose Marghi

Thesis submitted to the Faculty of the Graduate School of the  
University of Maryland, College Park, in partial fulfillment  
of the requirements for the degree of  
Master of Science  
2004

Advisory Committee:  
Associate Professor Bonnie Braun, Chair  
Professor Norman Epstein  
Assistant Professor Jaslean La Taillade



## DEDICATION

In loving memory of my mother Sheila Craig Steen.  
1926-1960.

When I called, You answered me, You inspired me with courage.  
Psalm 138

## ACKNOWLEDGEMENTS

I would like to extend my appreciation to the members of my thesis committee. I would like to thank Dr. Bonnie Braun for her enthusiasm, creativity and spirit. Dr. Braun's caring for the mothers of "Rural Families Speak" is a testament to her integrity. I would like to thank Dr. Jaslean La Taillade for her emotional support and expertise in brainstorming and data analysis. I would like to thank Dr. Norman Epstein for his clear thinking and words of praise at the defense. I would also like to thank Dr. Laura Hoard for extending my understanding of data analysis.

I would like to thank my immediate and extended family who have supported me throughout the completion of my graduate training. I would like to honor my beloved husband Vahid Marghi and my children Adib Jesse Marghi and Erfan William James Marghi who deserve recognition for their sacrifice so that I could attend The University of Maryland. I would like to honor Jack and Jo Thornton and Jody and Jim Smith for having faith in me. I would like to honor Allahina Russel for her shining example and indomitable spirit. I would like to thank Rachel Cleveland for her pride in my accomplishments. I would like to thank Susan Conbere for sharing her knowledge of Microsoft Word. I would also like to thank the following people who have walked with me on my journey: Mrs. Khadem, Marie Proctor, Vera Fusco, Primrose, Gerry, and Jimmy Gerrard, Julia Measures, Gretchen Ndousse-Fetter, Cynthia Baube, Carol Lotfi, and Joseph Russel.

I would like to express my gratitude to the Department of Family Studies faculty, especially the clinical faculty of The Marriage and Family Therapy program for their high standards and commitment to therapy. I am sincerely humbled and thankful to have

received the Jennifer Becker Carswell award. Being acknowledged for my dedication and excellence by faculty that are dedicated and excellent is a privilege. I want to thank my fellow students in the Marriage and Family Therapy program who have enriched my graduate experience. I would like to thank Gillian Mitchell and Flori Willard for enriching my experience of co-therapy. I would like to thank Ashley Larson, Ginger Newman, Sara Phillips, and Mike Gialanella for their excellent support with my thesis. I would like to thank Kim Hurley for teaching ‘The Virtues Project’ Parenting Class with me. I would like to thank Alicia Dacey for her acceptance of a returning student. I enjoyed our assistantship together. I would like to thank Linda Peterson for her gentle manner. I would like to thank Jonnel Hector and Jokena Smith for their final practicum presentations. I learned a lot. I would like to thank Sarah Kursch for being my “Super Junior”. Last but certainly not least I would like to thank Sherry Starr for her words of wisdom.

Finally, this research would not have been possible without the funding provided for the NC-223 multi-state research project by the United States Department of Agriculture (NRICGP2000-01759), the American Association of Family and Consumer Sciences, the USDA-Maryland Department of Human Resource Food Stamp Nutrition Education Program and the University of Maryland.

## TABLE OF CONTENTS

List of Tables.....	vii
List of Figures.....	ix
Chapter I: Introduction.....	1
Chapter II: Review of Literature.....	6
Financial Poverty.....	6
Social Support.....	11
Religious Coping.....	13
Religious Practices.....	16
Depression.....	17
Financial Poverty in the Rural Family Speaks Sample .....	19
Social Support in the Rural Family Speaks Sample.....	19
Religious Coping and Practices in the Rural Family Speaks Sample .....	21
Symptoms of Depression in the Rural Family Speaks Sample .....	22
Theoretical Model.....	22
Purpose of the Study.....	28
Hypotheses.....	30
Chapter III: Methodology.....	31
Sample.....	31
Data Collection.....	32
Procedures.....	33
Independent Variable: Financial Poverty.....	34
Actual Poverty.....	34
Perceived Poverty.....	36
Moderating Variable: Parenting Social Support.....	36
Moderating Variable: Religious Coping.....	37
Moderating Variable: Religious Practices.....	38
Dependent Variable: Maternal Depression.....	39
Control Variables: Maternal Age and Maternal Race.....	40
Definition of Terms.....	42
Data Analysis.....	44
Moderator Model.....	44
Chapter IV:	
Results.....	46
Demographic Characteristics.....	46
Poverty.....	47
Parenting Social Support.....	48
Religious Coping.....	48
Religious Practices.....	48
Symptoms of Depression.....	49

Hypotheses Findings.....	51
Chapter V: Discussion.....	70
Characteristics of Rural Mothers.....	70
The Relationship between Poverty and Depression.....	73
The Relationship between Social Support, Religious Coping, Religious Practices and Symptoms of Depression.....	76
The Moderation of Parenting Social Support, Religious Coping and Religious Practices on Symptoms of Depression.....	78
Ecological Framework.....	79
Limitations.....	80
Recommendations.....	83
For Future Research.....	83
For Mental Health & Social Services Professionals, and Clergy.....	86
Conclusion.....	87
Appendix A: Income and Making Ends Meet.....	89
Appendix B: Social Support Measure.....	90
Appendix C: Role of Religious or Spiritual Beliefs.....	91
Appendix D: Depressive Measure.....	93
References.....	96



## LIST OF TABLES

1. Definitions of the Variables and Measures Used.....	43
2. Characteristics of the Sample.....	50
3. Measures.....	51
4. Bivariate Relationships between Variables for Hypothesis One.....	51
5. Bivariate Relationships between Variables for Hypothesis Two.....	52
6. Bivariate Relationships between Variables for Hypothesis Five.....	55
7. Hierarchical Multiple Regression Analysis of the Interaction of Actual Poverty and Parenting Social Support for Moderating Symptoms of Depression .....	56
8. Bivariate Correlations on Variables in Regression: Actual Poverty and Parenting Social Support.....	56
9. Hierarchical Multiple Regression Analysis of the Interaction of Economic Situation Change and Parenting Social Support for Moderating Symptoms of Depression.....	57
10. Bivariate Correlations on Variables in Regression: Economic Situation Change and Parenting Social Support .....	57
11. Hierarchical Multiple Regression Analysis of the Interaction of Income Adequacy and Parenting Support for Moderating Symptoms of Depression.....	59
12. Bivariate Correlations on Variables in Regression: Income Adequacy and Parenting Social Support.....	59
13. Hierarchical Multiple Regression Analysis of the Interaction of Actual Poverty and Religious Coping for Moderating Symptoms of Depression.....	60
14. Bivariate Correlations on Variables in Regression: Actual Poverty and Religious Coping.....	61
15. Hierarchical Multiple Regression Analysis of the Interaction of Economic Situation Change and Religious Coping for Moderating Symptoms of Depression.....	62
16. Bivariate Correlations on Variables in Regression: Economic Situation Change and Religious Coping .....	62
17. Hierarchical Multiple Regression Analysis of the Interaction of Income Adequacy	

and Religious Coping for Moderating Symptoms of Depression.....	63
18. Bivariate Correlations on Variables in Regression: Income Adequacy and Religious Coping.....	64
19. Hierarchical Multiple Regression Analysis of the Interaction of Actual Poverty and Religious Practices for Moderating Symptoms of Depression.....	65
20. Bivariate Correlations on Variables in Regression: Actual Poverty and Religious Practices.....	65
21. Hierarchical Multiple Regression Analysis of the Interaction of Economic Situation Change and Religious Practices for Moderating Symptoms of Depression.....	66
22. Bivariate Correlations on Variables in Regression: Economic Situation Change and Religious Practices.....	66
23. Hierarchical Multiple Regression Analysis of the Interaction of Income Adequacy and Religious Practices for Moderating Symptoms of Depression.....	68
24. Bivariate Correlations on Variables in Regression: Income Adequacy and Religious Practices.....	68

## LIST OF FIGURES

1. Study Variables as Conceptualized in Ecological Theory.....	27
2. Model for Analysis.....	29
3. Moderator Model.....	45

## CHAPTER I: Introduction

According to the United States Census Data (2000), thirty-four million Americans live in financial poverty, nearly a fourth of Black and Hispanic women live in financial poverty, and over a third of women who head their own households are poor (U.S. Census Bureau, 2003). Financial poverty, and especially persistent long-term financial poverty, is much more common for rural families than for urban families (U.S. Department of Health and Human Services, 2002). Decades of research show that poverty is a risk factor affecting mental health and well-being (Belle, 1990). When compared to individuals in higher income brackets, individuals in poverty experience mental health problems more often and with greater severity (Neugebauer, Dohrenwend, & Dohrenwend, 1980; Simmons-Wescott & Braun, 2004). Researchers interested in women's mental health have paid particular attention to symptoms of depression due to their prevalence among women (Belle, 1990).

Women are at greater risk than men for poverty and depression, and low-income women with children are especially at risk for depression (Belle, 1990; Garrison, Marks, Lawrence, & Braun, in press; Lennon, Blome & English, 2001; Mazure, Keita, & Blehar, 2002). Maternal depression has been linked to numerous negative outcomes for both mothers and their children. There is a relationship between maternal depression and problems with unemployment, problems with job performance, dependence on public assistance, lack of positive communication among family members, and poor outcomes for children including academic problems, behavior problems, physical, and mental health problems (Ahluwalia, McGroder, Zaslow, & Hair, 2001; Albright & Tamis-LeMonda, 2002; Garrison et al., in press; Kohler, Anderson, Oravec, & Braun, 2003;

Lennon, et al., 2001, Jacob & Johnson, 1997; Petterson & Albers, 2001; Simmons-Wescott & Braun, 2004). Rank (2000) notes that stresses associated with economic hardship contribute to the higher rates of domestic violence and child abuse in some poor families.

The significance of poverty adversely affecting mental health is of special significance in rural communities. Rural low-income mothers and children have limited social service resources with which to combat their health problems, specifically limited mental health services, and may have beliefs about mental health that inhibit seeking assistance. Limitations of mental health services in rural areas include: (a) a shortage of qualified and available mental health providers, (b) the long distances rural residents must travel for services, (c) the high cost of treatment, (d) few outpatient mental health services, (e) few or no inpatient mental health facilities, and (f) possible treatment of mental health problems by primary care physicians although some studies suggest that even primary care physicians do not provide mental health services (Chandler & Campbell, 2002; Garrison et al., in press; Mulder, Kendel, & Shellenberger, 1999; Simmons-Wescott & Braun, 2004; U.S. Department of Health and Human Services, 2002). Due to social norms and beliefs that equate having a mental health problem with shame and stigma, some rural residents further limit their resources by not consulting with a primary care physician (Chandler & Campbell, 2002; Simmons-Wescott & Braun, 2004).

However, social support has been shown to moderate the effects of financial poverty on mental health. Social support can insulate mothers against negative effects of stressors that threaten optimal parenting and family functioning; enhance family well-

being; alleviate family stress; promote successful family adaptation; and nurture positive parental attitudes (Dunst, Trivette, Hamby, & Pollack, 1990; Hanline & Daley, 1992). Members of the mother's support system may be especially likely to help her cope with feelings of low-self esteem, loneliness and heavy parenting responsibilities (McLoyd, 1990; McLoyd, 1998). A mother's support system may include partners, relatives, friends, co-workers, and professionals such as therapists, social workers, physicians, teachers, and day care providers (McLoyd, 1990; McLoyd, 1998). Research has shown that for rural, low-income mothers, social support is an important resource in providing instrumental and emotional support for mothers in their parental role (Islam, 2004; Kohler et al., 2003; Simmons-Westcott, 2004; Walker & Reschke, 2003). The domain of social support that was studied was parenting social support.

Additionally, religion has been shown to moderate the effects of chronic stress from poverty on mental health. The religious community, or family-neighborhood-church complex, is central to the traditional way of life for rural families, and when compared to their urban counterparts, research has shown that rural women utilize religion as a protective factor and resource to cope with life and increase life satisfaction (Braun & Marghi, 2003; Chandler & Campbell, 2002; Fischer, 1982). Despite the challenges of poverty, many rural, low-income women "bounce back" or "bounce forward" to reach or surpass a pre-crisis level of functioning with stories of personal and relational transformation and growth from adversity (Boss, 2001; Chandler & Campbell, 2002; Vandergriff-Avery, 2001; Walsh, 2003). Vandergriff-Avery (2001) highlighted that in addition to stories of adversity and challenge, rural, low-income mothers also spoke of stories of accomplishment, optimism, and coping.

Given the need for coping with rural poverty and the associated increase in symptoms of depression in mothers associated with poverty, the need to combat the limited available mental health resources, and the salience of social support and religion as resources for some rural, low-income mothers, this study sought to extend prior studies in order to inform members of the helping professions about the relationship of social support and religion to poverty and symptoms of depression as possible resources in an arsenal of reliable strategies and methods needed to meet the needs of rural, low-income mothers. The domains of religion that were studied were religious coping and religious practices. The study is timely because of its relevance to current federal policy supporting religious groups that offer community service and encouraging secular and religious organizations to work together for the sake of their mutual communities (Bush, 2002). Given that social services in rural communities are limited, it is especially important that religious and secular organizations pool their resources to help rural communities.

One challenge to a collaboration between the faith-based and mental health professionals is common differences in their ideological orientations (Chandler & Campbell, 2002; Odell, 2003). This difference in worldviews may make it difficult for some secular therapists to discuss religion in the therapy hour while religious professionals are used to discussing religion in their counseling. While comfortable with discussing the resource of social support, many therapists are not informed of the positive effects of religion nor are they used to discussing religion as a resource with their clients, although this is changing (Aponte, 2003; Becvar, 2003; Carlson, Kirkpatrick, Hecker, & Killmer, 2002; Ferner, 2003; Hoogestraat & Trammel, 2003; Odell, 2003). Strongly

religious clients need to have their religious worldview accepted before they will open themselves up and be vulnerable with a therapist (McWilliams, 2001).

An additional purpose of this study was to inform therapists of the current research about the positive effects of religion so that for those clients for whom religion is salient, the incorporation of religion into the therapy hour can be an additional tool for helping rural, low-income mothers cope with mental health challenges (Odell, 2003). Finally, it was hoped that this study would inform clergy and religious workers how rural, low-income women use social support and religion as a resource.

In summary, the focus of this study was to explore how parenting social support, religious coping, and religious practices may moderate the effects of poverty on depression among a sample of rural, low-income mothers.



## CHAPTER II: Literature Review

The following sections review the literature on the key study variables of financial poverty, parenting social support, religious coping, religious practices and symptoms of depression. Ecological theory was used as the framework for the study. Additionally, resilience theory was used to incorporate the concepts of risk and protective factors.

### *Financial Poverty*

Financial poverty is defined as being poor and having inadequate resources for reasonably comfortable living (Webster, 2001). The official U.S. government definition of poverty is the poverty line, which is based on a total family income less than the threshold appropriate for that family, based on a minimal standard of living (U.S. Census Bureau, 2003). Increasing numbers of Americans are living below the poverty line due to the deleterious consequences of the structure of society with an increase in single-parent families headed by women affected by the unequal pay structure of sexism; inadequate jobs or the creation of new jobs primarily in the poorly paid service sector; inadequacy of child support payments following divorce; limited decent affordable child care; limited access to unemployment compensation; erosion of economic assistance to low-income families; and the social problems of homelessness and racism (Belle, 1990; Seccombe, 2002). The unequal pay structure of sexism increases a mother's risk of living at, or below the poverty line due to lower earning power. When comparing men and women's earnings, by looking at men and women who work full-time for at least 50 weeks in a given year, women earn only 77 cents for every dollar men earn (Institute for Women's Policy Research, 2004). However, when comparing men and women's total lifetime

earnings, as measured by the average annual earnings of men and women in their prime work years (age 26 to 59 years), women earn only 38 cents for every dollar men earn (Institute for Women's Policy Research, 2004).

Financial poverty is especially prominent among minority mothers. The risk of financial poverty in Black-female headed households is 10 times that of White male-headed households while the risk of poverty for Puerto Rican female-headed households is almost 15 times that found among White male-headed households (Belle, 1990). Most people become poor during some period of their lives and the duration of poverty lasts one to two years (Rank & Hirschl, 1999a; Rank & Hirschl, 1999b; Rank, 2000; Rank, 2001); however, Blacks and female-headed households are at risk for persistent poverty lasting years (Belle, 1990; Seccombe, 2002).

In addition to the periodic or chronic stress of financial poverty, rural, low-income mothers and their families face many other adverse challenges including low levels of educational attainment and vocational training, unemployment, and limited access to adequate housing, health care and social services (Christenson & Flora, 1991). Additionally, in rural communities, well-paying jobs are limited because many rural areas are reliant on low-wage, service sector jobs. Thus, even when rural families have working adults, and the "rural poor are more likely to be consistently employed than their urban counterparts" (Dolan, Seiling, Braun, & Katras, 2002, p. F5); they often have inadequate incomes for meeting their needs. For rural, low-income mothers, "Being poor is hard work...making ends meet becomes a complicated system based on earned income; governmental subsidies such as Medicaid, school lunch and breakfast programs, fuel assistance; personal shopping strategies; and reliance on friends and family to fill in the

gaps” (Katrass, Dolan, Braun & Seiling, 2002. p. F5). In addition to the hard work associated with being poor, rural, low-income mothers experience the normative and non-normative challenges that their urban and suburban counterparts struggle with such as marital stress, ongoing physical and/or psychological problems, domestic abuse, crime, delinquency, and drug abuse (Bokemeier & Garkovich, 1991).

As stated in the introduction, research has shown that different variables moderate the effect of poverty on mental health (Belle, 1990). Hall, Williams, & Greenberg (1985) studied low-income mothers (73% Black and 27% White), who received healthcare from the North Carolina Community Hospital, Greensboro, North Carolina, and found that marital status and employment status moderated the effect of poverty on mental health. Among unmarried, low-income mothers, unemployment, housing problems and inadequate income were the stress factors highly correlated with symptoms of depression whereas for married low-income women stress factors highly correlated with symptoms of depression were role overload and marital difficulties. Hall et al. (1985) found that unemployed mothers with small social networks were more likely to have high depressive symptom levels while unemployed mothers with large social networks were less likely to have high depressive symptom levels.

Financial poverty can prevent men and women from carrying out their gender-based role obligations to the family and may cause gender differences in response to financial stress (Belle, 1990; Conger, Lorenz, Elder, Simons, & Ge, 1993), although the research on gender differences is equivocal. Some research states that the relationship between inadequate income and depression is increased for men since their primary role to the family is economic. However, single mothers shoulder primary economic

responsibility for their families and may be expected to suffer increased depression for failure to fulfill their economic responsibilities (Conger et al., 1993; Ross & Huber, 1985). Mills, Grasmick, Morgan and Wenk (1992) found that economic strain, or the individual's perception of financial inadequacy, as well as financial concerns and worries was the same for men and women. Wolf (1987) also found that failure to fulfill role expectations exacerbated the descent from poverty into depression in a sample of low-income women; that the negative social name "bad provider" and breaches of conscience because of poverty "I am a thief" made up specific experiences that precipitated their depressions; and that single parent status, or an incapacitated husband, made wage-earning a critical component of successful role performance as a mother.

To fully understand the difficult task of raising children under conditions of poverty, Olson and Banyard (1993) studied white, single, low-income mothers raising young children in small rural Northeastern communities and in a midsize Midwestern college community. Their review of the literature revealed that single, low-income mothers of young children experienced higher rates of life stress than their married counterparts; found financial stress to be the most significant source of emotional stress (Makosky 1982; Richards, 1989); are at heightened risk for anxiety, depression and health problems; and are especially vulnerable to feelings of hopelessness and despair due to the chronic strains of poverty, which, when combined with the task overload associated with single parenting, increased their vulnerabilities to new life stresses (Olson and Banyard, 1993). Mothers in their sample experienced the following stressors via self-report in a daily diary (Olson & Banyard, 1993, p. 51): "stressful interactions with their children (56%); stressful encounters with other adults (21%); financial stressors (8%); household

stressors (5%); work stressors (4%); negative affective states such as depression and anxiety (4%); personal illness (1%); and ecological stressors (1%)”. The most common examples of financial stressors were of not having enough money to buy food, pay bills, and buy supplies for the family.

Olson and Banyard (1993) found that financial stressors were so pervasive in the lives of these single low-income mothers that the mothers only reported them when they were of crisis proportions. For example, eviction notices, threats to shut off heat in the dead of winter, or having little or no food were considered to be crises. Their findings that financial stressors comprised only 8% of the mother’s stressors contradicted their literature review findings that financial stressors are the most emotionally distressing life conditions experienced by low-income mothers. However, in line with prior research, the majority of mothers used self-reliant, active coping behaviors to deal with their financial stressors (Dill & Feld, 1982; McAdoo, 1986; Richards, 1989; Stack, 1974). Olson and Banyard (1993) found that financial “microcrises” increased feelings of hopelessness and despair for some mothers which accounted for their variability in coping. Mothers without financial “microcrises” were more able to cope with their life stressors.

In summary, research shows that poverty affects mental health, especially among rural, low-income and minority mothers with children. Equivocal research exists regarding whether gender makes a difference when men and women are unable to fulfill their economic responsibility to their families. Financial stressors are so pervasive in the lives of single low-income mothers that they only report them when they are of crisis proportions, and mothers without financial crises are better able to cope. Among unmarried, low-income mothers, unemployment, housing problems, and inadequate

income were the risk factors highly associated with symptoms of depression, whereas for married low-income women the risk factors associated with symptoms of depression were role overload and marital difficulties. Being poor is hard work.

### *Social Support*

One variable that moderates maternal depression due to poverty is social support (Kohler et al., 2003; Simmons-Westcott, 2004; Stack, 1974). Sanderson (2004) defines social support as the presence or amount of social relationships; the perception of available assistance; and the receipt of assistance. Social support is believed to increase an individual's sense of well-being, facilitate positive coping, and strengthen family functioning (Belsky, 1984; Letiecq, Anderson, & Koblinsky, 1998; McLoyd, 1990; Tyler, 2004). Barerra (1986) stated that an individual's perception of being reliably connected to others in their social network is of particular importance. Research with men and women found perceived social support to be related to less depression, better parenting practices, and enhanced child well-being (Reinherz, Giaconia, Hauf, Wasserman & Silverman, 1999).

Among African American mothers extended kinship relationships provide strength and social support (Boyd-Franklin, 2003). Many African American families function as extended families in which relatives with differing blood ties are incorporated into a structure of mutual emotional and economic support (Boyd-Franklin, 2003). One of the most important survival mechanisms of the Black community is reciprocity within African American extended kinship relationships (Boyd-Franklin, 2003; Stack, 1974). Reciprocity is "the process of helping each other and exchanging and sharing support as well as goods and services" (Boyd-Franklin, 2003, p. 53).

However, research findings indicate that receiving social support is not without cost, and for poor women, in particular, social networks may be a two-edged sword (Belle, 1982). Receiving social support may be associated with worries and upsets because low-income women often lack the ability to choose if, and with whom, they will interact. Most members of their social support network experience lives equally as stressful, with problematic social interactions that negatively impact psychological well-being (Todd & Worell, 2000). As stated, among their sample of low-income women, Olson and Banyard (1993), found that interpersonal relationships with adults ranked second; followed by stressful interactions with friends and acquaintances; followed by stressful interactions with relatives. Examples of stressful interactions with friends and acquaintances included conflicts with boyfriends, crises in friends' lives, and having friends make difficult or time consuming demands (Olson & Banyard, 1993). Examples of stressful interactions with family included family crises such as death, illness and divorce, as well as conflicts with and impositions from family members, including conflict with ex-husbands over child support and visitation (Olson & Banyard, 1993). In a sample of poor, Black urban mothers, social support networks exacted high emotional costs (Stack, 1974). Milardo (1987) and Riley and Eckenrode (1986) report that low-income women with extensive social networks tend to give more support than they receive. Because truly supportive social relationships are protective of mental health in conditions of high stress, it is important to examine social networks among low-income women to determine what factors contribute to an effective network that is more supportive than stressful (Belle, 1990).

In summary, research on social support shows: Social relationships are protective of mental health in conditions of high stress such as poverty. However, low-income women may experience giving more support than they receive and may find social support fraught with worries and concerns. Problematic social interactions may negatively impact psychological well-being.

### *Religious Coping*

As stated earlier in this review of literature, the chronic stress of poverty negatively affects mental health. Yet all rural, low-income mothers are not depressed, and some spoke of stories of accomplishment, optimism, and coping (Vandergriff-Avery, 2001). A central concern of the present study was why some mothers are able to exhibit positive coping. Since religion is central to the heart of rural life and religion is more likely to be relied on, when experiencing difficult times, religion may be an answer for those who are economically disadvantaged compared to those who are well-to-do (Pargament, 1997). It is therefore essential to examine how rural, low-income mothers use their religion to cope in order to determine the effects of religion in decreasing the stress of poverty.

When living with chronic stress, people lose hope because it seems as if there is no end in sight to their problems (Krause, Liang, & Gu, 1998). Religion, as an important coping resource, can offset the deleterious effects of stress on health (Ellison, 1994; Krause, 1998; Pargament, 1997). Religious coping is defined as the use of religious beliefs or practices to reduce the emotional distress caused by loss or change (Koenig, 2002). For this study, religious coping is defined as religious beliefs or religious



cognitions that reduce anxiety, increase hope or a sense of control (Koenig, 2002). Pargament (1997) described how a variety of religious cognitions may help cope with stress which may decrease depressive symptoms. People using religion as a coping resource may experience life events to be less threatening and less stressful to the extent that they ascribe to the belief that their lives are controlled by a higher being; that stressful life events happen for a reason; or that life events are opportunities for spiritual growth (George, Larson, Koenig, & McCullough, 2000). Feeling the presence of God and believing that one is not alone during stressful times may have a helpful effect (Hackney and Sanders, 2003; Pargament, 1997; Wilder, 2002). Likewise, religious coping may assist in the development of a sense of self-worth not based on economic resources (Krause & Tran, 1989).

There are two patterns of religious coping which have implications for health (Pargament, Smith, Koenig, Perez, 1998). Positive religious coping is an expression of a sense of the sacred, a secure relationship with God, and a belief that there is meaning to be found in life and a sense of spiritual connectedness with others (Pargament et al., 1998). Pargament defines the positive religious coping behaviors:

Benevolent religious reappraisals: Redefining the stressor through religion as benevolent and potentially beneficial. Collaborative religious coping: Seeking control through a partnership with God in problem solving. Seeking spiritual support: Searching for comfort and reassurance through God's love and care. Spiritual connection: Seeking a sense of connectedness with transcendent forces. Religious purification: Searching for spiritual cleansing through religious actions. Seeking help from clergy or members: Searching for comfort and reassurance through the love and care of congregation members and clergy. Religious helping: Attempting to provide spiritual support and comfort to others. Religious forgiveness: Looking to religion for help in letting go of anger, hurt, and fear associated with an offense (Pargament et al., 1998, p. 711).

Negative religious coping is defined as “expressions of a less secure relationship with God, a tenuous and ominous view of the world, and a religious struggle in the search for significance” (Pargament et al., 1998, p. 712). The following are forms of negative religious coping:

Punitive religious reappraisals: Redefining the stressor as a punishment from God for the individual’s sins. Demonic religious reappraisals: Redefining the stressor as the act of the Devil. Reappraisals of God’s powers: Redefining God’s powers to influence the stressful situation. Spiritual discontent: Expressions of confusion and dissatisfaction with God. Self-directing religious coping: Seeking control through individual initiative rather than help from God. Interpersonal religious discontent: Expressions of confusion and dissatisfaction with clergy or members (Pargament et al., 1998, p. 711).

In the mental health arena, positive and negative coping patterns are associated with different outcomes (Pargament et al., 1998). According to Pargament et al. (1998), “the positive religious coping pattern was tied to benevolent outcomes, including fewer symptoms of psychological distress, reports of psychological and spiritual growth as a result of the stressor, and interviewer ratings of greater cooperativeness” (p. 721). The negative religious coping pattern was associated with signs of emotional distress, such as depression, poorer quality of life, psychological symptoms, and callousness towards others. In effect, religion can be a source of distress as well as a source of solutions in coping. For this study, positive religious coping was assessed by three indicators: Do mothers get strength and support from God during difficult times? Does prayer or talking to God help mothers cope with difficulties and stress? Is it important to see God’s guidance when making important decisions?

Empirical data indicate a beneficial relationship between religiosity and mental health that brings into question the statements by the early leaders of psychology

equating religion as pathological (Ellis, 1980; Freud, 1933/1961; Garrison et al., in press). In a meta-analysis of religiosity and mental health, Hackney and Sanders (2003), showed that there is a beneficial relationship between religiosity and mental health regardless of the definitions of religiosity (personal devotion-attachment to God, institutional religion-participation in church activities or ideological religion-focused on the beliefs in religious activity) or mental health (psychological distress-negative mental health, life satisfaction-positive mental health, or self-actualization-growth oriented aspects of mental health). Additionally, in their meta-analysis, Smith, McCullough, and Poll (2003) found that higher life stress was associated with stronger negative correlations of religiousness and symptoms of depression although all levels of inferred life stress were associated with negative correlations of religiousness and depressive symptoms.

This large and rapidly growing body of research about the benefits of religion to mental health, going back as far as the 1880s, (Koenig, McCullough, & Larson, 2001), indicates that certain aspects of religious practices may be inversely related to symptoms of depression with greater positive religious practices associated with fewer symptoms of depression (Braam, van den Eeden, Prince, Beekman, Kivela, & Lawlor, 2001; Koenig, George, & Peterson, 1998; Koenig et al., 2001; Hackney & Sanders, 2003; Seybold & Hill, 2001).

### *Religious Practices*

As stated, religious coping includes the use of religious practices which reduce the emotional distress caused by loss or change (Koenig, 2002). For this study, religious

practices are defined as the external or behavioral expressions of religious beliefs (Koenig, 2002, Marler & Hadaway, 2003). Research focusing on the inter-personal level, acknowledges that religious practices, such as attendance at services, with a focus on the social and behavioral aspects of religion, can assist in dealing with stressors (Hackney & Sanders, 2003; Wilder, 2002). Social support affiliated with religious groups has been found to be negatively associated with symptoms of depression (Koenig et al., 2001, George et al., 2000; Smith et al., 2003). Putnam (2000) found that people actively practicing religion had more informal social contacts and were more active in civic engagements than people who were not actively involved in religion.

In the present study, the religious practices that were studied were: mothers attendance at religious services, mothers attendance at religious activities other than services, for example, adult Sunday school classes, Bible study groups, or prayer groups, and the participation of the mother's children in church services and church activities. Religious coping and religious practices, then, are used to regulate emotion during times of illness, change, and circumstances that are out of the person's control.

### *Depression*

In the United States, depression is one of the most common of all mental health disorders, affecting 10 to 25 percent of adults annually (United States Department of Health and Human Services, 2000). The ratio of depression in women, when compared to men, is two to one with depression being the leading cause of disability in women (Harvard Medical School, 2004). Women have higher rates of depression than men because women are more likely to acknowledge symptoms of depression and seek

treatment, while typically men deny symptoms, become irritable, and angry, and drink heavily (Harvard Medical School, 2004).

Stress is a trigger for depression acknowledged more by women than men, with research studies showing that women are three times more likely than men to experience a stressful event, and be disproportionately subjected to certain types of severe traumatic stress, especially child sexual abuse, adult sexual assaults and domestic violence. As caregivers who subordinate their needs to care for others, with too much to do in too little time, with too little control over how it is done, women are more likely than men to experience every day stress that leads to depression. Additionally, in an unhappy marriage, women are three times more likely to be depressed than their husbands. Women are more physically sensitive to their emotions than men and are more likely than men to complain of physical symptoms attributable to depression such as fatigue, appetite loss, insomnia and pain, in addition to the more traditional symptoms, such as, sadness, hopelessness, apathy, irritability and loss of concentration. Garrison et al., (in press) found, in reviewing the mental health literature (Ahluwalia et al., 2001; Belle, 1990; Bruce, Takeuchi, & Leaf, 1991; Coiro, 2001; Edin & Lein, 1997; Kessler, McGonagle, Zhao, & Nelson, 1994; Lennon et al., 2001; Mazure et al., 2002; McLoyd, 1998; Murray & Lopez, 1996; Robins & Regier, 1990; Shonkoff, & Phillips, 2000; Vandivere, Moore, & Zaslou, 2000), that U.S. poor women are even more at risk for depression, especially lower socioeconomic mothers with young children.

Mothers with major depression are less likely to work twenty or more hours per week and are more likely to be welfare dependent. However, researchers are unclear as to whether being depressed leads to these behaviors or if the stress of being on welfare and

only employed part-time, triggers depression (Danziger, Kalil, & Anderson, 2000; Jayakody, Danziger, & Pollack, 2000).

*Financial Poverty in the Rural Family Speaks Sample of Rural, Low-Income Mothers*

The effects of limited incomes on the well-being of rural families overtime is the central focus of a fourteen state longitudinal study known as NC-223 “Rural, low-income Families: Tracking their Well-Being and Functioning in the Context of Welfare Reform” known also as, "Rural Families Speak". Numerous analyses from that study are available. Kohler et al. (2003) sought to determine if marital or partnered status mediated the effects of poverty. They did not find evidence that married or partnered mothers fared better economically than their non-married or not partnered counterparts although other sources of social support helped to buffer the mothers against their economic and other life challenges (Kohler et al., 2003). The annual family incomes of mothers partnered with their children’s fathers was not different from the annual family incomes of mothers not partnered with their children’s fathers. Having a male partner in the home did not equate to family economic well-being. In fact, nearly two-thirds of the mothers struggled economically, with household incomes under 150% of the poverty line.

*Social Support in the Rural Family Speaks Sample of Rural, Low-Income Mothers*

Kohler et al. (2003) found that being partnered or non-partnered did not affect maternal levels of depression (a finding reinforced by Islam, 2004). Many mothers juggled relationships with multiple men, both current partners and former partners, with one-fourth of the mothers involved with more than one nonresidential father and with

one-third of the mothers involved with a partner or spouse other than their children's father. For 27% of the mothers, being partnered with a child's father may have exacerbated depression due to conflict over parenting in their relationships with the children's fathers. These researchers also found that mothers without symptoms of clinical depression experienced higher levels of family and community support than did mothers with symptoms of clinical depression. Similarly, Simmons-Westcott, and Braun (2004) found that for mothers without symptoms of depression, social support was higher.

Family support among these mothers included frequent high contact, close emotional relationships, and regular assistance. Many of the mothers reported that, of their family members, their own mothers were the most helpful in preventing them from going into economic and emotional distress (Kohler et al., 2003). Islam (2004) also found that the higher the perceived level of social support, the lower the depression scores and that, for mothers who maintained their marital status, along with maintenance of high levels of perceived support, their depression symptoms remained low.

Additional evidence of the role of social support was uncovered by another research team studying the mothers in the same multi-state study. Walker and Reschke (2003) found that social support helped rural, low-income mothers find childcare and that the "proximity of relatives was perhaps the most striking advantage for many rural mothers...a large network of extended family living nearby provided many social and economic supports, not the least of which was child care" (p. F6). In summary, for this sample of rural, low-income mothers, there are equivocal data regarding the benefits of

social support, with some experiencing positive and economic supports, and others experiencing more stress due to partner conflict.

*Religious Coping and Religious Practices in the Rural Family Speaks Sample of Low-Income Rural Mothers*

Vandergriff-Avery (2001), investigating resilience through protective and recovery factors among rural low-income families facing stress and crisis, provided evidence of the presence of spirituality and religiosity using qualitative data. Expanding her study, Braun and Marghi (2003) produced quantitative data, identifying faith, expressed as spiritual and religious practices, as a resiliency factor in the lives of rural, low-income mothers that positively impacted their life satisfaction, despite their context of poverty. Braun and Marghi (2003) also found that the majority of mothers identified themselves as religious or spiritual. Garrison et al. (in press) found that, for the rural, low-income mothers in the same study, those who exhibited less symptoms of depression held stronger religious beliefs than mothers with more depressive symptoms.

Garrison et al. (in press) found that for some of the rural, low-income mothers who had limited professional, marital, recreational, and civic-related secular social support, compared to mothers of higher socioeconomic status, the social support derived from religious practices in their faith community may be an important resource. Additionally, religious practices were more highly correlated with a reduction in symptoms of depression than other domains of religion.



*Symptoms of Depression in the Rural Family Speaks Sample of Rural, Low-Income Mothers*

Braun and Rudd (2002), investigating the symptoms of depression of mothers in the Rural Family Speaks study, found that approximately 50% of the mothers were at-risk for depression; a rate nearly two to five times that of the national average rate of 10 to 25 percent for symptoms of depression in the general population (USDHHS, 2000).

Simmons-Wescott and Braun (2004) found that those rural mothers with symptoms of depression were less likely to be working, earning lower wages if employed, feeling less confident in their parenting skills, experiencing more chronic health conditions, experiencing less satisfaction with social support and experiencing less overall life satisfaction. Additionally, Simmons-Wescott & Braun (2004) found that many of the mothers experiencing symptoms of depression did not know, or acknowledge, that they were depressed and that, although depressed mothers had lower levels of life satisfaction than non-depressed mothers, nearly 40% of depressed mothers reported being satisfied with their lives. Simmons-Wescott and Braun (2004) hypothesized that this last finding may reflect the negative views mothers have of mental health problems or that these mothers may cope by accepting their lives and finding life satisfaction similarly to the cognitive reappraisals associated with positive religious coping.

*Theoretical Model*

For this study, an ecological model was used to examine the influences of social support, religious coping, and religious practices on the relationship between poverty and maternal depression. Additionally, the ABC-X model from family stress theory and

resilience theory, or the ability to withstand and rebound from disruptive life challenges (Walsh, 2003), was discussed using the concepts of risk and protective factors.

An ecological model is a useful framework to understand how individuals and families can be influenced by the different environmental settings within which they function. Bronfenbrenner (1979) brought together ideas from ecological systems theory and field theory to form his book The Ecology of Human Development which sought to explain variations in child development (Klein & White, 1996; Meyers et al., 2002). Bronfenbrenner (1979) challenged the assumption that development can occur only within the individual and posited that development is always a relationship between the individual and his or her immediate environment. The individual grows and adapts through interchanges with its immediate ecosystem, the family, and more distant environments such as school. Individual behavior is considered within a nexus of interconnected and nested social systems including the individual or microsystem level, family, genetics, hospital, day care, school, peer group and neighborhood or mesosystem level, community or exosystem level, and the overarching economic, political, cultural, and social forces that influence individuals or macrosystem level (Bronfenbrenner, 1986; Meyers et. al., 2002).

The microsystem involves individual roles, characteristics and relations. The mesosystem involves the settings in which one interacts and the interrelations between two or more settings. The exosystem involves settings in which one does not directly interact but still affect the individual. The macrosystem involves the cultural values and variables that affect all individuals. The chronosystem incorporates time or the events and experiences of an individual throughout the life course, the developmental history of the

individual (Bronfenbrenner, 1989). The basic principle in the ecological model is the “connectedness and embeddedness of various ecological levels and the continual need for adaptation to the constant currents of change” (Klein & White, 1996, p. 226). In essence, an individual’s behavior is a reflection of how he or she adapts to his or her environment across time.

According to Buboltz and Sontag (1993), and Harden and Koblinsky (1999), stress or risk factors in one level may impact the other four levels. Additionally, since the levels are systemically interrelated, protective factors, or buffers at one level, may likewise result in positive outcomes at one or more of the other levels.

Family stress theory uses Hill’s (1949) roller coaster model, which offered a beginning to understanding the pathways of resilience and risk and protective factors. A (the event and related hardships) interacts with B (the family’s crisis meeting resources) interacts with C (the definition the family makes of the event) which produces X (the crisis) (DeHaan, Hawley, & Deal, 2002; McCubbin, Cauble, Comeau, Patterson, & Needle, 1980). Risk factors (Hill’s A) increase the barriers to effective functioning for an individual either in childhood or throughout the life span. Examples of risk factors include parental divorce, poverty, physical illness and/or mental illness (Hawley, 2000). Protective factors (Hill’s B and C) are resources that help individuals buffer the effects of adversity (Hawley, 2000).

In general, resilience is most likely found when risk factors are minimized and protective factors are present (Hawley, 2000). Risk and protective factors change over time and are dependent on context (Hawley, 2000; Rutter, 1989). Cowan, Cowan and

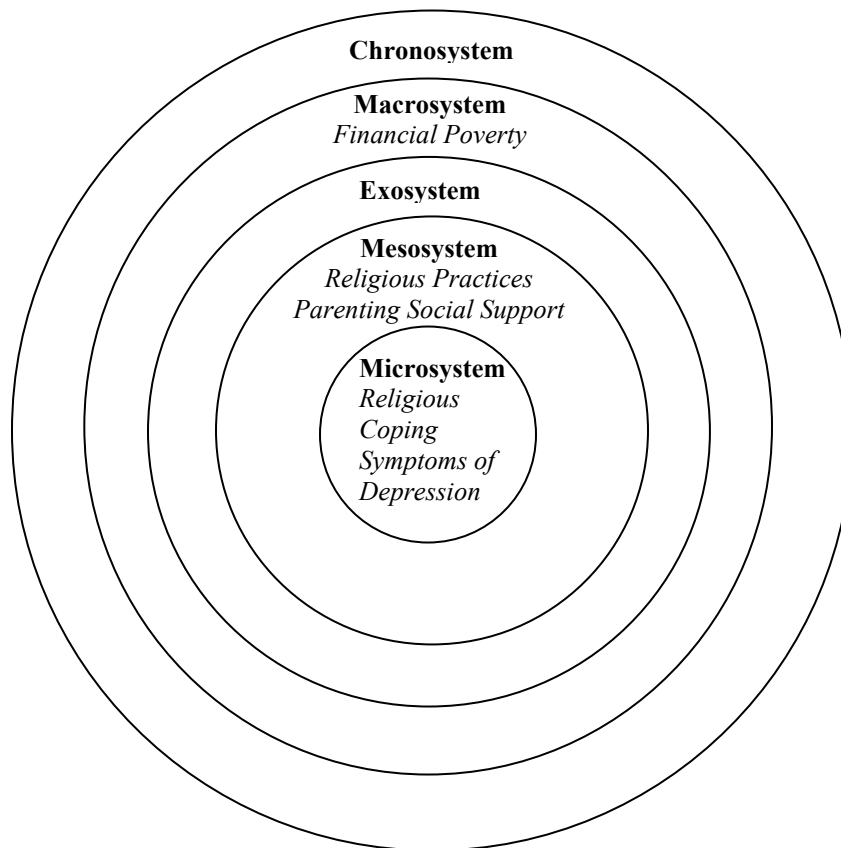
Schulz (1996) state that: (a) Protective factors can reduce the impact of risk; (b) Individuals in a risk category may not have experienced many of the stressful experiences that tend to be associated with the risk; or (c) Individuals may develop coping skills to counteract risk and respond to challenges in a way that cancels the negative impact of risk or even advances the individual to new levels of adaptation.

Ecological theory has guided empirical investigations of how maternal personal maturity, maternal depression, stressful life events, social support, family of origin difficulties, education, and income affect family functioning; family genetics; relationships between the family and the hospital, day care, peer group, school, work, parental employment, parental support networks, and the community (Bronfenbrenner, 1986; Meyers et al., 2002). It served as the theoretical framework for the NC-223 multi-state, longitudinal study of rural families entitled, “Rural, low-income Families: Tracking their Well-Being and Functioning in the Context of Welfare Reform.”

This study extended previous research based on ecological theory by examining the effect of religiosity on mental health in an understudied population of rural, low-income mothers. A strength of this theoretical framework is that it accounts for both individual and environmental influences in attempting to understand outcomes and enables the researcher to look at numerous variables at different levels of influence. For purposes of this study, the macrosystem of a mother’s experience of poverty and how she interacts with the mesosystems of social support, and religious practices to produce her microsystem experience of religious coping and symptoms of depression was investigated at one point in time. Additionally, the current study examined the risk and protective factors of resiliency theory in an ecological framework to determine if

parenting social support, religious coping, and religious practices intervene as moderators in the relationship between financial poverty and maternal depression. See Figure 1.

Figure 1: Study Variables as Conceptualized in Ecological Theory

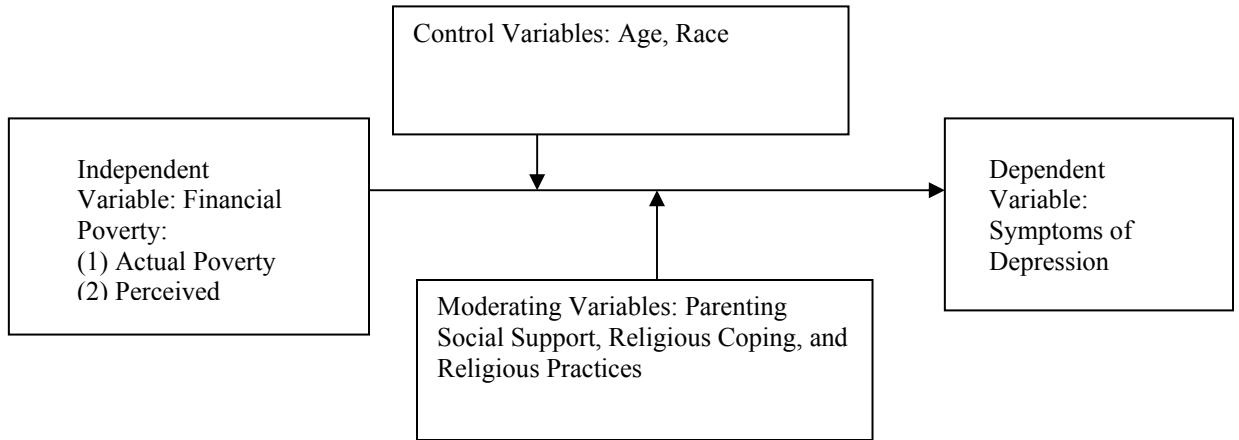


### *Purpose of the Study*

The purpose of this study was to investigate whether parenting social support, religious coping, and religious practices, moderate the relationship between poverty and maternal depression as a basis for informing the helping professions, informing secular and religious therapy and education, and coordinating efforts for services in rural, low-income populations. The study adds to the limited body of knowledge about these factors among rural, low-income mothers and to the research about how mothers use religion as a resource (Dollahite, Marks, Goodman, 2004).

According to Ebaugh (2002), Americans are a religious people with high participation in religious practices. A U.S. report found that 95% of all married couples and parents identify with a religious affiliation (Mahoney, Pargament, Tarakeshwar, & Swank, 2001), yet relatively little is known about religious coping and religious practices as protective factors in a rural population. This study adds to knowledge about the roles these domains of religion play in rural families in the 21st century (Boss, 2002; Braam et al., 2001; Garrison et al., in press; Koenig et al., 1998; Pargament et al., 1998). The current study extended the analysis done of mothers participating in the multi-state study, “Rural Families Speak”. None of the prior studies provided sufficient evidence to inform how to assist rural mothers experiencing poverty and symptoms of depression in achieving a sense of well-being. This study sought to answer the following general question, “Among rural, low-income mothers, do experiences with parenting social support, religious coping and religious practices moderate the effect of financial poverty on depression?” See Figure 2.

Figure 2: Model for Analysis





### *Hypotheses*

Based on theory and previous research, especially the studies that were conducted on the Rural Families Speak sample, the following hypotheses were made:

1. There will be a negative association between actual poverty, perceived poverty and symptoms of depression.
2. There will be a negative association between social support, religious coping, and religious practices and symptoms of depression.
3. Minority mothers will experience higher levels of actual and perceived poverty compared to their White counterparts.
4. Minority mothers will experience higher levels of social support, religious coping, and religious practices compared to their White counterparts.
5. There will be a positive association between age and actual and perceived poverty and symptoms of depression.
6. Parenting social support will moderate the effects of actual and perceived poverty on symptoms of depression.
7. Religious coping will moderate the effects of actual and perceived poverty on symptoms of depression.
8. Religious practices will moderate the effects of actual and perceived poverty on symptoms of depression.

## CHAPTER III: Methodology

### *Sample*

In 1998, a team of researchers from 15 land-grant universities were authorized by the United States Department of Agriculture (USDA)-affiliated Agricultural Experiment Stations to conduct a unique, multi-state, longitudinal study known as NC-223 “Rural, Low-income Families: Tracking their Well-Being and Functioning in the Context of Welfare Reform” known also as, "Rural Families Speak".<sup>1</sup> The study will continue through 2008. The goal of the study was to understand factors affecting the well-being of rural, low-income families. The research team sought to fill a void of knowledge regarding the lived experiences of these families and to use the findings to inform public policy and programs directed towards this population.

Beginning in 2000, data were collected from the mothers in 415 families living in 24 counties in 14 states using common instruments and open-ended questions. The 14 states represent diverse regions of the United States, including the West Coast, the Midwest, the Northeast and the South.<sup>2</sup> The NC-223 sample comprised mothers from counties designated as “rural” based on Butler and Beale’s (1994) rural-urban continuum codes. Using this system of classification, counties are classified by population and proximity to a major metropolitan area, with a classification of zero being the most urban and a classification of nine being the most rural. All of the counties sampled in this study were classified as a six or higher on the continuum.

For the multi-state study, families had to meet the following eligibility criteria:

---

<sup>1</sup> <http://www.ruralfamilies.umn.edu>.

<sup>2</sup> California, Indiana, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Nebraska, New Hampshire, New York, Ohio, Oregon, and Wyoming.

1. Mothers had to be at least 18 years of age.
2. At least one child under the age of 13 must be living with the mother.
3. Family eligible for, or receiving, food stamps or the Supplemental Nutrition Program for Women, Infants, and Children (WIC).
4. Preference was given to families with at least one preschool child so that day care arrangements of low-income families could be included as a study focus.

In 2001, data for Wave 2 were collected from 316 mothers. For the current analysis, Wave 2 data were used because this was the only year an instrument measuring religious coping and religious practices was administered. Six states chose not to administer the instrument thus limiting the sample. Additionally, for this study, the sample was further limited to those mothers who completed all of the following instruments or questions employed in the study resulting in data from the following seven states: Kentucky, Louisiana, Massachusetts, Maryland, Minnesota, Nebraska and Ohio and a sample size of 115 mothers.

#### *Data Collection*

Tape-recorded interviews of 60-120 minutes were conducted in the native language of the mothers, in their homes or private meeting places in the community, by trained researchers. The interviews were guided by semi-structured interview protocols, consisting of standardized survey instruments and open-ended questions. Interviews yielded both quantitative and qualitative data about each participant's household composition, family well-being, family schedules, physical and mental health, life skills, community life, housing, household expenses, knowledge of community services, work

history, current employment, sources of income, attitudes about and experiences with welfare reform, transportation, child care, family of origin, educational experiences, efforts to make ends meet, food security, parenting, and social support.

### *Procedures*

The data for this study were collected from the second wave of interviews as part of the NC-223 study. The measures were woven throughout the interview process. Each state was required to collect data from at least 30 participants in the first wave in order to be included in the national study. Recruitment procedures varied from state to state, but in general, convenience sampling techniques, rather than random sampling techniques, were used.

Mothers eligible to participate received a letter explaining the intent and conditions of “Rural Family Speaks”. Upon the mother’s agreement to participate, a member of the research team met with the participant at a place chosen by the participant for a period not lasting more than two hours. Mothers were asked to sign a consent form to participate in the study and to allow use of excerpts of their taped responses without identifying information. Mothers were reminded of the longitudinal nature of the study and were requested to provide at least three contacts who would know how to locate them during the study years. Contact with the mothers is maintained during the study period via telephone calls, mailings, and occasional personal contacts.

The interview was taped for use by a transcription team. The data collection teams from each state were made up of a combination of university faculty members from multiple disciplines (many of whom are Cooperative Extension appointees, graduate and undergraduate students, county Extension Educators, county social service employees,

and when necessary, translators). Interviews were transcribed by each state using a common format and coded by the Oregon State University research team. Quantitative data were entered into SPSS (version 10.0). Qualitative coding with the WinMax coding program was also conducted at Oregon State using principles of grounded theory to code for thematic content. However, for the purposes of this study, only quantitative data was examined.

*Independent Variable: Financial Poverty*

For this study, poverty was measured in two ways: (a) Actual poverty measured by the poverty line and (b) Perceived poverty measured by economic situation change and income adequacy.

*Actual Poverty*

For the first component, the family's income in relation to the 2001 poverty line was measured from a series of questions asking the mother to identify sources and amounts of income (see in Appendix A). The poverty line, or poverty threshold, is how poverty statistics are measured in census publications for federal agencies by Statistical Policy Directive 14, issued by the Office of Management and Budget (OMB). The original poverty measure was developed in the Social Security Administration during 1963-1964. It was adopted by the Council of Economic Advisors, and the OMB subsequently revised it slightly in 1969 and 1981 (U.S. Census Bureau, 2003).

The current poverty measure has two components which are: (a) Poverty thresholds based on family income level and (b) size of the family that is compared with these thresholds (U.S. Census Bureau, 2003). The following money income is used to compute family income: earnings, unemployment compensations, worker's

compensation, Social Security, Supplemental Security Income, public assistance-TANF, veteran's payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources (U.S. Census Bureau, 2003). Income that is not included to compute poverty status includes: noncash benefits (such as food stamps and housing subsidies) (U.S. Census Bureau, 2003).

The poverty threshold is computed on before-tax income, excludes capital gains or losses, and includes all income of family members living in a household but does not include non-relatives such as housemates (U.S. Census Bureau, 2003). To compute a poverty threshold, each person or family is assigned one out of 48 poverty thresholds which vary according to the size of the family and are the dollar amounts used to determine poverty status. Family income determines who is poor. If a family's total income is less than the threshold for the family's size and composition, the family and everyone in it are considered poor. The total number of people below the poverty line is the sum of the number of people in poor families and the number of unrelated individuals with incomes below the poverty threshold.

Bauer, Braun, and Olson (2000), used a continuum of economic well-being to classify families based on the poverty line. Families in this sample were classified according to the four categories for classification, including: "In-crisis"--total household income below the poverty line; "At-risk"--total household income between the poverty line and 150% of the poverty line; "Safe"--total household income between 150% and 200% of the poverty line; and "Thriving"--total household income

above 200% of the poverty line. Bauer et al. (2000) used these categories representing cut-offs for public assistance based on the poverty line.

### *Perceived Poverty*

For this study, the ABC-X theoretical model (McCubbin et al, 1980) was conceived as: A (poverty with its related hardships) interacts with B (the mother's resources of parenting social support, religious coping, and religious practices) which interacts with C (the mother's perception of poverty) to produce the crisis X (symptoms of depression). Perception is critical in determining the severity of a stressor event because perception is the "meaning" or cognitive reappraisal given to the event (McCubbin et al., 1980). In this case, the meaning mothers gave to their economic situation and income adequacy. Therefore, for this study, poverty was measured separately by both actual income and by perception regarding that income. The perception measure had two components: change in economic situation during the last year and adequacy of family income. The perception data came from two questions (see Appendix A):

Question 1: "Compared with last year, would you say that your family's economic situation has: 5. Improved a lot, 4. Improved a little, 3. Remained the same, 2. Gone down a little, and 1. Gone down a lot".

Question 2: "To what extent do you think your income is enough for you to live on": 1. Not at all adequate, 2. Can meet necessities only, 3. Can afford some of the things we want but not all we want, 4. Can afford about everything we want, 5. Can afford about everything we want and still save money".

### *Moderating Variable: Parenting Social Support*

Based on Sanderson (2004)'s definition of social support, parenting social support was defined, in this study, as the amount of social support mothers perceived they were receiving as a parent. Parenting social support was used as a moderating variable between

the effect of poverty and maternal mental health as measured by the symptoms of depression. Parenting social support was measured by “The Parenting Ladder” (see in Appendix B), an assessment instrument which is divided into two sections: (a) Perception of competence as a parent and (b) A rating of the amount of parenting support. For this study, the second section, measuring the amount of social support for mothers as a parent, was used. The second part of the instrument is composed of six questions and utilizes a six-point Likert-type scale. Responses range from low (0) to medium (3) to high (6). The instrument was constructed by the Oregon State University Family Policy Program for utilization in a statewide evaluation of the Healthy Start Program which offers short and long term assistance and support to families (Richards, 1998). Cronbach alpha for parental support was 0.86 (n=403) using all six items (Richards, 1998). For this study, the Chronbach alpha for parental support using all six items was 0.81 (n=115); for all items of “The Parenting Ladder”, the Chronbach alpha was 0.79 (n=115).

*Moderating Variable: Religious Coping*

Religious coping is defined, in this study, as religious beliefs or a host of religious cognitions that reduce anxiety, increase hope, and increase a sense of control (Koenig, 2002). Religious coping was measured using three indicators adapted from the work of Koenig, Smiley, and Gonzales (1988) contained in the first three questions of the “Role of Religious or Spiritual Beliefs instrument, a seven item instrument (see in Appendix C): (1) When dealing with difficult times in my life I get much personal strength and support from God.<sup>3</sup>; (2) Prayer helps me with difficulties and stress in my life; and (3) It is

---

<sup>3</sup> Due to the use of the word “God” in the “Role of Religious or Spiritual Beliefs” instrument God will be used throughout the study; however, usage of additional language, such as, “a higher power” or some larger, usually “supernatural reality” could be more inclusive. The use of only the word God in the instrument could exclude mothers who are spiritual but do not identify with a Godhead.



important to see God's guidance when making every important decision in my life. The answers to the three religious coping indicators are given using a four point Likert-type scale: (1) Strongly disagree, (2) Disagree, (3) Agree, (4) Strongly agree. Answers of agree and strongly agree indicate the presence of religious coping. Due to high correlations between the religious coping questions, one religious coping composite variable was made. "The internal consistency reliability estimates for the religious coping composite measure is 0.94" (Krause, 1998, p. 658). For this study, the Chronbach alpha for all of the items in the "Role of Religious or Spiritual Beliefs" instrument was 0.82 (n=115). For this study, the Chronbach alpha for the three-item religious coping composite measure was 0.91 (n=115).

*Moderating Variable: Religious Practices*

Religious practices were defined, for this study, as the external or behavioral expressions of religious beliefs<sup>4</sup> (Koenig, 2002; Marler & Hadaway, 2002). Religious practices include the extent to which mothers experience benefits from religious services, religious activities other than religious services, and children's religious services and religious activities. Religious practices were measured using the last four questions of the "Role of Religious or Spiritual Beliefs" instrument (see in Appendix C). Question four measures whether the mothers self-identify as a member of a church or other place of worship. Questions five through seven measure religious practices: (5) How often do you attend religious services? (6) How often do you participate in religious activities other than religious services? (7) Are your children active in church or other religious activities; and How often do they participate? The answers to the religious practices

---

<sup>4</sup> The "Role of Religious or Spiritual Beliefs" instrument identified mothers as members of a church or other place of worship. For consistency and brevity the word "church" will be used throughout the study although faith community and place of worship could be more inclusive.

questions are given using a six point Likert-type scale: (6) Nearly every day, (5) At least once a week, (4) A few times a month, (3) Once a month or so, (2) A few times a year, and (1) Never. Religious practices were indicated by the number of times mothers and their children attend services.

Due to high correlations between the religious practices questions, a single religious practices composite variable was made. The internal consistency reliability estimates for the religious practices composite measure is 0.74 (Krause, 1998). For this study, the Chronbach alpha for the four-item religious practices composite measure was 0.83 (n=115).

*Dependent Variable: Maternal Depression*

The dependent variable of maternal depression is a measure of the absence or presence of depressive symptoms. To assess the mother's depressive symptomology, the Center for Epidemiological Studies-Depression Scale (CES-D) (Radloff, 1977) was used, (see in Appendix D). This 20-item scale uses a four point Likert-type scale in which the mothers responded to such questions as, "During the past week, how often did you feel lonely?", "How often did you have a poor appetite?", and "How often did you have crying spells?" Responses from the CES-D range from 0 = "rarely or none of the time (less than 1 day)" to "most of the time (5-7 days)" (Radloff, 1977). Indices of depressive symptomology are computed by summing the ratings of each of the 20 items, with reversed scores for the four positive mental health items (items 4, 8, 12 and 16). Total scores may range from 0 to 60, with lower scores indicating lower levels of depressive symptoms. A score of 16 or above on the CES-D is considered clinically significant for symptoms of depression (Radloff, 1977).

The CES-D has been shown to be a reliable measure, with high internal consistency, test-retest repeatability, and validity. Coefficient alpha and Spearman-Brown coefficients were 0.90 or above for both clinical and general samples. Split-half correlations were 0.85 for patient groups and 0.77 for general groups (Robinson, Shaver, & Wrightsman, 1991). The psychometric properties have previously been found to be consistent across age, sex, and ethnic subgroups (Radloff & Locke, 1986). Adequate validity was also found with a wide variety of populations (Ensel, 1986; Radloff, 1977). Cronbach's alpha is .88 for low income populations (Richards, Pamulapati, Corson, & Merrill, 2000). For this study, the Chronbach alpha for all twenty items of the CES-D was 0.79 (n=115).

*Control Variables: Maternal Age and Maternal Race*

Age was measured by self-reported birth-date during the first interview. Maternal age was used as a control variable because it had been linked to maternal depression and life satisfaction (Simmons-Wescott & Braun, 2004). In their study on the relationship of maternal depression to life satisfaction, Simmons-Wescott & Braun (2004) found that women ages 18-42 reported levels of depression that remained relatively steady with a slight peak for women age 33 to 37. Women age 43 and older reported significantly higher levels of depression yet were the age group that reported the highest levels of life satisfaction. The authors hypothesized that the unexpected high level of life satisfaction reflected both their aging process, in that, according to the literature, older women have more mental and physical problems; earn less; are more mature; and to their worldview, in that, they have gained perspective on their lives leading to more life satisfaction (Simmons-Wescott & Braun, 2004). However, Smith et al. (2003) found that the

relationship between religiousness and depression was not moderated by age. Due to the equivocal findings, age was controlled as a variable in this study.

Race was self-identified during the first interview based on the categories of Non-Hispanic White; Hispanic/Latino; African-American; Native American, or mixed race. Maternal race was used as a control variable as it has been linked to financial poverty, social support, religiosity, and depression. When compared to their urban counterparts, both African American and European American rural subgroups find the culture of religion to be salient, although attendance at religious services and participation in religious activities are more common among younger, female, African-American participants than among older, male, White participants, albeit women and elderly individuals have higher religious identification than men (Bergan & McConatha, 2000; Chandler & Campbell, 2002; Mitchell & Weatherly, 2000).

Jacobson, Heaton, and Dennis (1990) found that while White Americans and African Americans have *quantitatively* similar theologies they have *qualitatively* different experiences in church with African American services involving a heightened degree of personal involvement and “other-worldliness” thought to be tied to the function of the church in the African American community, which was to create tightly knit communities, and to provide emotional support necessary to endure the hardships of slavery (Arcury et al., 2000; Billingsley, 1999; Brody & Flor, 1998; Chandler and Campbell, 2002). Carrying on the function of the church, African Americans often function as members of extended families or larger kin networks providing support to families, parents, and children. For rural African American families, the rural church has

been identified as a resource for nurturance, emotional support, and cultural identity for mothers and their children (Brody & Flor, 1998).

In their meta-analysis of 147 research projects, Smith et al. (2003) found that the relationship between religiousness and depression was not moderated by race or ethnicity. However, in their meta-analysis of 34 studies, Hackney and Sanders (2003) found that the relationship between religiousness and depression was moderated by race with African Americans exhibiting more use of religion. Due to the equivocal findings, minority status was controlled as a variable in this study.

### *Definition of Terms*

A number of variables in this study can be defined in varying terms. Therefore, a table of term definitions is provided along with the measures used in this study. See Table 1 for a summary of the definitions of the variables and the measures used in this study.

Table 1: Definitions of the Variables and Measures Used.

Concept	Definition	Measures
Independent Variable: <b>Financial Poverty</b>	Being poor due to insufficient income and perception of being poor.	The measure for actual poverty was defined as a percentage of the 2001 poverty line for household size divided into four categories: (1) In-Crisis: below the poverty line or less than 100%; (2) At-Risk: 100%-150% of the poverty line; (3) Safe: 151-200% of the poverty line; (4) Thriving: greater than 200% of the poverty line. Actual poverty is measured from one item from “Income and Making Ends Meet”. The perceived poverty or the measure of the mother’s perception of being poor was the mother’s assessment of: (a) Economic situation change or a comparison of current to past economic situation and (b) Income adequacy or the ability to provide for her family. Perceived poverty is measured from two items from “Income and Making Ends Meet”.
Moderating Variable: <b>Parenting social support</b>	Perceiving parenting help from family, friends and professionals.	Total scores of parental support from “The Parenting Ladder”.
Moderating Variable: <b>Religious Coping</b>	Religious coping is the religious beliefs or cognitions that reduce anxiety, increase hope and increase a sense of control.	First three questions on the “Role of Religious or Spiritual Beliefs” instrument.
Moderating Variable: <b>Religious Practices</b>	Religious practices are the external or behavioral expressions of religious beliefs.	Last four questions on the “Role of Religious or Spiritual Beliefs” instrument.
Dependent Variable: <b>Depression</b>	Experiencing symptoms that are identified as being at risk for clinical depression as defined by the Diagnostic and Statistics Manual for Mental Disorders	Total scores of depression scales from the CES-D instrument.
Control Variable: <b>Maternal Age</b>	Mother’s age in years since birth.	Maternal age was classified as a continuous variable and as: 1=young adult to age 24, 2=age 25 to 39, and 3=age 40 and over.
Control Variable: <b>Maternal Race and/or Ethnicity</b>	Maternal race was self-identified during the first interview: Non-Hispanic White, Hispanic/Latino, African-American, Native American, or mixed race.	Maternal race was measured as 1=Majority [Non-Hispanic White], 2= Minority [Hispanic/Latino, African-American, Native American, or mixed race]

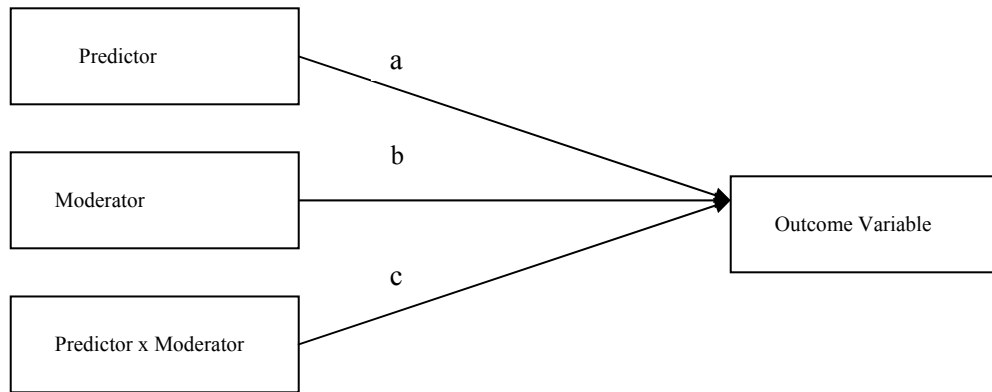
### *Data Analysis*

Descriptive statistics were generated for all variables, as appropriate. Correlations were employed to assess relationships between the variables. *T*-tests were used to determine if any differences existed between minority and non-minority mothers. Multiple hierarchical regressions were utilized to determine if parenting social support, religious coping and religious practices moderated actual and perceived poverty on symptoms of depression for all mothers.

#### *Moderator Model*

Parenting social support, religious coping, and religious practices were analyzed using the Baron and Kenny (1986) moderator model. Baron and Kenny (1986) state that in this model, the arrow from the independent variable to the dependent variable represents (Path a). The arrow from the moderator variable to the dependent variable represents (Path b), and the arrow from the interaction of the independent variable and moderator variable to the dependent variable represents (Path C). The moderator hypothesis is supported if the interaction (Path c) is significant. There may be main effects for the independent variable and the moderator (Paths a and b) but these are not directly relevant conceptually when testing the moderator hypothesis. Additionally, to support the moderator hypothesis it is desirable that the moderator variable be uncorrelated with both the independent and dependent variables. In order to assess if the moderator variable was uncorrelated with both the independent and dependent variables correlations were done. See Figure 3.

Figure 3: Moderator Model (Baron & Kenny, 1986, p. 1174).





## CHAPTER IV: Results

### *Demographic characteristics*

Demographic characteristics of the study sample are presented in Table 2. This sample is from Wave 2, obtained in 2001. However, all age and race data are based on Wave 1, obtained in 2000.

The study sample for this investigation consisted of mothers ranging in age from 17-58. The mean age for mothers was 29.7 (SD=8.09). The majority of mothers were in the age group of 25-39 (53.0%); followed by mothers in the age group 17-24 (31.3%); with the least mothers in the age group 40 and over (15.7%).

The majority of the mothers, 89 (77.4%), were Non-Hispanic White. The remaining 26 (22.6%) were minorities self identified as: 2 (1.7%), Hispanic/Latino; 18 (15.7%), African American; 2 (1.7%), Native American; and 4 (3.5%), multiracial.

Most of the mothers, 30 (26.1%) were employed at the same job in 2001 as in 2000. Twenty-seven (23.5%) were employed at a new job in 2001. Twenty-one (18.3%) mothers without jobs in 2000 found jobs and were employed in 2001. Ten mothers (8.7%) who had been employed in 2000 were not employed in 2001. Twenty-six mothers (22.6%) were not employed either year. For employment data one case was missing, (n=114).

The majority of mothers, 72 (62.6%), belonged to a church or place of worship; 43 (37.4%) did not. The majority of mothers 41 (35.7%) had two children. Two mothers (1.7%) had no children; 34 (29.6%) mothers had one child; 41 (35.7%) mothers had two children; 21 (21%) mothers had three children; 11 (9.6%) mothers had four children; four

(3.5%) mothers had five children; one (0.9%) mother had six children; and one (0.9%) mother had seven children.

The majority of mothers, 60 (52.2%), were single, separated and divorced while the rest of the mothers, 55 (47.8%), were married or living with a partner. Among these mothers, 40 (34.8%) were single; 40 (34.8%) were married; 15 (13.0%) were living with a partner; 14 (12.2%) were divorced; and 6 (5.2%) were separated.

### *Poverty*

Using the poverty level categories, the majority of mothers 111 (96.5%) were in the “At-Risk” poverty level (100-150% of the poverty line) using family income and family size as a measure of poverty. The remainder of the other mothers: 4 (3.5%) were in the “In-Crisis” category.

The mothers gave the following answers to the statement that measured perceived poverty based on economic situation change: Gone down a lot, 8 (7.0%); Gone down a little, 19 (16.5%); Remained the same, 25 (21.7%); Improved a little, 38 (33.0%); Improved a lot, 25 (21.7%). The majority of the mothers stated that their economic situation had improved, 63 (54.7%); 27 (23.5%) perceived a drop in their economic situation; 25 (21.7%) experienced no change. The mothers gave the following answers to the statement that measured perception of income adequacy, “Do you think your income is enough for you to live on?” Not at all adequate, 13 (11.3%); Can meet necessities only, 21 (18.3%); Can afford some of the things we want but not all we want, 63 (54.8%); Can afford about everything we want, 10 (8.7%); Can afford about everything we want and still save money, 8 (7.0%).

### *Parenting Social Support*

On “The Parenting Ladder”, satisfaction with parenting social support was computed as a total score: Low (0), Medium (1-3), and High (4-6). For the questions on this instrument, mothers reported experiencing the following levels of perceived support as parents: Low: 0 (0%); Medium, 13 (11.4%); and High, 102 (88.7%).

### *Religious Coping*

In response to the statement, “When dealing with difficult times in my life I get much personal strength and support from God”, 6 (5.2%) strongly disagreed; 5 (4.3%) disagreed; 54 (47.0%) agreed; 50 (43.5%) strongly agreed. In summary, 104 (90.5%) of the mothers reported getting strength and support from God.

In response to the statement, “Prayer helps me cope with difficulties and stress in my life”, 6 (5.2%) strongly disagreed; 10 (8.7%) disagreed; 51 (44.3%) agreed; 48 (41.7%) strongly agreed. In summary, 99 (86.0%) of the mothers reported coping, with difficulties and stress, by praying.

In response to the statement, “It is important to see God’s guidance when making every important decision in life”, 6 (5.2%) strongly disagreed; 14 (12.2%) disagreed; 41 (35.7%) agreed; 54 (47%) strongly agreed. In summary, 95 (82.7%) of the mothers reported using God’s guidance to make important decisions in life.

### *Religious Practices*

In answer to the question, “How often do you attend religious services?” 22 (19.1%) reported never; 34 (29.6%), a few times a year; 1 (0.9%), once a month or so; 24 (20.9%), a few times a month; 30 (26.1%), at least once a week; 4 (3.5%), nearly every day.

In answer to the question, “How often do you participate in religious activities?” 53 (46.1%) reported never; 24 (20.9%), a few times a year; 5 (4.3%), once a month or so; 7 (6.1%), a few times a month; 24 (20.9%), at least once a week; 2 (1.7%), nearly every day.

In answer to the question, “Are your children active in services and activities and how often?” 35 (30.4%) reported never; 8 (7.0%), a few times a year; 1 (0.9%), once a month or so; 21 (18.3%), a few times a month; 44 (38.3%), at least once a week; 6 (5.2%), nearly every day. In summary, 58 (50.5%) of mothers reported attending church services from a few times a month to daily. In summary, 33 (24.1%) mothers reported attending activities from a few times a month to daily. In combination, three-fourths of the mothers (74.6%) reported personally attending church services and activities a few times a month to daily. Approximately two-thirds of the children 71 (61.8%) participated in services and activities according to their mothers report.

#### *Symptoms of Depression*

Total scores of the CES-D range from 0 to 60. A score of 16 or above on the CES-D is considered clinically significant for symptoms of depression (Radloff, 1977). The majority of the mothers scored below the score of 16: 67 (58.3%) and the rest of the mothers scored 16 or above: 48 (41.7%). For further detail of demographic characteristics of the sample see Table 2.

Table 2  
 Characteristics of the Sample

Characteristic	Wave 2 (n=115)		n	(%)
	M	(SD)		
Age in years	29.7	(8.09)		
Race				
Non-Hispanic White			89	(77.4%)
Hispanic/Latino			2	(01.7%)
African American			18	(15.7%)
Native American			2	(01.7%)
Multiracial			4	(03.5%)
Minority vs. Non-Minority	1.23	(0.42)		
Employment Status	2.78	(1.50)		
Marital Status	2.20	(1.19)		
Single			40	(34.8%)
Separated			6	(05.2%)
Divorced			14	(12.2%)
Married			40	(34.8%)
Living with Partner			15	(13.0%)
Number of Children	2.2	(1.25)		
Member of a Church/Place of Worship	0.63	(0.49)		

As previously stated, the following measures were used: “Income and Making Ends Meet” was used to measure actual and perceived financial poverty. “The Parenting Ladder” was used to measure parenting social support. “The Role of Religious and Spiritual Beliefs” was used to measure religious coping and practices. And, the CES-D was used to measure symptoms of depression. For information about the measures see Table 3.

Table 3  
Measures

Name of Measure	Wave 2 (N=115)			
	M	(SD)	n	(%)
Continuous Actual Poverty	116.203	92.496		
Categories of Poverty Line	1.965	.184		
‘‘In-Crisis’’			4	(3.5%)
‘‘At-Risk’’			111	(96.5%)
‘Safe’’			0	(0%)
‘‘Thriving’’			0	(0%)
Income Change	3.5	1.20		
Income Adequacy	2.8	.99		
Parenting Social Support Scores	28.0	6.46		
Religious Coping Composite	3.25	.76		
Religious Practices Composite	2.99	1.52		
Symptoms of Depression Scores	15.3	11.29		

*Hypotheses Findings*

Hypothesis One stated that there will be a negative association between actual poverty, perceived poverty, and symptoms of depression. Findings regarding hypothesis One are found in Table 4.

Table 4: Bivariate Relationships between Variables for Hypothesis One (n=115).

Variable	1. AP	2. ESC	3. IA	4. SD
1. Actual Poverty	1	-.05	.06	.05
2. Economic Situation Change		1	.35**	-.27**
3. Income Adequacy			1	-.42**
4. Symptoms of Depression				1

\*\*p<.01 (2-tailed)

There was no correlation between actual poverty and symptoms of depression. The hypothesis of a negative association between actual poverty and symptoms of depression was not supported. For perceived economic situation change and symptoms of depression there was a significantly negative correlation ( $r=-.27$ ,  $p<.01$ ), such that, as there are higher levels of economic situation change, there are lower depression scores.. The hypothesis of a negative association between perceived economic situation change and symptoms of depression was supported. For perceived income adequacy and symptoms of depression there was a significantly negative correlation ( $r=-.42$ ,  $p<.01$ ), such that, as there are higher levels of income adequacy, there are lower depression scores. The hypothesis of a negative association between income adequacy and symptoms of depression was supported.

Hypothesis Two stated that there will be a negative association between social support, religious coping, and religious practices and symptoms of depression. Findings regarding hypothesis Two are found in Table 5.

Table 5: Bivariate Relationships between Variables for Hypothesis Two (n=115).

Variable	1 PSS	2 RC	3 RP	4 SD
1. Parenting Social Support	1	.19*	.11	-.42**
2. Religious Coping		1	.38**	-.10
3. Religious Practices			1	-.20*
4. Symptoms of Depression				1

\*\* $p<.01$  (2-tailed) \* $p<.05$  (2-tailed)

For parenting social support and symptoms of depression there was a significantly negative correlation ( $r=-.42$ ,  $p<.01$ ), such that, as there are higher levels of parenting social support, there are lower depression scores. The hypothesis of a negative association between parenting social support and symptoms of depression was supported.

The correlation between religious coping and symptoms of depression was not significant. The hypothesis of a negative association between religious coping and symptoms of depression was not supported.

For religious practices and symptoms of depression there was a significantly negative correlation ( $r = -.20$ ,  $p < .05$ ), such that, as there are higher levels of religious practices, there are lower depression scores. The hypothesis of a negative correlation between religious practices and symptoms of depression was supported.

Hypothesis Three stated that minority mothers will experience higher levels of actual and perceived poverty compared to their White counterparts. Three *t*-tests were run to test the difference between the means for actual and perceived poverty. For actual poverty, the mean poverty level for the minority mothers was 106.35. For actual poverty, the mean poverty level for the non-minority mothers was 119.08. The *t*-test result was:  $t(113) = .62$ ,  $p = .05$ , ns. The hypothesis for differences in actual poverty was not supported.

For perceived economic situation change, the mean for the minority mothers was 3.69; the mean for the non-minority mothers was 3.39. The *t*-test result was:  $t(113) = 1.12$ ,  $p = .05$ , ns. The hypothesis for differences in perceived poverty, expressed as perception of economic situation change, was not supported.

For perceived income adequacy, the mean for the minority mothers was 2.88; the mean for the non-minority mothers was 2.80. The *t*-test result was:  $t(113) = -.39$ ,  $p = .05$ , ns. The hypothesis for differences in perceived poverty, expressed as perception of income adequacy, was not supported.



Hypothesis Four stated that minority mothers will experience higher levels of social support, religious coping, and religious practices, and lower symptoms of depression, compared to their White counterparts. Four *t*-tests were run to test the difference between the means. Due to the highly correlated nature of the religious coping and religious practices individual items, composite scores were made for each. Religious coping and religious practices composite scores were used for *t*-tests. For social support, the mean for the minority mothers was 28.69; the mean for the non-minority mothers was 27.81. The *t*-test result was:  $t(113) = -.61, p=.05, ns$ . The hypothesis for differences in social support was not supported.

For religious coping, the mean for the minority mothers was 3.60; the mean for the non-minority mothers was 3.15. The *t*-test result was:  $t(113) = -2.76, p<.01$ . The hypothesis for differences in religious coping was supported.

For religious practices the mean of the minority mothers was 3.18; the mean for the non-minority mothers was 2.94. The *t*-test result was:  $t(113) = -.70, p=.05, ns$ . The hypothesis for differences in religious practices was not supported.

For symptoms of depression, the mean of minority mothers was 16.77; the mean for the non-minority mothers was 14.90. The *t*-test result was:  $t(113) = -.74, p=.05, ns$ . The hypothesis for differences in symptoms of depression was not supported.

Hypothesis Five stated that there will be a positive association between age, actual and perceived poverty, and symptoms of depression. For information about hypothesis Five see Table 6.

Table 6: Bivariate Relationships between Variables for Hypothesis Five (n=115).

Variable	1. Age	2. AP	3. ESC	4. IA	5. SD
1. Age	1	.03	-.11	.02	.02
2. Actual Poverty		1	-.046	.06	.05
3. Economic Situation Change			1	.35**	-.27**
4. Income Adequacy				1	-.42**
5. Symptoms of Depression					1

\*\*p<.01 (2-tailed) \*p<.05 (2-tailed)

There was no association between age and actual poverty. There was no association between age and perceived poverty as measured by economic situation change. There was no association between age and perceived poverty as measured by income adequacy. There was no association between age and symptoms of depression. The hypothesis was not supported.

Tests for hypothesis Six, Seven, and Eight did not control for age or differences between minority and non-minority mothers, as these control variables were not statistically significant in hypotheses three and five. Hypotheses Six, Seven and Eight were analyzed using the Baron and Kenny (1986) moderator model.

For hypotheses Six, Seven and Eight, hierarchical regression analysis and correlations were completed to see if parenting social support, religious coping and religious practices were moderators. The interaction effect for each independent variable and each moderator was used to test hypotheses Six, Seven, and Eight.

Hypothesis Six states that parenting social support will moderate the effects of actual and perceived poverty on symptoms of depression. For the moderation of parenting social support on actual poverty, see Table 7 and Table 8.

Table 7: Summary of Hierarchical Multiple Regression Analysis of the Interaction of Actual Poverty (Poverty Line) and Parenting Social Support for Moderating Symptoms of Depression (n=115).

Model Variable	B	SE	Beta	R	R <sup>2</sup>	R <sup>2</sup> change	F change	df1	df2	Sig. F. change
1. Actual poverty	-1.046E-02	.01	-.09	.09	.01	.01	.83	1	113	.36
2. Parental social support	-.68	.15	-.39	.39	.16	.15	19.76	1	112	.00
3. Interaction of actual poverty and parenting support	2.081E-03	.00	.56	.41	.16	.01	1.18	1	111	.28

Table 8: Bivariate Correlations on Variables in Regression: Actual Poverty (Poverty Line) and Parenting Social Support (n=115).

Variable	1. AP	2. PSS	3. Interaction	4. SD
1. Actual Poverty	1	.13	.96**	-.09
2. Parenting Social Support		1	.35**	-.39**
3. Interaction of Actual and Parenting Support			1	-.15
4. Symptoms of Depression				1

\*\*p<.01 (2-tailed)

For this sample, social support did not moderate actual poverty on symptoms of depression since the interaction of actual poverty and parenting support was not significant (p=.28, ns). The hypothesis was not supported.

The moderator variable of parenting social support had a significantly negative correlation with the dependent variable of symptoms of depression ( $r=-.39$ ,  $p<.01$ ). Since it is best to have the moderator uncorrelated with both the independent and dependent variables to provide a clear moderator, this confirms that the hypothesis was not

supported. There was a main effect of parental social support, but that was not relevant to the moderator hypothesis.

Hypotheses Six stated that parenting social support will moderate the effects of actual and perceived poverty on symptoms of depression. For the moderation of parenting social support on the measure of perceived poverty named economic situation change see Table 9 and Table 10.

Table 9: Summary of Hierarchical Multiple Regression Analysis of the Interaction of Perceived Poverty (Economic Situation Change) and Parenting Social Support for Moderating Symptoms of Depression (n=115).

Step Model	B	SE	Beta	R	R <sup>2</sup>	R <sup>2</sup> change	F change	df1	df2	Sig. F change
1. Economic situation change	-2.51	.85	-.27	.27	.07	.07	8.68	1	113	.00
2. Parental Social Support	-.65	.15	-.37	.46	.21	.14	19.25	1	112	.00
3. Interaction of economic situation change and parental social support	-1.296E-02	.12	-.05	.46	.21	.00	.01	1	111	.92

Table 10: Bivariate Correlations on Variables in Regression: Perceived Poverty (Economic Situation Change) and Parenting Social Support (n=115).

Variable	1. ESC	2. PSS	3. Interaction	4. SD
1. Economic situation change	1	.10	.81**	-.27**
2. Parenting Social Support		1	.63**	-.39**
3. Interaction of Economic situation change and Parenting Support			1	-.42**
4. Symptoms of Depression				1

\*\*p<.01 (2-tailed)

Parenting social support did not moderate perceived poverty (economic situation change) on symptoms of depression since the interaction of economic situation change and parenting social support was not significant ( $p=.92$ , ns). The hypothesis was not supported.

The independent variable of economic situation change had a significantly negative correlation with symptoms of depression ( $r= -.27$ ,  $p<.01$ ); the moderator variable of parenting social support had a significantly negative correlation with the dependent variable of symptoms of depression ( $r=-.39$ ,  $p<.01$ ); and the dependent variable of symptoms of depression had a significantly negative correlation with the interaction variable which is comprised of the independent and moderator variables ( $r=-.42$ ,  $p<.01$ ). Since it is best to have the moderator uncorrelated with both the independent and dependent variables to provide a clear moderator, this confirms that the hypothesis was not supported. There was a main effect of economic situation change and parental social support but the effect was not relevant to the moderator hypothesis.

Hypotheses Six stated that parenting social support will moderate the effects of actual and perceived poverty on symptoms of depression. For the moderation of parenting social support on the measure of perceived poverty named income adequacy see Table 11 and Table 12.

Table 11: Summary of Hierarchical Multiple Regression Analysis of the Interaction of Perceived Poverty (Income Adequacy) and Parenting Support for Moderating Symptoms of Depression (n=115).

Model	B	SE	Beta	R	R <sup>2</sup>	R <sup>2</sup> change	F change	df1	df2	Sig. F. change
1. Enough Income	-4.85	.97	-.42	.42	.18	.18	24.79	1	11	.00
2. Parental Social Support	-.54	.15	-.31	.52	.27	.09	13.69	1	11	.00
3. Interaction of enough income and parental social support	2.078E-02	.15	.07	.52	.27	.00	.02	1	11	.89

Table 12: Bivariate Correlations on Variables in Regression: Perceived Poverty (Income Adequacy) and Parenting Social Support (n=115).

Variable	1. IA	2. PSS	3. Interaction	4. SD
1. Income Adequacy	1	.24**	.85**	-.42**
2. Parenting Social Support		1	.68**	-.39**
3. Interaction of Income Adequacy and Parenting Support			1	-.51**
4. Symptoms of Depression				1

\*\*p<.01 (2-tailed)

Parenting social support did not moderate perceived poverty (income adequacy) on symptoms of depression. The interaction of income adequacy and parenting social support was not significant (p=.89, ns). The hypothesis was not supported.

The independent variable of income adequacy had a significantly positive correlation with parenting social support ( $r=.24$ ,  $p<.01$ ), and a significantly negative correlation with the dependent variable symptoms of depression ( $r= -.42$ ,  $p<.01$ ). The moderator variable of parenting social support had a significantly negative correlation

with the dependent variable of symptoms of depression ( $r = -.39, p < .01$ ). The dependent variable of symptoms of depression had a significantly negative correlation with the interaction variable which is comprised of the independent and moderator variables ( $r = -.51, p < .01$ ). Since it is best to have the moderator uncorrelated with both the independent and dependent variables to provide a clear moderator, this confirms that the hypothesis was not supported. There were main effects of income adequacy and parental social support, but that was not relevant to the moderator hypothesis.

Hypothesis Seven stated that religious coping will moderate the effects of actual and perceived poverty on symptoms of depression. For the moderation of religious coping on actual poverty see Table 13 and Table 14.

Table 13: Summary of Hierarchical Multiple Regression Analysis of the Interaction of Actual Poverty (Poverty Line) and Religious Coping for Moderating Symptoms of Depression (n=115).

Model	B	SE	Beta	R	R <sup>2</sup>	R <sup>2</sup> change	F change	df1	df2	Sig. F Change
1. Actual Poverty (Poverty Line )	-1.046E-02	.01	-.09	.09	.01	.01	.83	1	11	.36
2. Religious coping composite	-1.55	1.4	-.10	.13	.02	.01	1.23	1	11	.27
3. Interaction of actual poverty and religious coping	-2.987E-02	.02	-.79	.21	.05	.03	3.25	1	11	.07

Table 14: Bivariate Correlations on Variables in Regression: Actual Poverty (Poverty Line) and Religious Coping (n=115).

Variable	1. AP	2. RC	3. Interaction	4. SD
1. Actual Poverty	1	-.09	.93**	-.09
2. Religious Coping Composite		1	.22*	-.10
3. Interaction of Poverty and Religious Coping			1	-.15
4. Symptoms of Depression				1

\*\*p<.01 (2-tailed) p\*<.05 (2-tailed)

Religious coping did not moderate actual poverty on symptoms of depression since the interaction of actual poverty and religious coping was not significant at (p=.07, ns). The hypothesis was not supported.

However, there appeared to be a trend of religious coping moderating actual poverty which needs to be investigated in future data analysis. Since it is best to have the moderator uncorrelated with both the independent and dependent variables to provide a clear moderator and since this did occur, indicative of the noted trend, the finding lends support for a further examination of religious coping as a moderator on actual poverty for symptoms of depression.

Hypothesis Seven stated that religious coping will moderate the effects of actual and perceived poverty on symptoms of depression. For the moderation of religious coping on the measure of perceived poverty named economic situation change see Table 15 and Table 16.



Table 15: Summary of Hierarchical Multiple Regression Analysis of the Interaction of Perceived Poverty (Economic Situation Change) and Religious Coping for Moderating Symptoms of Depression (n=115).

Model	B	SE	Beta	R	R <sup>2</sup>	R <sup>2</sup> change	F change	df1	df2	Sig. F Change
1. Economic situation change	-2.50	.85	-.27	.27	.07	.07	8.68	1	113	.00
2. Religious coping composite	-.86	1.37	-.06	.27	.07	.00	.40	1	112	.53
3. Interaction of economic situation change and religious coping	1.94	1.16	.85	.31	.10	.02	2.79	1	111	.10

Table 16: Bivariate Correlations on Variables in Regression: Perceived Poverty (Economic Situation Change) and Religious Coping (n=115).

Variable	1. ESC	2. RC	3. Interaction	4. SD
1. Economic situation change	1	.15	.83**	-.27**
2. Religious Coping Composite		1	.64**	-.10
3. Interaction of economic situation change and Religious Coping			1	-.23*
4. Symptoms of Depression				1

\*\*p<.01 (2-tailed) p\*<.05 (2-tailed)

Religious coping did not moderate perceived poverty (economic situation change) on symptoms of depression since the interaction of economic situation change and religious coping was not significant (p=.10, ns). The hypothesis was not supported.

The independent variable of economic situation change had a significantly negative correlation with the dependent variable of symptoms of depression ( $r=-.27$ ,  $p<.01$ ). The interaction variable, which includes the independent and moderator variables,

had a significantly negative correlation with the dependent variable of symptoms of depression ( $r=-.23, p<.01$ ). Since it is best to have the moderator uncorrelated with both the independent and dependent variables to provide a clear moderator, this confirms that the hypothesis was not supported. There is a main effect of economic situation change but that was not relevant to the moderator hypothesis.

Hypothesis Seven stated that religious coping will moderate the effects of actual and perceived poverty on symptoms of depression. For the moderation of religious coping on the measure of perceived poverty named income adequacy see Table 17 and 18.

Table 17: Summary of Hierarchical Multiple Regression Analysis of the Interaction of Perceived Poverty (Income Adequacy) and Religious Coping for Moderating Symptoms of Depression (n=115).

Model	B	SE	Beta	R	R <sup>2</sup>	R <sup>2</sup> Change	F change	df1	df2	Sig. F Change
1.Income Adequacy	-4.85	.97	-.42	.42	.18	.18	24.79	1	113	.00
2. Religious coping composite	-1.73	1.27	-.12	.44	.19	.01	1.88	1	112	.17
3.Interaction of income adequacy and religious practices	2.22	1.29	-.75	.46	.21	.02	2.97	1	111	.09

Table 18: Bivariate Correlations on Variables in Regression: Perceived Poverty (Income Adequacy) and Religious Coping (n=115).

Variable	1. IA	2. RC	3. Interaction	4. SD
1. Income Adequacy	1	-.05	.79**	-.42**
2. Religious Coping Composite		1	.54**	-.10
3. Interaction of Income Adequacy and Religious Coping			1	-.37**
4. Symptoms of Depression				1

\*\*p<.01 (2-tailed)

Religious coping did not moderate income adequacy on symptoms of depression since the interaction of income adequacy and religious coping was not significant at ( $p=.09$ , ns). The hypothesis was not supported.

The independent variable of income adequacy had a significantly negative correlation with the dependent variable of symptoms of depression ( $r=-.42$ ,  $p<.01$ ). The interaction variable which includes both the independent and moderator variables had a significantly negative correlation with the dependent variable of symptoms of depression ( $r=-.37$ ,  $p<.01$ ). Since it is best to have the moderator uncorrelated with both the independent and dependent variables to provide a clear moderator, this confirms that the hypothesis was not supported. There was a main effect of income adequacy but that was not relevant to the moderator hypothesis.

Hypothesis Eight stated that religious practices will moderate the effects of actual and perceived poverty on symptoms of depression. For the moderation of religious practices on symptoms of depression see Table 19 and 20.

Table 19: Summary of Hierarchical Multiple Regression Analysis of the Interaction of Actual Poverty (Poverty Line) and Religious Practices for Moderating Symptoms of Depression (n=115).

Model	B	SE	Beta	R	R <sup>2</sup>	R <sup>2</sup> change	F change	df1	df2	Sig. F Change
1. Actual Poverty (Poverty Line)	-1.046E-02	.01	-.09	.09	.01	.01	.83	1	113	.36
2. Religious practices composite	-1.43	.69	-.19	.21	.04	.04	4.27	1	112	.04
3. Interaction of actual poverty and religious practices	-1.322E-02	.01	-.42	.25	.06	.02	2.46	1	111	.12

Table 20: Bivariate Correlations on Variables in Regression: Actual Poverty (Poverty Line) and Religious Practices (n=115).

Variable	1. AC	2. RP	3. Interaction	4. SD
1. Actual Poverty	1	.11	.82**	-.09
2. Religious Practices Composite		1	.54**	-.20*
3. Interaction of Actual Poverty and Religious Practices			1	-.21*
4. Symptoms of Depression				1

\*\*p<.01 (2-tailed) p\*<.05

Religious practices did not moderate actual poverty on symptoms of depression since the interaction of actual poverty and religious practices was not significant (p=.12, ns). The hypothesis was not supported.

The interaction variable which includes both the independent and moderator variables, had a significantly negative correlation with the dependent variable of symptoms of depression ( $r=-.21$ ,  $p<.01$ ). The moderator was uncorrelated with both the independent and dependent variables which provides a clear moderator; however, the

interaction of actual poverty and religious practices is not significant. Therefore, the hypothesis was not supported.

Hypothesis Eight stated that religious practices will moderate the effects of actual and perceived poverty on symptoms of depression. For the moderation of religious practices on the measure of perceived poverty named economic situation change see Table 21 and 22.

Table 21: Summary of Hierarchical Multiple Regression Analysis of the Interaction of Perceived Poverty (Economic Situation Change) and Religious Practices for Moderating Symptoms of Depression (n=115).

Model	B	SE	Beta	R	R <sup>2</sup>	R <sup>2</sup> change	F change	df1	df2	Sig. F Change
1. Economic Situation Change	-2.51	.85	-.27	.27	.07	.07	8.68	1	113	.00
2. Religious Practices Composite	-1.49	.66	-.20	.33	.11	.04	5.10	1	112	.03
3. Interaction of economic situation change and religious practices	.30	.55	.18	.34	.11	.00	.31	1	111	.58

Table 22: Bivariate Correlations on Variables in Regression: Perceived Poverty (Economic Situation Change) and Religious Practices (n=115).

Variable	1. ESC	2. RP	3. Interaction	4. SD
1. Economic situation change	1	-.01	.53**	-.27**
2. Religious Practices Composite		1	.80**	-.20*
3. Interaction of Economic situation change and Religious Practices			1	-.29**
4. Symptoms of Depression				1

\*\*p<.01 (2-tailed) p\*<.05

Religious practices did not moderate economic situation change on symptoms of depression since the interaction of economic situation change and religious practices was not significant ( $p=.58$ , ns). The hypothesis was not supported.

The independent variable of economic situation change had a significantly negative correlation with the dependent variable of symptoms of depression ( $r=-.27$ ,  $p<.05$ ). The moderator variable of religious practices had a significantly negative correlation with the dependent variable of symptoms of depression ( $r=-.20$ ,  $p<.05$ ). The interaction variable which is comprised of the independent and dependent variables had a significantly negative correlation with the dependent variable of symptoms of depression ( $r=-.29$ ,  $p<.01$ ). Since it is best to have the moderator uncorrelated with both the independent and dependent variables to provide a clear moderator, this confirms that the hypothesis was not supported. There is a main effect of economic situation change but that was not relevant to the moderator hypothesis.

Hypothesis Eight stated that religious practices will moderate the effects of actual poverty and perceived poverty on symptoms of depression. For the moderation of religious practices on the measurement of perceived poverty named income adequacy see Table 23 and Table 24.

Table 23: Summary of Hierarchical Multiple Regression Analysis of the Interaction of Perceived Poverty (Income Adequacy) and Religious Practices for Moderating Symptoms of Depression (n=115).

Model	B	SE	Beta	R	R <sup>2</sup>	R <sup>2</sup> change	F Change	df1	df2	Sig. F change
1. Income Adequacy	-4.85	.97	-.42	.42	.18	.18	24.79	1	113	.00
2. Religious Practices Composite	-1.25	.63	-.17	.46	.21	.03	3.99	1	112	.05
3. Interaction of income adequacy and religious practices	.49	.61	.25	.46	.21	.00	.64	1	111	.42

Table 24: Bivariate Correlations on Variables in Regression: Perceived Poverty (Income Adequacy) and Religious Practices (n=115).

Variable	1. IA	2. RP	3. Interaction	4. SD
1. Income Adequacy	1	.07	.59**	-.42**
2. Religious Practices Composite		1	.81**	-.20*
3. Interaction of Income Adequacy and Religious Practices			1	-.36**
4. Symptoms of Depression				1

\*\*p<.01 (2-tailed) p\*<.05

Religious practices did not moderate income adequacy on symptoms of depression since the interaction of income adequacy and religious practices was not significant (p=.42, ns). The hypothesis was not supported.

The independent variable of income adequacy had a significantly negative correlation with the dependent variable of symptoms of depression ( $r=-.42$ ,  $p<.05$ ). The moderator variable of religious practices had a significantly negative correlation with the

dependent variable of symptoms of depression ( $r=-.20$ ,  $p<.05$ ). The interaction variable which is comprised of the independent and moderator variables had a significantly negative correlation with the dependent variable of symptoms of depression ( $r=-.36$ ,  $p<.01$ ). Since it is best to have the moderator uncorrelated with both the independent and dependent variables to provide a clear moderator, this confirms that the hypothesis was not supported. There was a main effect of income adequacy but that was not relevant to the moderator hypothesis.



## CHAPTER V: Discussion

This study explored the relationship between financial poverty, parenting social support, religious coping, religious practices, and symptoms of depression among rural, low-income mothers. The study built on previous research examining the way in which social support, religious coping, and religious practices affect the occurrence of symptoms of depression. While research suggests that social support and religious coping and religious practices are protective factors against depression, there has been little research exploring these factors within a rural, low-income population. Research of religion as a protective factor or resource for rural, low-income mothers is especially scarce.

### *Characteristics of Rural Mothers*

This sample of rural, low-income mothers was two-thirds non-minority and one-third minority. The mean age was approximately 30. Slightly over half of the mothers were single, separated and divorced; the rest were married or lived with a partner. The majority of mothers had two children. The characteristics of this sample are representative of the rural, low-income mothers studied in the “Rural Families Speak” population thus far.

These mothers are truly the “working poor” with all of the mothers in the “In-Crisis” or “At-Risk” categories of poverty despite the fact that two-thirds of the mothers work both outside and inside the home. For a family of three, “At-risk” means less than \$15,000 per year in earnings, just above the poverty line (Institute for Women’s Policy Research, 2004).

Social support is a resource for providing instrumental and emotional support for mothers in their role as a parent. The mothers in this sample reported experiencing medium to high social support, a finding similar to that of other research on the “Rural Families Speak” study (Islam, 2004; Kohler et al., 2004; Simmons-Westcott, 2004; Simmons-Westcott & Braun, 2004; Walker & Reschke, 2003).

The mothers reported experiencing religious coping; nine-tenths reported getting strength and support from God; four-fifths reported coping with difficulties and stress by praying; and four-fifths reported using God’s guidance to make important life decisions. Additionally, these mothers experienced some of the family-neighborhood-church complex through religious practices as evidenced by the findings that approximately two-thirds reported belonging to a church or house of worship while approximately three-fourths of mothers and two-thirds of children attend church services and activities.

The wide-spread use of religion among this subsample of the larger, “Rural Families Speak” sample is similar to other analyses of the larger sample (Braun & Marghi, 2003, Garrison et al., in press; Vandergriff-Avery, 2001). The findings in this sample that rural, low-income mothers report using religious coping and religious practices confirms research that states that rural residents are likely to acknowledge and participate in religion (Arcury et al., 2000; Fischer, 1982).

Religious coping and perceiving support from God is highly correlated with self-esteem and tolerance for highly stressful situations (Chandler & Campbell, 2002; Maton, 1989). Religious coping possibly functioned against the risk factor of poverty in preserving the mental health of the majority (60%) of these rural, low-income mothers who did not show clinically significant depressive symptoms compared to the 40% who

did. Religious practices increase social relationships, improve poor health behaviors, decrease depression, and improve mental health (Strawbridge, Shema, Cohen, & Kaplan 2001). Religious practices could possibly have functioned against the risk factor of poverty in preserving the mental health of the majority of these mothers.

A greater percentage of mothers reported using religious coping than reported performing religious practices. Also, more mothers were performing religious practices than belonged to a church or house of worship. In traditional social science, “spirituality” represents the intrinsic relationship or connection to God, a supernatural reality; whereas “religion” represents the more extrinsic behavior of religious practices (Pargament, 1999; Marler & Hadaway, 2002). In this study, religious coping represented spirituality; religious practices, represented religion.

Although the majority of Americans see themselves as both spiritual and religious there is a trend towards Americans becoming “more spiritual” and “less religious”, in a sense, moving away from “institutionalized” religion to a more personal experience (Marler & Hadaway, 2002). There are many possibilities why mothers would utilize religious coping and not belong to a church (discord with the pastor, discord with the congregation, for example), or attend religious practices without belonging to a church (church shopping). Given, the prevalence of religion in this sample of rural, low-income mothers (only 4.5% do not use religious coping), it would be important to understand more about the use of religious coping, or spirituality, as a means of dealing with life--especially in relation to mental health.

### *The Relationship between Poverty and Depression*

Two-fifths (40%) of the mothers scored above 16 on the CES-D which is higher than the incidence of depression found in the general population (10-25%) (USDHHS, 2000). This finding is similar to the findings of other researchers on the “Rural Families Speak” studies (Braun & Rudd, 2002; Garrison et al., in press). Again, being similar to the mothers in the larger study is not surprising.

What is surprising is that when asked about the adequacy of their income, the majority of mothers 63 (54.8%) felt that they could afford about everything they want despite living in the “In-Crisis” and “At-Risk” poverty level. Given the mother’s high rate of depression, which typically lends itself to negative perceptions of the world, the mothers might be expected to report that their income was not at all adequate or meets necessities only. Several explanations are possible.

One possible explanation for this positive assessment of income adequacy might be found in the context of their residence. Perhaps having similar rural, low-income peers who are also living in poverty affects the perception of adequacy. In comparison with their friends, some of the mothers may indeed be able to afford about everything they want. Another plausible explanation might be found in the level of social support mothers reported receiving from others in the community including family members, spouses, and friends or groups. Both the instrumental and emotional support may attenuate not only their symptoms of depression but the effects of poverty on their perception of income adequacy. Still another explanation may lay in their interpretation of income and of adequacy. If these mothers are receiving support with economic value, they may be able to make their earned income stretch to meet most of their needs and would thus perceive

that their income is adequate. Further research is needed to determine why these mothers perceive their income to be adequate when their actual income has them living at or below the poverty line.

It was hypothesized that there would be a negative relationship with poverty and depression, such that as actual and perceived poverty was higher symptoms of depression would be lower. Bivariate correlations were conducted on the variables. Actual poverty showed no relationship with symptoms of depression. However, perceived poverty showed a negative relationship with symptoms of depression, as hypothesized, such that, as the mother's perception of economic situation and income adequacy was higher, their levels of depression were lower. In effect, this showed that the mother's perceptions may have more impact on mental health as measured by depressive symptoms than actual income may have on mental health as measured by depressive symptoms.

The finding that perceived poverty relates to symptoms of depression more than actual poverty supports the importance of understanding an individual's perception of a situation as described in Hill's (1949) roller coaster model of family response to crisis (McCubbin et al., 1980). Perception is critical in determining the severity of a stressor event because perception is the "meaning" given to the event (McCubbin et al., 1980). In this case, the meaning mothers gave to their economic situation and income adequacy may have been more important than how the family's income per family size compared to the poverty line.

It was hypothesized that there would be a positive association between age, actual and perceived poverty, and symptoms of depression. Bivariate correlations were

conducted on the variables. However, in this sample, there was no association between age, actual and perceived poverty, and symptoms of depression. A plausible explanation is that the sample is small in number and that the age range of the mothers is not broad enough to include a significant number of older mothers which might demonstrate an association between age, actual and perceived poverty, and symptoms of depression as noted in other research (Simmons-Westcott & Braun, 2004; Krause, 1998). Additional research would be needed to understand the age association.

It was hypothesized that minority mothers would experience higher levels of actual and perceived poverty compared to their White counterparts. Three *t*-tests were run to test the means. The hypothesis that minority mothers would experience higher levels of actual poverty was not supported. The hypothesis that minority mothers would experience higher levels of perceived poverty, both economic situation change and income adequacy was not supported. However, the means between the minority and non-minority mothers showed trends indicating that minority mothers experienced less improvement in their economic situation in the last year, more severe poverty, yet reported a better perception of the adequacy of their income.

To more accurately understand these relationships, higher numbers of minority mothers would be needed to discern whether the trends in the means do support the hypotheses that minority mothers will experience higher levels of actual and perceived poverty compared to their White counterparts. Additionally, the higher levels of perceived income adequacy could possibly be due to higher levels of social support, especially within the African American community, (Stark, 1974; Belle, 1990). Future

research would be needed to determine if higher levels of perceived income adequacy among minority mothers is associated with higher levels of social support.

*The Relationship between Social Support, Religious Coping, Religious Practices and Symptoms of Depression*

It was hypothesized that there would be a negative association between social support, religious coping, religious practices and symptoms of depression; such that when social support, religious coping, and religious practices were higher levels of depression were lower. Bivariate correlations were conducted on the variables. There were negative associations for parenting support and religious practices such that when parenting support and religious practices were higher, levels of depression were lower. However the negative association with religious coping and symptoms of depression was not significant.

Additionally, it was hypothesized that minority mothers would experience higher levels of social support, religious coping, religious practices and lower symptoms of depression compared to their White counterparts. Four *t*-tests were run to test the means. The hypothesis that minority mothers would experience higher levels of social support was not supported.

The hypothesis that minority mothers would experience higher levels of religious coping was supported. Given the context of racism and the role of the church for minority mothers, it is not surprising that religious coping was found to be used by minority mothers. Most of the minority sample was African American and for African Americans the role of the church has been to increase hope and a sense of control during the past period of slavery and currently during persistent discrimination and racism (Arcury et al.,

2000; Billingsley, 1999; Boyd-Franklin, 2003; Brody & Flor, 1998; Chandler and Campbell, 2002). For African American mothers, racism and sexism combine to produce a “double jeopardy”; being a low-income mother produces a “triple jeopardy” increasing risk for symptoms of depression. If African Americans, and other minorities, in this sample, believe that their lives are controlled by a higher being, that stressful events happen for a reason, that life is for spiritual growth, and that there will be heavenly recompense for earthy suffering, then they are dealing with the challenges of life through religious coping.

The hypothesis that minority mothers would experience higher levels of religious practices was not supported. However, the means between the minority and non-minority mothers showed trends indicating that minority mothers experienced more social support, more religious practices, and more symptoms of depression. To more accurately capture these relationships, higher numbers of minority mothers would be needed to discern whether the trends in the means do support the hypotheses that minority mothers will experience higher levels of social support, religious coping, religious practices and lower symptoms of depression, compared to their White counterparts.

In retrospect, the hypothesis stating that minority mothers would experience lower symptoms of depression was formed without taking advantage of the literature review on discrimination and racism experienced by minority mothers (Belle, 1990; Seccombe, 2002). In future research, this hypothesis should be amended to state that minority mothers would experience higher symptoms of depression due to discrimination and racism.



*The Moderation of Parenting Social Support, Religious Coping and Religious Practices on Symptoms of Depression*

It was hypothesized that (a) Parenting social support would moderate the effects of actual and perceived poverty on symptoms of depression; (b) Religious coping would moderate the effects of actual and perceived poverty on symptoms of depression; and (c) Religious practices would moderate the effects of actual and perceived poverty on symptoms of depression. The findings did not support the hypotheses. However, there was a trend showing that religious coping may moderate the effects of actual and perceived poverty on symptoms of depression. Several explanations as to why parenting social support, religious coping, and religious practices did not moderate the effects of financial poverty on symptoms of depression are possible.

It is plausible that the financial poverty reported by these mothers, as measured by actual and perceived poverty, is too severe for parenting social support, religious coping and religious practices to function as moderators. This explanation is highly likely given that the mothers are “In-Crisis” and “At-Risk” in the poverty line categories. It is plausible that while the mothers experienced medium to high parenting social support it may be that the instrumental and emotional support they reported receiving is primarily from family and friends in similar financial difficulties and is not enough to lift them out of severe poverty. It is also plausible that while religious coping showed a trend towards functioning as a moderator that it did not function as a moderator because no matter how much the mothers relied on their interpersonal relationship with God to cope with their financial struggles, belief in God is not money to pay bills or put food in the kitchen. Similarly, while the mothers were very active in religious practices it is plausible that

religious practices also did not function as a moderator because they socialized at church with people with similar financial difficulties.

However, the finding that parenting social support, religious coping and religious practices did not moderate the effects of actual and perceived poverty on symptoms of depression did not negate the findings that all of the variables but actual poverty had main effects on symptoms of depression including: perceived poverty (economic situation change and income adequacy), parenting social support, religious coping, and religious practices.

### *Ecological Framework*

It is important for researchers and therapists to interpret these findings in light of the ecological, stress and resiliency models. The findings from this study revealed evidence of resources in the micro, and mesosystem levels reinforcing the utility of the ecosystem theoretical framework. These rural, low-income mothers appeared to have strong interpersonal relationships with God, family, friends and others as evidenced by medium to high parenting social support, the use of religious coping, and the practices of going to church services and activities which may contribute to the lack of symptoms of depression among the majority of the mothers.

However, the study did not present evidence of sustained conditions over time. The chronosystem level incorporates the resiliency theory that risk and protective factors can change over time. In the macrosystem of the rural environment where these mothers lived, it's feasible that the interaction of actual poverty, economic situation change and income adequacy can change over time. It is also feasible that the mental health of the mothers (microsystem) might change depending on their situations and abilities to

withstand and rebound from chronic stress and disruptive life challenges. At all levels of systems, mothers might find challenges and resources to deal with those challenges.

Thus, a longitudinal examination of these mothers is necessary to test the time component of the ecological theory.

### *Limitations*

Although the current study provided an important contribution to literature in the area of rural financial poverty, parenting social support, religious coping, religious practices and symptoms of depression in mothers, there are a number of limitations that need to be considered.

First, this study involved the use of secondary data for analysis. The study from which the sample was drawn was not specifically designed to investigate how rural, low-income mothers cope with symptoms of depression. Therefore, only available measures could be used to examine the relationships of financial poverty, parenting social support, religious coping and religious practices on symptoms of depression.

A second limitation was the use of “The Parenting Ladder” to measure social support. This instrument is not a standardized measure of social support which makes it difficult to generalize the findings to other samples and populations. Additionally, the measure did not identify the sources of social support which could be useful to provide insight into how different types of social support affect the mother’s symptoms of depression.

A third limitation was the lack of information about religious affiliation on the “Role of Religious and Spiritual Beliefs” measure. Information about religious

affiliations would be useful to provide insight into how belonging to different religious affiliations may affect symptoms of depression.

A fourth limitation was the number and ratio of mothers grouped into each racial category. This study likely did not provide an accurate report of how actual and perceived poverty, parenting social support, religious coping, and religious practices affect symptoms of depression in rural, low-income mothers of all races. In addition, minority mothers, especially African American mothers, may not perceive poverty as much of a risk factor for symptoms of depression as the experience of discrimination and racism. Discerning whether poverty or racism was more associated with symptoms of depression for minority mothers was not explored in this study.

A fifth limitation of this study was that it is not longitudinal in nature and did not look at the variables chronologically over time which would incorporate the chronosystem level of the ecological framework. Belle (1990) recommends longitudinal studies of the relationship of financial poverty to depression to disentangle the implications of persistent poverty from those of short-term economic reverses. Additionally, studying the variables of perceived poverty, parenting social support, religious coping, religious practices and symptoms of depression over time would create a more accurate understanding of their complex interactions among rural, low-income mothers. It would be helpful to know, for example, if some of the mothers, for whom religion was salient, utilized negative instead of positive religious coping to handle life's challenges. According to the literature (Pargament et al., 1998), negative coping consists of experiencing a less secure relationship with God, an ominous view of the world, and a religious struggle for meaning which can contribute to depression.

A sixth limitation was the limited data collection on religious coping and practices since not all of the states collected that data. Because six states did not collect the data, the sample from Wave 2 was reduced from a potential 316 to 199. Also, some data were missing from those who did complete the other measures used for this study, reducing the sample size still further to a small sample size (n=115). This reduction in numbers affected the power of the statistical analysis and may have affected the findings.

A seventh limitation was the sample itself. There were a number of potential threats to external validity in this study. Findings can not be generalized because a non-probability sample was used and the sample was not randomly selected. To be recruited for the lengthy interviews required for this study most mothers experienced pre-existing relationships with a local community or social service agency which could have influenced their perceptions of social support or experience of symptoms of depression. Regional differences can be obscured when analyzing data from rural mothers from 14 different states all together.

Finally, the study relied on the use of quantitative data only. Qualitative data was collected which might be useful for a more comprehensive understanding of the relationships of the variables in this study.

## *Recommendations*

### *For Future Research*

The findings and limitations suggest a number of recommendations for future research:

1. This study highlighted the need for more qualitative and quantitative research in the area of risk and protective factors for mothers and their families living in rural poverty and at-risk for depression.

2. The chronosystem level needs to be included by conducting a longitudinal study of the factors included in this study with Wave 2, Wave 3, and future waves of the “Rural Families Speak” data to determine the effects of poverty on the onset and duration of depressive symptoms in rural, low-income mothers. Additionally, a longitudinal investigation of the factors in this study could evaluate if the risk factors for depression persist and if the protective factors continue over time.

One rationale for a longitudinal study is based on the findings related to perception of poverty. Among mothers who perceived that their income was adequate to meet their families' basic needs, depressive symptoms were less than for those mothers who did not perceive their income to be adequate. A longitudinal study would help to reveal if this was an aberrant finding or if it holds over time. If it is true, then further investigation is needed to determine why. It may be that needs are being met through barter, assistance from family and friends or public assistance and therefore, using adequacy of income may not be sufficient.

3. Future research could investigate the finding that there were higher levels of income adequacy in minority mothers. It could answer the question, “Is an increase in

parenting social support tied to increased income adequacy for minority mothers?” This finding bears investigating due to the highly correlated nature between perceived poverty and symptoms of depression. Additionally, poverty may be less of a significant risk factor for symptoms of depression among minority mothers than discrimination and racism. Future research could investigate the relationship of poverty and racism to see how each contributes to symptoms of depression among minority rural, low-income mothers. Independent tested measures of perceived poverty and racism could be used to explore the effects of poverty and racism on the symptoms of depression among minority mothers.

4. The sample could be modified to strengthen findings. A research design that includes a randomized rural and non-rural sample over time matched to a control group would improve the generalizability of the findings. It would also be helpful to expand to include a sample of varying levels of income to determine if these findings are limited to low-income mothers. Additionally, due to possible regional differences, research comparing rural samples from all regions of the country and varying types of rural counties would improve the utility of the findings.

5. For future studies, a standardized measure of social support should be used that would not limit the measure of social support to parenting social support; would measure other sources of social support; and would more accurately define the amount of social support each person is receiving. Such a measure would be helpful to improve the reliability and validity of the parenting social support findings.

6. Because of individual variations among social scientists in their definitions of the domains of religion and the lack of standardized measures of religiosity and

spirituality, it would be helpful for comparison of findings if definitions were standardized. Increased uniformity in definitions of the multiple constructs of religion would increase generalizability.

7. More sophisticated measurement instruments of religious coping and religious practices have been developed and could be used in the future. One example of a more thorough measure of religious coping developed by leaders in the field of the scientific study of religion (Pargament and Koenig, 1997) is the RCOPE Scale consisting of 104 indicators of over 21 different religious coping responses.

8. Data on religious affiliation is needed to ascertain differences between religious coping and religious practices among the wide variety of faith communities with which Americans identify (Dollahite et al., 2004).

9. Future research could investigate the reported differences in religious coping, religious practices and membership in a faith community to answer such questions as: “Do the higher numbers in religious coping compared to religious practices and membership in a faith community indicate a trend away from institutionalized religion to a more personal experience? Are the mothers dissatisfied with their congregation?” More inclusive language in the instruments such as “higher power” instead of God could include people who identify more with personal spiritual experiences than institutionalized religion.

10. While the average mother in this study had more symptoms of depression than the general population, the majority did not meet the diagnosis for depression according to the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV). Future



research could investigate the differences between mothers who experience symptoms of depression and mothers who do not experience symptoms of depression.

*For Mental Health & Social Services Professionals, Clergy and Public Policy*

The findings and limitations suggest a number of recommendations for consideration by mental health professionals and clergy as they seek to support rural, low-income mothers living in their communities.

The first recommendation is the incorporation into secular therapy of discussion that includes the domains of religious coping and religious practices for clients, for whom religion is salient, as recommended in previous literature (Chandler and Campbell, 2002; Odell, 2003; Prest, Russel, & Souza, 1999; Shafranske, 1996; Sperry, 2001). At least one study, Propst, Ostrom, Watkins, Dean and Mashburn (1992), found in a clinical trial treating depression in religious individuals, that religiously based psychotherapy produced the best results. Given the relationship of religious coping and practices to the mental health of these mothers, there is some evidence that supports this recommendation.

The second recommendation is the incorporation into religious therapy of secular ideas, such as screening parishioners for depression and referring to mental health providers for medication or additional therapy, if needed.

For the sake of their mutual communities, the third and final recommendation is for mental health organizations and religious organizations to build a working relationship (Bush, 2002). If the goal is to understand and treat the whole individual in therapy--body, mind, and spirit--then the practitioners in the fields of mental health and

religious service must lead the way in uniting these worlds for the benefit of their clients and parishioners.

### *Conclusion*

The main purpose of this study was to examine the relationships between financial poverty, parenting social support, religious coping, religious practices, and symptoms of depression among rural, low-income mothers. One would expect, given the fact that all of these mothers were very poor (“In-Crisis” and “At-Risk”) that the correlation between poverty and depression would be one to one, such that every poor mother would be depressed. However, this finding did not occur among the sample under investigation. Although the mothers experienced symptoms of depression higher than the average population, sixty percent of the mothers did not meet the DSM-IV diagnosis of clinical depression. A plausible interpretation could be that although these mothers are living in severe economic poverty, they draw on both internal and external resources to cope with life’s challenges. For this sample, the mothers relied on their social network, including their family-neighborhood-faith community complex and on a higher power.

Although the findings of the study did not support the hypotheses that parenting social support, religious coping, and religious practices moderated the effects of poverty on depression, the findings did suggest that there is a relationship between the factors, such that, for all mothers, the higher the perceived poverty, parenting social support, and religious practices, the lower the symptoms of depression. Additionally, for minority mothers, the higher the use of religious coping, the lower the symptoms of depression.

The finding that some factors were associated with lower levels of depression suggests a hopeful conclusion: While these mothers are financially poor, they may be rich in social support and religious faith.

APPENDIX A: Income and Making Ends Meet  
(Excerpted from NC-223 Multi-State Research Project)

Actual Poverty Questions:

Sources of Income	Weekly	Biweekly	Monthly	Other
Wages & Salaries (self)				
Wages & Salaries (partner)				
Tips, Commission, Overtime				
Social Security Disability				
Social Security Retirement/ Pensions				
Supplementary Security Income				
TANF				
Unemployment Compensation				
Worker's Disability Compensation				
Veteran's Benefits				
Child or Spousal Support				

Perceived Poverty Questions:

Compared with last year, would you say that your family's economic situation has...

**[CIRCLE NUMBER OF RESPONSE]**

- 5 Improved a lot
- 4 Improved a little
- 3 Remained the same
- 2 Gone down a little
- 1 Gone down a lot

To what extent do you think your income is enough for you to live on?

**[CIRCLE NUMBER OF RESPONSE]**

- 1 Not at all adequate
- 2 Can meet necessities only
- 3 Can afford some of the things we want but not all we want
- 4 Can afford about everything we want
- 5 Can afford about everything we want and still save money

APPENDIX B: Social Support Measure  
(Excerpted from “The Parenting Ladder”, Richards, 1998)

**THE PARENTING LADDER**

- 6 High
- 5
- 4
- 3 Medium
- 2
- 1
- 0 Low

**Parenting is often smoother when others are there to help. Where would you put yourself on the Parenting ladder in terms of:**

- Other parents for you to talk to? \_\_\_\_\_
- Someone to help you in an emergency? \_\_\_\_\_
- Someone to offer helpful advice or moral support? \_\_\_\_\_
- Someone for you to relax with? \_\_\_\_\_
- Professional people to talk to when you have a question about your child? \_\_\_\_\_
- Your overall satisfaction with the amount of support in your life? \_\_\_\_\_

APPENDIX C: Role of Religious or Spiritual Beliefs  
(Excerpted from Krause, 1988)

We want to know the extent to which you agree with the following:

1. When dealing with difficult times in my life. I get much personal strength and support from God. (Circle the number of your answer.)

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

2. Prayer helps me cope with difficulties and stress in my life. (Circle the number of your answer.)

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

3. It is important to see God's guidance when making every important decision in life. (Circle the number of your answer.)

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Here are some statements about the extent and role of religious or spiritual beliefs in a person's life.

4. Are you a member of a church or other place of worship? (Circle the number of your answer.)      YES                      NO

5. How often do you attend religious services? (Circle the number of your answer.)

- 6 Nearly every day
- 5 At least once a week
- 4 A few times a month
- 3 Once a month or so
- 2 A few times a year
- 1 Never

6. How often do you participate in religious activities other than religious services? I am thinking of things like adult Sunday school classes, Bible study groups, or prayer groups.

(Circle the number of your answer.)

- 6 Nearly every day
- 5 At least once a week
- 4 A few times a month
- 3 Once a month or so
- 2 A few times a year
- 1 Never

7. Are your children active in church or other religious activities? If so, how often do they participate? (Circle the number of your answer.)

- 6 Nearly every day
- 5 At least once a week
- 4 A few times a month
- 3 Once a month or so
- 2 A few times a year
- 1 Never

## APPENDIX D: Depression Measure

(Excerpted from “The CES-D Scale, A Self-Report Depression Scale for Research in the General Population, Radloff, 1977)

### **During the Past Week:**

1. I was bothered by things that don't usually bother me.
  - a. Rarely or None of the Time
  - b. Some or a Little of the Time
  - c. Occasionally or a Moderate Amount of Time
  - d. Most or All of the Time
  
2. I did not feel like eating; my appetite was poor.
  - a. Rarely or None of the Time
  - b. Some or a Little of the Time
  - c. Occasionally or a Moderate Amount of Time
  - d. Most or All of the Time
  
3. I felt that I could not shake the blues even with help from my family and friends.
  - a. Rarely or None of the Time
  - b. Some or a Little of the Time
  - c. Occasionally or a Moderate Amount of Time
  - d. Most or All of the Time
  
4. I felt that I was just as good as other people.
  - a. Rarely or None of the Time
  - b. Some or a Little of the Time
  - c. Occasionally or a Moderate Amount of Time
  - d. Most or All of the Time
  
5. I had trouble keeping my mind on what I was doing.
  - a. Rarely or None of the Time
  - b. Some or a Little of the Time
  - c. Occasionally or a Moderate Amount of Time
  - d. Most or All of the Time
  
6. I felt depressed.
  - a. Rarely or None of the Time
  - b. Some or a Little of the Time
  - c. Occasionally or a Moderate Amount of Time
  - d. Most or All of the Time



7. I felt that everything I did was an effort.
  - a. Rarely or None of the Time
  - b. Some or a Little of the Time
  - c. Occasionally or a Moderate Amount of Time
  - d. Most or All of the Time
  
8. I felt hopeful about the future.
  - a. Rarely or None of the Time
  - b. Some or a Little of the Time
  - c. Occasionally or a Moderate Amount of Time
  - d. Most or All of the Time
  
9. I thought my life had been a failure.
  - a. Rarely or None of the Time
  - b. Some or a Little of the Time
  - c. Occasionally or a Moderate Amount of Time
  - d. Most or All of the Time
  
10. I felt fearful.
  - a. Rarely or None of the Time
  - b. Some or a Little of the Time
  - c. Occasionally or a Moderate Amount of Time
  - d. Most or All of the Time
  
11. My sleep was restless.
  - a. Rarely or None of the Time
  - b. Some or a Little of the Time
  - c. Occasionally or a Moderate Amount of Time
  - d. Most or All of the Time
  
12. I was happy.
  - a. Rarely or None of the Time
  - b. Some or a Little of the Time
  - c. Occasionally or a Moderate Amount of Time
  - d. Most or All of the Time
  
13. I talked less than usual.
  - a. Rarely or None of the Time
  - b. Some or a Little of the Time
  - c. Occasionally or a Moderate Amount of Time
  - d. Most or All of the Time

14. I felt lonely.
- Rarely or None of the Time
  - Some or a Little of the Time
  - Occasionally or a Moderate Amount of Time
  - Most or All of the Time
15. People were unfriendly.
- Rarely or None of the Time
  - Some or a Little of the Time
  - Occasionally or a Moderate Amount of Time
  - Most or All of the Time
16. I enjoyed life.
- Rarely or None of the Time
  - Some or a Little of the Time
  - Occasionally or a Moderate Amount of Time
  - Most or All of the Time
17. I had crying spells.
- Rarely or None of the Time
  - Some or a Little of the Time
  - Occasionally or a Moderate Amount of Time
  - Most or All of the Time
18. I felt sad.
- Rarely or None of the Time
  - Some or a Little of the Time
  - Occasionally or a Moderate Amount of Time
  - Most or All of the Time
19. I felt that people disliked me.
- Rarely or None of the Time
  - Some or a Little of the Time
  - Occasionally or a Moderate Amount of Time
  - Most or All of the Time
20. I could not “get going.”
- Rarely or None of the Time
  - Some or a Little of the Time
  - Occasionally or a Moderate Amount of Time
  - Most or All of the Time

## References

- Agnes, M., & Guralnik, D.B. (Eds.). (2001). *Webster's new world college dictionary* (4<sup>th</sup> ed.) Foster City, CA: IDG Books Worldwide, Inc.
- Albright, M., & Tamis-LeMonda, C. (2002). Maternal symptoms of depression in relation to dimensions of parenting in low-income mothers. *Applied Developmental Science, 6*(1), 24-34.
- Ahluwalia, S.K., McGroder, S.M., Zaslow, M.J., & Hair, E.C. (2001). *Symptoms of depression among welfare recipients: A concern for two generations*. Washington: DC: Child Trends.
- Anderson, E.A., Braun, B., Oravec, L., & Kohler, J. (2003). Relationship constellation and dynamics of low-income mothers: Implications for marriage-promotion policy initiatives. *National Council on Family Relations: Focus on Rural America*, F4-F5.
- Aponte, H. (2003). The soul of the marriage and family therapist. *Family Therapy Magazine, 2*(5), 14-19.
- Arcury, T.A., Quandt, S.A., McDonald, J., & Bell, R.A. (2000). Faith and self management of rural older adults. *Journal of Cross-Cultural Gerontology, 15*, 55-74.
- Barling, J. (1990). *Employment, stress, and family functioning*. New York: Wiley.
- Baron, R.M., & Kenny, D.A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology, 51*(6), 1173-1182.
- Barrera, M., Jr. (1986). Distinctions between social support concepts, measures, and

- models. *American Journal of Community Psychology*, 14(4), 413-441.
- Bauer, J.W., Braun, B., & Olson, P.D. (2000). Welfare to well-being framework for research, education, and outreach. *The Journal of Consumer Affairs*, 34(1), 62-80.
- Becvar, D. S. (2003). Utilizing spiritual resources as an adjunct to family therapy. *Family Therapy Magazine*, 2(5), 31-33.
- Belle, D. (1982). *Lives in stress: Women and depression*. Beverly Hills, CA: Sage.
- Belle, D. (1990). Poverty and women's mental health. *American Psychologist*, 45(3), 385-389.
- Belsky, J. (1984). The determinants of parenting: A process model. *Child Development*, 55, 83-96.
- Bergen, A., & McConatha, J.T. (2000). Religiosity and life satisfaction. *Activities, Adaptation, and Aging*, 24(3), 23-34.
- Billingsley, A. (1999). *Mighty like a river: The Black church and social reform*. Oxford, New York: Oxford University Press.
- Bokemeier, J.L., & Garkovich, L.E. (1991). Meeting rural family needs. In C.B. Flora, & J.A. Christenson (Eds.), *Rural policies for the 1990s* (pp. 114-127). Boulder, CO: Westview Press.
- Boss, P. (2001). *Family stress management: A contextual approach*. Newbury Park, CA: Sage Publications.
- Boss, P. (2002). *Family stress management: A contextual approach*, (2<sup>nd</sup> ed.). Thousand Oaks, CA: Sage Publications.
- Boyd-Franklin, N. (2003). *Black families in therapy: Understanding the African American experience* (2<sup>nd</sup> ed.) (pp.52-72). New York: The Guilford Press.

- Braam, A.W., van den Eeden, P., Prince, M.J., Beekman, A.T.F., Kivelae, S.L., & Lawlor, B.A. (2001). Religion as a cross-cultural determinant of depression in elderly Europeans: Results from the EURODEP collaboration. *Psychological Medicine, 31*, 803-814.
- Braun, B., & Marghi, J.R. (2003). Rural families speak: Faith, resiliency, and life satisfaction among low-income mothers. *Michigan Family Review, 8*(1), 9-18.
- Braun, B., & Rudd, M. (2002). Individual and family factors associated with depressive symptoms among rural, low-income women. *Presentation at the National Rural Women's Health Conference*, Washington, D.C., September 2002.
- Brody, G., & Flor, D. (1998). Maternal resources, parenting practices, and child competence in rural single-parent African-American families. *Child Development, 69*(3), 813-816.
- Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge, MA: Harvard University Press.
- Bronfenbrenner, U. (1986). Ecology and the family as a context for human development: Research perspectives. *Developmental Psychology, 22*(6), 723-742.
- Bronfenbrenner (1989). Ecological systems theory. In R. Vasta (Ed.), *Six theories of child development: Revised formulations and current issues* (pp. 185-246). Greenwich, CT: JAI Press.
- Bruce, M.L., Takeuchi, D., & Leaf, P.J. (1991). Poverty and psychiatric status. *Archives of General Psychiatry, 48*, 470-474.
- Bubolz, M.M. & Sontag, M.S. (1993). Human ecology theory. In P. Boss, W. Doherty, R. LaRossa, W. Schumm, & S. Steinmetz (Eds.) *Sourcebook of family theories*

- and methods* (pp. 419-448). New York: Plenum Press.
- Bush, G. (2002). President Bush implements key elements of his faith-based initiative. Retrieved March 7, 2003 from <http://www.whitehouse.gov/news/releases>.
- Butler, M.A., & Beale, C.L. (1994). *Rural-urban continuum codes of metro and non-metro counties, 1993*. (Staff Report No. 9425), Agricultural and Rural Economy Division, Economic Research Service, Washington, D.C.: USDA.
- Carlson, T.D., Kirkpatrick, D., Hecker, L., & Killmer, M. (2002). Religion, spirituality, and marriage and family therapy: A study of family therapist's beliefs about the appropriateness of addressing religious and spiritual issues. *The American Journal of Family Therapy, 30*, 157-171.
- Chandler, A.A., & Campbell, C.D. (2002). *Barricades to benefits: Religion as a rural woman's resource*. Newberg, OR: Graduate School of Clinical Psychology, George Fox University.
- Christenson, J.A., & Flora, C.B. (1991). A rural policy agenda for the 1990s. In C.B. Flora & J.A. Christenson (Eds.). *Rural Policies for the 1990s* (pp. 333-337). Boulder, CO: Westview Press.
- Coiro, M.J. (2001). Symptoms of depression among women receiving welfare. *Women Health, 32*, 1-23.
- Conger, R. D., Lorenz, F. O., Elder, G. H., Simons, R. L., & Ge, X. (1993). Husband and wife differences in response to undesirable life events. *Journal of Health and Social Behavior, 1993, 34*, 71-88.
- Cowan, P., Cowan, C., & Schultz, M. (1996). Thinking about risk and resilience in families. In E. Hetherington & E. Blechman (Eds.), *Stress, coping, and resiliency*

- in children and families: Family research consortium-advances in family research*, (pp. 1-38). Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.
- Danziger, S.K., Kalil, A., & Anderson, N.J. (2000). Human capital, health and mental health of welfare recipients: Co-occurrences and correlates. *Journal of Social Issues*, 54, 637-656.
- DeHaan, L., Hawley, D.R., Deal, J.E. (2002). Operationalizing family resilience: A methodological strategy. *The American Journal of Family Therapy*, 30, 275-291.
- Dill, D., & Feld, E. (1982). The challenge of coping. In D. Belle (Ed.), *Lives in stress: Women and depression* (pp. 145-161). Beverly Hills, CA: Sage.
- Dohrenwend, B.S. (1973). Social status and stressful life events. *Journal of Personality and Social Psychology*, 28, 225-235.
- Dolan, T.E., Seiling, S., Braun, B., & Katras, M.J. (2002). Rural families speak: The challenge of employment. *National Council on Family Relations Report: Family Focus*, 47, F4-F5.
- Dollahite, D.C., Marks, L.D., & Goodman, M.A. (2004). Families and religious beliefs, practices, and communities: Linkages in a diverse and dynamic cultural context. In M.J. Coleman & L.H. Ganong (Eds.), *The handbook of contemporary families: Considering the past, contemplating the future*. Thousand Oaks: Sage.
- Dunst, C.J., Trivette, C.M., Hamby, D., & Pollack, B. (1990). Family systems correlates of the behavior of young children with handicaps. *Journal of Early Intervention*, 14, 204-218.
- Ebaugh, H.R. (2002). Presidential address 2001, return of the sacred: Reintegrating religion in the social sciences. *Journal for the Scientific Study of*

*Religion*, 41(3), 385-395.

Edin, K., & Lein, L. (1997). *Making ends meet*. New York: Russell Sage Foundation.

Ellis, A. (1980). Psychotherapy and atheistic values: A response to A.E. Bergin's "Psychotherapy and religious values." *Journal of Consulting and Clinical Psychology*, 48, 635-639.

Ellison, C. G. (1994). Religion, the life stress paradigm, and the study of depression. In J.S. Levin (Ed.), *Religion in aging and health: Theoretical foundations and frontiers* (pp. 78-121). Thousand Oaks, CA: Sage.

Ensel, W. (1986). Measuring depression: The CES-D scale. In N. Lin, A. Dean, & M. Ensel (Eds.), *Social support, life events, and depression* (pp. 51-70). New York: Academic Press, Inc.

Ferner, K.E. (2003). Mind-body-spirit: Treating the whole person. *Paradigm*, 7(1), 8-9.

Fischer, C. (1982). *To dwell among friends: Personal networks in town and city*. Chicago: University of Chicago.

Freud, S. (1933/1961). A religious experience. In S. Freud (Ed.), *The standard edition of the complete works of Sigmund Freud* (pp. 169-172). London: Hogarth. (Original work published in 1933).

Garrison, M. E. B., Marks, L.D., Lawrence, F.C., & Braun, B. (in press). The influence of religious beliefs and practices on depression: A study of rural, low-income mothers. *Journal of Family Relations*.

George, L.K., Larson, D.B., Koenig, H.G., & McCullough, M.E. (2000). Spirituality and health: What we need to know, what we need to know. *Journal of Social and Clinical Psychology*, 19, 102-116.



- Gottlieb, B.H. (1997). *Coping with chronic stress*. New York: Plenum.
- Hackney, C.H., & Sanders, G.S. (2003). Religiosity and mental health: A meta-analysis of recent studies. *Journal for the Scientific Study of Religion*, 42(1), 43-55.
- Hall, L.A., Williams, C.A., & Greenberg, R.S. (1985). Supports, stressors, and depressive symptoms in low-income mothers of young children. *American Journal of Public Health*, 75(5), 518-522.
- Hanline, M.F., & Daley, S.E. (1992). Family coping strategies and strengths in Hispanic, African-American, and Caucasian families of young children. *Topics in Early Childhood Education*, 12, 351-366.
- Harden, B., & Koblinsky, S. (1999). Double exposure: Children affected by family and community violence. In R.L. Hampton (Ed.), *Family Violence: Prevention and treatment* (2<sup>nd</sup> ed) (pp. 66-101). Thousand Oaks, CA: Sage.
- Harvard Medical School, Harvard, Harvard Mental Health Letter. (2004, May). Women and depression. Retrieved June 1, 2004, from the Harvard Mental Health Letter Web site: <http://www.health.harvard.edu>
- Hawley, D.R. (2000). Clinical implications of family resilience. *The American Journal of Family Therapy*, 28, 101-116.
- Hill, R. (1949). *Families under stress*. New York: Harper and Row.
- Hinkle, D. E., Wiersma, W., Jurs, S.G. (1998). *Applied statistics for the behavioral Sciences*, (4<sup>th</sup> Ed.). Boston: Houghton Mifflin Company.
- Hoogestraat, T. & Trammel, J. (2003). Spiritual and religious discussions in family therapy: Activities to promote dialogue. *The American Journal of Family Therapy*, 31(413), 413-426.

- Institute for Women's Policy Research (2004). Still a man's labor market: The long term earnings gap. Retrieved June 24, 2004, from <http://www.iwpr.org/pdf/LongTermPR6-4-04.pdf>
- Islam, J. S. (2004). Marital relationship status, social support and psychological well-being among rural, low-income mothers. Unpublished master's thesis. University of Maryland.
- Jacob, T., & Johnson, S. (1997). Parent-child interaction among depressed fathers and mothers: Impact on child functioning. *Journal of Family Psychology, 11*(4), 391-409.
- Jacobson, C.K., Heaton, T.B., & Dennis, R.M. (1990). Black-White differences in religiosity: Item analysis and a formal structural test. *Sociological Analysis, 51*, 257-270.
- Jayakody, R., Danziger, S., & Pollack, H. (2000). Welfare reform, substance abuse and mental health. *Journal of Health Politics, Policy and Law, 25*, 623-651.
- Katras, M.J., Dolan, E.M., Braun, B., & Seiling, S. (2002). Rural families speak: Making ends meet after welfare reform. *National Council on Family Relations Report: Family Focus, 47*, F3-F4.
- Kessler, R.C., McGonagle, K.A., Zhao, S., & Nelson, C.B. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. *Archives of General Psychiatry, 51*(1), 8-19.
- Klein, D.M., & White, J.M. (1996). *Family theories: An introduction* (pp. 211-240). U.S.: Sage Publications.
- Koenig, H.G. (Ed.) (1998). *Handbook of religion and health*. San Diego, CA: Academic.

- Koenig, H. G., (2002). *Spirituality in patient care: Why, how, when and what*. Philadelphia: Templeton Foundation Press.
- Koenig, H.G., George, L.K., & Peterson, B.L. (1998). Religiosity and remission of expression in medically ill older patients. *American Journal of Psychiatry*, 155, 536-542.
- Koenig, H.G., McCullough, M.E., & Larson, D.B. (2001). *Handbook of religion and health*. New York: Oxford University Press.
- Koenig, H. G., Smiley, M., & Gonzales, J.A. (1988). *Religion, health, and aging*. New York: Greenwood.
- Kohler, J.K., Anderson, E.A., Oravec, L., & Braun, B. (2004). Relationship constellations and dynamics of low-income rural mothers. *Affilia: Journal of Women and Social Work*, 19, (2), 160-173.
- Krause, N. (1998). Neighborhood deterioration, religious coping, and changes in health during late life. *The Gerontologist*, 38, 6, 653-664.
- Krause, N., Liang, J., & Gu, S. (1998). Financial strain, received support, and anticipated support in the P.R. C., *Psychology and Aging*, 13, 56-68.
- Krause, N., & Tran, T. (1989). Stress and religious involvement among older Blacks *Journal of Gerontology: Social Sciences*, 44, 54-513.
- Lennon, M.C., Blome, J., & English, K. (2001). *Depression and low-income women: Challenges for TANF and welfare-to-work policies and programs*. New York: NY: National Center for Children in Poverty, Columbia University.
- Leticq, B.A., Anderson, E.A., & Koblinsky, S. A. (1998). Parenting social support of homeless and housed mothers: A comparison of temporary and permanent

- housing arrangements. *Family Relations*, 47, 415-422.
- Mahoney, A., Pargament, K.I., Tarakeshwar, N., & Swank, A.B. (2001). Religion in the home in the 1980s and 90s: A meta-analytic review and conceptual analyses of links between religion, marriage and parenting. *Journal of Family Psychology*, 15, 559-596.
- Makosky, V. (1982). Sources of stress: Events or conditions? In D. Belle (Ed.), *Lives in stress: Women and depression* (pp. 35-53). Beverly Hills, CA: Sage.
- Marler, P.L., & Hadaway, C.K. (2002). "Being Religious" or "Being Spiritual" in America: A zero-sum proposition. *Journal for the Scientific Study of Religion*, 41(2), 289-300.
- Maton, K. (1989). The stress-buffering role of spiritual support: Cross-sectional and prospective investigations. *Journal for the Scientific Study of Religion*, 28(3), 310-323.
- Mazure, C.M., Keita, G.P., & Blehar, M.C. (2002). *Summit on women and depression: Proceedings and recommendations*. Washington, DC: American Psychological Association.
- McAdoo, H. (1986). Strategies used by Black single mothers against stress. In M. Simms, & J. Malveaux (Eds.), *Slipping through the cracks: The status of Black women* (pp. 153-166). New Brunswick, NJ: Transaction Books.
- McCubbin, H.I., Joy, C.B., Cauble, A.E., Comeau, J.K., Patterson, J.M., & Needle R.H. (1980). Family stress and coping: A decade review. *Journal of Marriage and the Family*, 42(4), 855-871.
- McLoyd, V.C. (1990). The impact of economic hardship on Black families and children:

- Psychological distress, parenting and socio-economic development. *Child development*, 6(2), 311-346.
- McLoyd, V.C. (1998). Socioeconomic disadvantage and child development. *American Psychologist*, 53, 185-204.
- McWilliams, N. (2001). Psychodynamic Case Conceptualization. *Seattle Psychoanalytic Institute*. Presented on February, 12, 2001.
- Meyers, S.A., Varkey, S., Aguirre, A.M. (2002). Ecological correlates of family functioning. *The American Journal of Family Therapy*, 30, 257-273.
- Milardo, R. (1987). Changes in social networks in women and men following divorce: A review. *Journal of Family Issues*, 8, 78-96.
- Mills, R. J., Grasmick, H. G., Morgan, C. S., & Wenk, D. A. (1992). The effects of gender, family satisfaction, and economic strain on psychological well-being. *Family Relations*, 41, 440-445.
- Mithchell, J., & Weatherly, D. (2000). Beyond church attendance: Religiosity and mental health among rural older adults. *Journal of Cross Cultural Gerontology*, 15, 37-54.
- Mulder, P.L., Kendel, M.B., & Shellenberger, S. (1999). The behavioral health care needs of rural women. *American Psychological Association*. Retrieved April 24, 2004, from <http://www.apa.org/rural/ruralwomen.pdf>
- Murray, C.J., & Lopez, A.D. (1996). Alternative visions of the future: Projecting mortality and disability, 1990-2020. In J.C. Murray and A.D. Lopez (Eds.), *The global burden of disease: A comprehensive assessment of mortality and disability*

- from diseases, injuries and risk factors in 1990 and projected to 2020* (pp. 325-395). Boston: Harvard University Press.
- Neugebauer, D.D., Dohrenwend, B.P., & Dohrenwend, B.S. (1980). The formulation of hypotheses about the true prevalence of functional psychiatric disorders among adults in the United States. In B.P. Dohrenwend, B.S., Dohrenwend, M.S., Gould, B., Link, R., Neugebauer, & R. Wunsch-Hitzig (Eds.), *Mental Illness in the United States* (pp. 45-94). New York: Praeger.
- Odell, M. (2003). Intersecting worldviews: Including vs. imposing spirituality in therapy. *Family Therapy Magazine*, 2(5), 26-30.
- Olson, S.L. & Banyard, V. (1993). Stop the world so I can get off for a while: Sources of daily stress in the lives of low-income single mothers of young children. *Family Relations*, 42(1), 50-56.
- Pargament, K.I. (1997). *The psychology of religion and coping*. New York, NY: Guilford.
- Pargament, K.I. (1999). The psychology of religion and spirituality? Yes and no. *International Journal for the Psychology of Religion*, 9, 3-16.
- Pargament, K., Smith, B., Koenig, H., & Perez, L. (1998). Patterns of positive and negative religious coping with major life stressors. *Journal for the Scientific Study of Religion* 37(4), 710-724.
- Peterson, S.M., & Albers, A.B. (2001). Effects of poverty and maternal depression on early child development. *Child Development*, 72(6), 1794-1813.
- Prest, L.A., Russel, R., & D'Souza, H. (1999). Spirituality and religion in training, practice and personal development. *Journal of Family Therapy*, 21, 60-77.

- Propst, L.R., Ostrom, R., Watkins, P., Dean, T., & Mashburn, D. (1992). Comparative efficacy of religious and nonreligious cognitive-behavior therapy for the treatment of clinical depression in religious individuals. *Journal of Consulting and Clinical Psychology, 60*, 94-103.
- Putnam, R.D. (2000). *Bowling alone*. New York: Simon & Schuster.
- Radloff, L.S. (1977). The CES-D Scale: A self report depression scale for research in the general population. *Applied Psychological Measurement, 1*, 385-401.
- Radloff, L., & Locke, B. (1986). The community mental health assessment survey and the CES-D Scale. In M. Weissman, J. Myers, & C. Ross (Eds.), *Community surveys of psychiatric disorders* (pp. 177-189). New Brunswick, NJ: Rutgers University Press.
- Rank, M.R. (2000). Socialization of socioeconomic status. In W.C. Nichols, M.A. Pace-Nichols, D. S. Becvar, & A.Y. Napier (Eds.), *Handbook of family development and intervention* (pp. 129-144). New York: Wiley.
- Rank, M.R. (2001). The effect of poverty on America's families: Assessing our research knowledge. *Journal of Family Issues, 22*, 882-903.
- Rank, M.R., & Hirschl, T.A. (1999a). The economic risk of childhood in America: Estimating the probability of poverty across the formative years. *Journal of Marriage and the Family, 61*, 1058-1067.
- Rank, M.R., & Hirschl, T.A. (1999b). The likelihood of poverty across the American adult lifespan. *Social Work, 44*, 201-216.
- Reinherz, H., Giaconia, R., Hauf, A.C., Wasserman, M., & Silverman, A. (1999). Major depression in the transition to adulthood: Risks and impairments. *Journal of*

*Abnormal Psychology, 108, 500-510.*

Richards, L.N. (1989). The precarious survival and hard-won satisfaction of White single-parent families. *Family Relations, 38, 396-403.*

Richards, L. N. (1998). One step at a time: A report on the outcomes of Oregon's 1996/1997 Even Start Programs. Prepared for Oregon Even Start Programs and Department of Community Colleges & Workforce Development. Corvallis, OR: College of Home Economics and Education, Oregon State University.

Richards, Pamulapati, Corson, & Merrill (2000). "I used to have my head down all the time. Now it's up." A report on the outcomes of Oregon's 1998/1999 Even Start Programs. *A report prepared for Oregon Even Start Programs and Department of Community Colleges and Workforce Development.*

Riley, D., & Eckenrode, J. (1986). Social ties: Subgroup differences in costs and benefits. *Journal of Personality and Social Psychology, 51, 770-778.*

Robins, L.N., & Regier, D.A. (Eds.). (1990). *Psychiatric disorders in America.* Ontario, Canada: Collier MacMilan.

Robinson, J., Shaver, P., & Wrightsman, L. (1991). Criteria for scale selection and evaluation. In J.P. Robinson, L. Wrightsman, & P. Shaver (Eds.), *Measures of personality and social psychological attitudes* (vol. 1) (pp. 1-24). San Diego: Academic Press.

Ross, C.E., & Huber, J. (1985). Hardship and depression. *Journal of Health and Social Behavior, 26, 312-327.*

Rutter, M. (1989). Pathways from childhood to adult life. *Journal of Child Psychology and Psychiatry, 30, 23-51.*



- Sanderson, C.A. (2004). *Health psychology* (pp. 180-212). Hoboken, NJ: John Wiley & Sons, Inc.
- Seccombe, K. (2002). 'Beating the odds' versus 'changing the odds': Poverty, resilience, and family policy. *Journal of Marriage and Family*, 64(2), 384-395.
- Seidlitz, L., Abernathy, A.D., Duberstein, P.R., Evinger, J.S., Chang, T.H., & Lewis, B.L. (2002). Development of the Spiritual Transcendent Index. *Journal for the Scientific Study of Religion*, 41(3), 439-453.
- Seybold, K.S., & Hill, P.C. (2001). The role of religion and spirituality in mental and physical health. *Current Directions in Psychological Science*, 10, 21-24.
- Shafranske, E.P. (Ed.). *Religion and the clinical practice of psychology*. Washington, D.C.: American Psychological Association.
- Shonkoff, J.P., & Phillips, D.A. (2000). *From neurons to neighborhoods: The science of early childhood development*. Washington, D.C.: National Academy of Sciences.
- Simmons-Wescott, L.A. (2004). Well being in a rural context: A model of select factors influencing health and economic well-being in rural, low-income mothers. Unpublished doctoral dissertation, University of Georgia, Athens.
- Simmons-Wescott, L.A., & Braun, B. (2004). Depression: A deterrent to psychological well-being among poor, rural mothers. *National Council on Family Relations Report*, F5-F7.
- Smith, T.B., McCullough, M.E., & Poll, J. (2003). Religiousness and depression: evidence for a main effect and the moderating influence of stressful life events. *Psychological Bulletin*, 129(4), 614-636.

- Sperry, L. (2001). *Spirituality in Clinical Practice: Incorporating the spiritual dimension in psychotherapy and counseling*. Philadelphia, PA: Brunner-Routledge.
- Stack, C. (1974). *All our kin: Strategies for survival in a Black community*. New York: Harper & Row.
- Strawbridge, W.J., Shema, S.J., Cohen, R.D., Kaplan, G.A. (2001). Religious attendance increases survival by improving and maintaining good health behaviors, mental health, and social relationships. *Annual Meeting of the Society of Behavioral Medicine*, 23(1), 68-74.
- Thomas, D.L., & Cornwall, M. (1990). Religion and family in the 1980s: Discovery and development. *Journal of Marriage and the Family*, 52, 983-992.
- Todd, J.L. & Worell, J. (2000). Resilience in low-income, employed, African American women. *Psychology of Women Quarterly*, 24, 119-128.
- Tyler, C.M. (2004). Role of maternal support and church attendance in moderating the relationship between maternal depression and African-American preschooler's behavior problems. Unpublished doctoral dissertation, University of Maryland, College Park.
- U.S. Department of Health and Human Services/Public Health Services. (1992). *Healthy People 2000: National health promotion and disease prevention objectives*. Boston: Jones & Bartlett.
- U.S. Department of Health & Human Services. (2002). One department Serving Rural America: Rural Task Force Report to the Secretary. Retrieved April 24, 2004, from <http://www.ruralhealth.hrsa.gov/PublicReport.htm>.
- U.S. Census Bureau (2003). Poverty: 1999, Census 2000 Brief. Retrieved March 24,

2004, from [www.census.gov/prod/2003\\_pubs](http://www.census.gov/prod/2003_pubs)

- Vandergriff-Avery, M. (2001). Rural families speak: A qualitative investigation of stress protective and crisis recovery strategies utilized by rural, low-income women and their families (Doctoral dissertation, University of Maryland, 2001). *Dissertation Abstracts International: A*, 62/12, 4350.
- Vandivere, S., Moore, K.A., & Zaslow, M. (2000). *Children's family environment: Snapshots of America's families II: A view from the nation and 13 states*. Washington, D.C.: The Urban Institute.
- Walker, S.K., & Reschke, K. (2003). Child-care issues facing contemporary rural families. *National Council on Family Relations Report*, F5-F6.
- Walsh, F. (2003). Family resilience: A framework for clinical practice. *Family Process*, 42(1), 1-18.
- Wilder, L.K. (2002). School of Family Life at Brigham Young University. *Marriage & Families*, 3-8.
- Willitis, F.K., & Crider, D.M. (1988). Religion and well-being: Men and women in the middle years. *Review of Religious Research*, 29, 281-294.
- Wolf, B. (1987). Low-income mothers at risk: The psychological effects of poverty related stress. Unpublished doctoral dissertation, Harvard Graduate School of Education, Cambridge.