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Internalizing Symptoms Associated with Emotional Abuse: An Examination of Religious Social Support as a Moderating Variable

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Abstract

Emotional abuse in childhood is linked to an increased risk for internalizing symptoms such as depression and anxiety in adulthood. Religious social support offers a promising defense in maintaining mental well-being in the face of trauma. This study aims to investigate if religious social support in childhood will moderate the impact of negative outcomes associated with emotional abuse. Further, this study will examine whether and how gender and ethnicity impact this relationship. The sample includes undergraduate students attending East Tennessee State University, located in the southeastern United States (n = 471, 73% female, 11% African American, M age = 20.37, SD = 4.84). Participants completed an online survey that asked about childhood experiences (e.g., emotional abuse, emotion socialization, religious social support) as well as current mental health (e.g., anxiety, depression). Data was analyzed using Statistical Software for the Social Sciences. Bivariate relations were examined through Pearson's correlations and moderated moderation was tested via the Hayes Process Macro (version 3.0, Model 3). Results indicated that religious social support from childhood was negatively related to depression and anxiety whereas negative religious experiences from childhood were positively related to depression and anxiety. Harsh emotion parenting from childhood was positively related to depression and anxiety in adulthood. Results did not find support for moderated moderation for predicting depression or anxiety. Chi-squared indicated no significant differences in the percentage of individuals who endorsed childhood emotional abuse due to ethnicity, gender, or the interaction of gender and ethnicity. Future research would benefit from longitudinal designs that follow children across time to better understand whether and how religious social support may be a buffer for emotional abuse experienced in childhood.

Keywords: religious social support, emotional abuse, anxiety, depression

According to the United States Department of Health and Human Services (2014), approximately three million U.S. children experience some form of maltreatment, annually. Childhood maltreatment is abuse or neglect of a child under the age of eighteen, including physical, sexual, and emotional abuse (World Health Organization, 2016). Approximately one out of four individuals in Tennessee (TN) report suffering from emotional abuse before the age of eighteen (Centers for Disease Control and Prevention (CDC), 2012). Compared to other forms of childhood maltreatment, emotional abuse is the least studied though it is the most prevalent type of abuse (Spinazzola et al., 2014) and research suggests that emotional abuse in childhood can increase risk for internalizing symptoms such as depression and anxiety in adulthood (Kendler et al., 2011; Van Vugt, Lanctot, Paquette, Collin-Vezina, & Lemieux, 2013). However, this risk is not a predetermined fate such that not everyone who experiences emotional abuse as a child will develop clinically significant internalizing symptoms (Kendler et al., 2011). Therefore, more research is needed to understand what factors may buffer the detrimental impact of early emotional abuse on later mental health.

In the light of exploring protective factors that might put a "buffer" between childhood emotional abuse and adult internalizing symptoms. Recent research has focused on protective factors that promote resilience in the face of past abuse (Afifi & MacMillan, 2011). Religious social support might offer a promising defense in maintaining mental well-being, even when exposed to trauma (Eliassen, 2013); however, past research on religious support has been inconsistent and has failed to consider how aspects of diversity (e.g., gender, ethnicity) impact the role of religious support in promoting well-being in the face of adversity (Hill, Kaplan, French, & Johnson, 2010; Janas, 2013). Thus, the primary aim of this study is to investigate whether religious social support experienced in childhood helps to buffer, or lessen, the negative

outcomes associated with emotional abuse, and if the protective function of religious support varies based on certain demographics (i.e., gender and ethnicity).

Emotional Abuse and Mental Health Problems in Later Life

Psychological violence, emotional maltreatment, verbal aggression, mental abuse, and psychological maltreatment are all ways to describe emotional abuse and neglect. For the sake of consistency and clarity, the term "emotional abuse" will refer to any psychological maltreatment a person is exposed to during childhood. Easily recognized forms of emotional abuse include bullying, yelling and screaming, belittling, threatening the child, and placing blame on the child (American Society for the Positive Care of Children, 2017). Emotional abuse usually occurs due to a power imbalance, such as parent/child relationships. Messages being conveyed to children who are victims of emotional abuse create undesired consequences. For example, a child who is suffering from direct forms of emotional abuse may feel unloved or see themselves as a "bad" child, which can lead to an increase in self-doubt and problematic behaviors (e.g., anxiety disorders; eating disorders and self-mutilation; Whitlock, 2010). However, not all types of emotional abuse are straightforward. Parents can expose children to emotional abuse without intending to do so. Implicit forms of emotional abuse involve continual negative communication patterns, such as sarcasm, rejection, shaming, unpredictive responses, continual family discord, and conflicting messages conveyed. It is important to note that occasional display of these behaviors is not necessarily destructive. Rather, subtler forms of emotional abuse are damaging when they occur chronically and consistently across time and situations and involve a perceived rejection, as a child may be conditioned to expect adverse repercussions.

Similar to other forms of abuse, emotional abuse causes damage to a person's development. Spinazzola and colleagues (2014) found that childhood emotional abuse was as

detrimental to mental health as sexual or physical abuse. Similarly, Van Vugt and colleagues (2013) concluded that emotional abuse was the strongest form of abuse associated with trauma-related symptoms (i.e., anxiety and depression), when compared to other forms of abuse (i.e., sexual or physical). One retrospective study found an increase of recurrent depression in adulthood following emotional abuse and family violence in childhood (Kessler & Magee, 1994). A more recent study, concluded that fear of criticism and rejection mediated the link between emotional abuse and adult major depression (Maciejewski & Mazure, 2006), which confirms findings of previous studies. Similarly, parent's harsh reactions to children's distressful emotions indicate to the child that the display of negative emotions is not acceptable, and such reactions have been linked to internalized symptoms in the child, likely due to an inability or unwillingness to display emotions (Roberts & Strayer, 1987). Together, these studies highlight that emotional abuse is detrimental to child mental health and puts one at risk for later mental health problems; however, none of these studies have examined factors that could moderate, or buffer, the traumatic impact. Religious social support could offer potential in aiding and promoting resilience in mental health.

Religious Social Support and Mental Health

Religious social support can be defined as the social support a person receives through social aspects of religious beliefs, such as participation in activities and active involvement within the community (Krause, Ellison, Shaw, Marcum, & Boardman, 2001). Research has examined how religious social support impacts mental health and behavior, for better or for worse. In other words, positive religious social support (e.g., social relationships in an individual's place of worship) could promote resilience in mental health, whereas negative religious interactions (e.g., religious contact that conveys a sense of obligation or guilt) could be

detrimental toward mental health. Many researchers have focused on the relationship between religious social support in terms of religious coping, and its effect on internalizing symptoms. Since there is limited research on religious social support and negative interactions, the literature on positive and negative religious coping will be discussed as a proxy for religious social support. Religious coping can be defined as the strategies a person uses when seeking out a higher power to help deal with a traumatic situation. These strategies can be either positive or negative, meaning the individual either perceives their deity or deities as supportive and strive to find meaning behind the situation, or the individual struggles with doubt, perceiving the situation as a punishment of faith. Furthermore, religious coping is an important aspect of religious social support, and often examined together when considering mental health. Rather than solely focusing on an individual's perceived relationship with a religious community, religious coping adds another dimension to examine the individual's perceived relationship with a divine power(s).

Few studies have looked directly at the link between religious social support and internalizing symptoms, and of those that have, results are mixed. For example, a cross-cultural study of university students in the U.S. and Botswana found no link between religious social support and levels of anxiety or depression (Mckim, 1995). While the literature on religious social support is limited, there is a broader literature that has examined aspects of religious coping. For example, a study of a British Christian sample concluded that negative religious coping (e.g., wondering whether God has abandoned someone or believing in a punishing, vengeful, or simply indifferent God), had the greatest impact on internalizing symptoms compared to positive religious coping (e.g., regular church attendance) and no religious coping (Brewer, Robinson, Sumra, Tatsi, & Gire, 2015). Furthermore, this study found no evidence to

support claims that positive religious support could function as a protective factor. These findings support that notion that negative religious coping can increase risk of internalizing symptoms.

Research examining positive religious coping suggests that there may be mental health benefits to religious social support. One study found that quality of religious social support was a protective factor against anxious symptomatology within a large sample of religiously and ethnically diverse adolescents, indicating that as quality of religious social support increased, anxiety symptoms decreased (Desrosiers, 2012). Similarly, another study found that religious social support, compared to other forms of social support, had a greater influence on coping mechanisms for internalizing symptoms from adolescent peers (Harrell & Powell, 2014). Furthermore, these findings support that social aspects of religion might reduce risk for internalizing symptoms (e.g., depressive symptoms). Literature on religious social support is limited. Few studies have looked at specific aspects of religious social support. Examining the relation between religious social support and emotional abuse is a novel study. Given that research on religious social support has yielded mixed conclusions regarding the impact on mental health, future research should further investigate factors related to whether and how religious social support may function as a protective factor. The direction of these results for both positive and negative types of religious social support may be due to individual differences in demographic factors. Research examining religiosity often closely focuses on religious coping, limiting the research available on religious social support. Therefore, additional research is needed to better understand whether religious social support is protective, and if so, for whom, by examining contextual aspects (i.e., gender and ethnic differences).

Contextual Factors and Religious Social Support

Contextual factors, such as gender and ethnicity, are important to take into consideration when analyzing findings in studies that focus on religious social support. Depending on the culture surrounding gender and ethnicity, these factors make a person's experiences and perceptions unique. When considering the mesosystem (e.g., a developing child's religious social interactions with family), Bronfenbrenner's Ecological System Model (Bronfenbrenner & Ceci, 1994) helps us make sense of how interactions with personal and environmental factors influence behavior and development (Harney, 2008). This means that individual differences may impact on the experience of protective factors, such as religious social support. Alone, gender or ethnicity, can act as risk or protective factors, impacting coping, resilience, and later in life mental health (O'Connell, Boat, & Warner, 2009). Further examination of these contextual factors may provide insight as to why certain individuals seem to benefit from religious social support, while others do not.

Gender and Religious Social Support

Deeply rooted gender differences and stereotypes may influence who seeks religious social support. In fact, it has been noted that women are more likely to use and benefit from religious social support as a strategy for coping compared to men (Eliassen, 2013). Although it is controversial which has a greater impact, gender differences between men and women are a mixture of nature, or biological factors (e.g., chromosomes, hormones, brain laterization), and nurture, or sociological factors (Choleris, Galea, Sohrabji, & Frick, 2018). At an early age, children develop ideologies of gender roles and stereotypes through socialization by parents, caregivers, teachers, and peers (Abraham, 1982). For example, stereotypical feminine characteristics are more expressive (e.g., using emotions), whereas stereotypical masculine

characteristics are more instrumental (e.g., practical/logical; Higginbotham & Weber, 1992). Expressive traits encompass a social aspect of displaying and coping with emotions, which can include seeking support and assurance in others. These findings provide insight as to why women may be more likely to seek religious social support. Further, men may be more likely than women to cope by suppressing emotions, while externalizing symptoms through risky behavior. One study found that men are more likely to turn to drinking as a relief for depressive symptoms (Foster et al., 2014). Another study examining gender differences in expressing emotions, found that men display more pride and anger, while women express higher levels of distress and sympathy (Durik, Hyde, Marks, Roy, Anaya, and Schultz, 2006). Higher levels of pride in men suggest that they may be attempting to hide vulnerability in social situations, which may explain why men are less likely to seek out social support when coping. Although anger can be suppressed internally or displayed through aggressive behavior, men tend to use external strategies for coping (Foster et al., 2014). In contrast, higher levels of sympathy and distress found in this study can be linked to expressive traits, which could explain why women tend to pursue coping through social support. Contextual factors surrounding gender ideologies and expression could potentially account for why research predominately shows religious social support to be more beneficial for women than for men.

Research on religious social support suggests that females tend to benefit more from religious social support when compared to males (Afifi & MacMillan, 2011; Eliassen, 2013; Janas, 2013). Studies that focus on females have found religious social support to be a protective factor against adverse mental health problems (Afifi & MacMillan, 2011; Eliassen, 2013). One longitudinal study found that, adolescent females suffering from above average stress and trauma benefited the most from religious involvement (e.g., use of belief, comfort seeking, and prayer)

and decreasing depressive symptoms, compared to male participants (Eliassen, 2013). However, findings are inconsistent in regard to whether religion is protective factor in the face of stress and trauma. For example, in a predominately male sample of firefighters, spirituality and religious coping did not act as a protective factor in the reduction of trauma symptoms (Janas, 2013). Unlike previous studies, these findings suggest that religious social support is not effective in reducing traumatic impact. However, this could be due to gender differences presented in the selection of participants for the study. Nevertheless, there are more factors than just gender differences that could contribute to inconsistencies in the literature. Next, we will examine how ethnicity impacts religious social support.

Ethnicity and Religious Social Support

Ethnicity can have an impact on how individuals of various cultures cope, which can ultimately have an effect on mental health (Causadias, 2013). The term ethnicity encompasses racial characteristics, in addition to aspects of culture. Although its definition is often debated, ethnicity can be referred to as the "acceptance of the group mores and practices pertaining to culture of origin, which instills a sense of belonging" (American Psychological Association, 2003). When analyzing who is likely to seek religious support, it is important to examine cultural differences among ethnic groups. The present study will consider ethnic differences between African American and Caucasian American young adults, as such we consider the cultural contexts surrounding those specific ethnic groups.

When considering ethnicity influences on mental health, it is essential to consider the historical background of slavery, racism, prejudice, and discrimination that African Americans have faced (Morelen & Thomassin, 2013). Slavery in the early U.S. may have influenced African American beliefs, since most European Americans followed Christian practices at the time when

slaves were brought to the U.S. Continued discrimination throughout history could have an influence on who seeks religious social support and who does not. However, support through religion surrounding culture and ethnicity can bring individuals together. According to Pew Research Center (2009), 78% of African Americans identify their religious beliefs as "Protestant." This illustrates that the majority of African Americans have continued to adopt Christian values and beliefs, even after slavery was banned. Religion may provide African Americans with a sense of belonging in a society in which they have been discriminated against for hundreds of years. The use of religion may help African Americans transition into society by reclaiming Christian faith (Carson, Lapsansky-Werner, & Nash, 2012; Cornelius, 1999). The historical context of slavery impacts religious values and practices in everyday life.

In addition to historical influences, it is also relevant to consider cultural values and practices. For instance, research shows that Caucasian American cultures tend to be more individualistic, whereas African American cultures tend to be more collectivistic (Higginbotham & Weber, 1992). Cultural values may influence these differences found in previous studies. For example, collectivistic values, more commonly found in African American compared to Caucasian American groups, involves ideas of community and interdependence. Furthermore, it is a central aspect of identity that binds individuals to the group with which they identify. Social support through shared religion may provide individuals with a sense of belonging to a group, which may explain why African Americans are more likely to seek out religious social support when coping to fulfil collectivistic needs, compared to other ethnic groups. On the contrary, individualistic values, more commonly found in Caucasian American compared to African American groups, tend to prioritize and emphasize personal autonomy, rather than the focus on the ethnic community in which they identity. Since individualism focuses on self-interest, these

cultures may associate needing help as a sign of weakness or a burden to others in the community, therefore, rejecting religious social support.

Examining underlying historical and cultural factors, such as values and practices, allows researchers to better understand contextual influences involving ethnicity. For instance, one study found religious social support was an effective coping strategy that worked as a protective factor for stress in African American adolescent females (Carleton, Esparza, Thaxter, & Grant, 2008). Since African American culture is also heavily influenced by matriarchy in spirituality and family (Sue & Sue, 2008), it may be that the matriarchal aspect of the culture that influences who seeks religious social support. Another study with African American participants, found religious social support was a protective factor for anxiety and depression (Sternthal, Williams, Musick, & Buck, 2010), regardless of gender. Further, when considering ethnic group differences, it is also important to hold in mind that ethnicity and socioeconomic status (SES) are separate, yet related constructs. On a group level, African Americans tend to be in a lower socioeconomic status (SES) bracket, in comparison to Caucasian Americans (Williams, Mohammed, Leavell, & Collins, 2012). Throughout American history, African Americans have endured discrimination and oppression, which has led to an overall lower average SES, and ultimately negatively impacting mental health. Discrimination related to past slavery have been instilled in social and legal U.S. traditions, resulting in present day discrimination and disadvantages in social aspects, such as SES (O'Connell, 2012). Available resources may be limited to African Americans, leading them to seek help within the community, such as religious social support, whereas Caucasian Americans may seek additional resources through professional help, such as counseling and therapy, relating back to collectivistic versus individualistic cultures.

Previous studies indicate that there are inconsistencies and mixed results regarding religion as a moderator in the relationship between emotional abuse in childhood and later mental health. More importantly, research has failed to examine as how religious social support could potentially be a protective factor against anxiety and depression in individuals who suffer from emotional abuse in childhood. Further, the inconsistencies in past research may be explained, in part, by differences in aspects of diversity. Intersectionality, for example, illustrates the dynamic relationship of overlapping and multiple identities related to oppression and discrimination. As such, some literature suggests that benefits of religious support vary based on one's ethnicity, gender, and the interaction of gender and ethnicity (Carleton, Esparza, Thaxter, & Grant, 2008; Eliassen (2013); Sternthal, Williams, Musick, & Buck, 2010). Therefore, it is essential to not only ask the question "is religious support in childhood a protective factor against early emotional abuse?" but to also ask the question "for whom?"

Present Study and Hypotheses

Emotional abuse in childhood can have a negative impact on mental health in adulthood, potentially contributing to symptoms of anxiety and depression. Some literature suggests that religious social support might be a protective factor against internalizing symptoms; however, no studies have specifically examined whether religious social support is a protective factor between emotional abuse in childhood and later internalizing symptoms. Further, previous research has shown many inconsistencies on relations revolving around the protective function of religious social support, particularly when considering differences related to contexts of diversity. Thus, it is important to examine whether religious social support is a protective factor in diverse samples. The primary research questions and hypotheses are as follows: (1) Does religious social support in childhood help to moderate, or lessen, the negative outcomes associated with emotional abuse

as a predictor for individuals who have experienced harsh parenting behavior? (H1) It is hypothesized that religious social support in childhood will help to moderate, or lessen, the negative outcomes associated with emotional abuse; (2) how do contextual factors impact this relationship? (H2) It is hypothesized that contexts of diversity will impact the nature of these relations such that religious social support will have the strongest effect in moderating internalized symptoms associated with emotional abuse in African American women in the context of intersectionality.

Methods

Participants

The sample includes undergraduate students (n = 472, *M* age = 20.37, SD = 4.84 years) from various psychology courses attending East Tennessee State University (ETSU), located in the southeastern U.S. For this study, participants who indicated 1) male or female for gender identity (73% female) and 2) European American or African American for ethnic identity (11% African American) were considered for analysis. Those who did not meet these criteria were excluded from analysis for this project.

Procedures

Self-report data was collected via an online survey platform, Research Electronic Data Capture (REDCap). REDCap is a secure online survey software for managing surveys and databases. This was a cross-sectional survey design study and data was collected via an online survey for six months. Participation was voluntary, and consent was obtained electronically prior to the study. As an incentive, students received credit in courses for completing the survey. The study asked participants to report on retrospective measures (i.e., their experiences from

childhood) and current emotional and psychological well-being. All procedures were IRB approved.

Measures

Retrospective measures. The Adverse Childhood Experiences Study (ACES; Felitti et al., 1998) consists of ten dichotomous questions and was used to examine interpersonal trauma and environmental trauma in childhood. For this study, only ACES items relating to emotional abuse were analyzed (i.e., item 1: "Did a parent or other adult in the household often ... Swear at you, insult you, put you down, or humiliate you? Or act in a way that made you afraid that you might be physically hurt?" Item 4: "Did you often feel that ... No one in your family loved you or thought you were important or special? Or Your family didn't look out for each other, feel close to each other, or support each other?"). The ACES questionnaire has shown to be a valid measure for investigating trauma and has been used in several past studies to examine trauma such as emotional abuse (Finkelhor, Shattuck, & Turner, 2013; Yeoman, Safranek, Buss, Cadwell, & Mannino, 2013). ACES items 1 and 4 showed good internal consistency in the present sample ($\alpha = .69$).

In conjunction with the ACEs Questionnaire, the Coping with Children's Negative Emotions Scale (CCNES; Fabes, Eisenberg, Bernzweig, 1990) was utilized to examine the extent to which the participant experienced harsh emotion reactions from parents during childhood. The CCNES has been tested to be a valid measure to determine harsh emotion parenting (Fabes, Poulin, Eisenberg, Madden-Derdich, 2002). The CCNES Questionnaire is comprised of twelve situations with a set of six subscales (3 supportive, 3 harsh), in which participants indicated parents' response on a 7-point Likert scale ranging 1-7 (1 being very unlikely and 7 being very likely). Since the focus of this study is emotional abuse, we were interested in the 3 harsh

subscales: distress reactions (DR), punitive reactions (PR), and minimization reactions (MR). DR ($\alpha = .68$) reflects the degree to which the participant's parent(s) experienced distress when expressing negative affect during childhood (e.g., "When you were a child, if you got sick and couldn't go to your friend's party, how likely would your parent/guardian have responded by getting angry?"). PR ($\alpha = .88$) reflects the degree to which the participant's parent(s) responded with discipline to avoid dealing with negative emotions in childhood (e.g., "When you were a child, if you fell off your bike and broke it, got upset, and cried, how likely would your parent/guardian have responded by telling you to stop crying or you won't be allowed to ride your bike anytime soon?"). MR ($\alpha = .89$) reflects the degree to which the participant's parent(s) devalue problems as a child (e.g., "When you were a child, if you lost some prized possession and reacted with tears, how likely would your parent/guardian have responded by getting upset with you for being so careless and then crying about it?"). Of the three harsh subscales, psychometric analyses have indicated that PR and MR create a Harsh Emotion Parenting (HEP) composite whereas DR remains a unique and separate subscale (Labella, 2018). As such, we use the HEP composite (MR + PR, $\alpha = .93$) and DR subscale ($\alpha = .70$) in the remaining analyses.

To measure religiosity and religious social support, the Brief Multidimensional Measurement of Religiousness and Spirituality (BMMRS; Fetzer Institute/NIA, 1999) was utilized. The BMMRS is a 38-item questionnaire, evaluating spiritual experiences, values and beliefs, religious and spiritual coping, religious support, commitment, and religious history. This questionnaire has been used in a variety of studies to measure religion and spirituality of participants (Eliassen, 2013; Janas, 2013), and has been tested to ensure validity across samples (Fetzer Institute/NIA, 1999). For the current study, we used two subscales from the BMMRS – the support subscale ($\alpha = .78$; i.e., "How often did the people in your congregation make you

feel loved and cared for?", or "How often did the people in your congregation listen to you talk about your private problems and concerns?") and the negative interaction subscale (α = .75; i.e., "How often did the people in your congregation make too many demands on you, or how often did the people in your congregation critical of you and the things you did?").

Current measures. The generalized anxiety disorder questionnaire (GAD-7; Spitzer, Kroenke, Williams, & Lowe, 2006) was used to examine symptoms of anxiety. This questionnaire consists of a 7-item Likert scale ranging from 0 to 3, examining symptoms of anxiety, such as nervousness, worry, and restlessness. The GAD-7 has been tested to be a valid measure for investigating symptoms of anxiety (Spitzer, Kroenke, Williams, & Lowe, 2006; Swinson, 2006). The GAD-7 showed good internal consistency in the present sample (α = .92).

The Center for Epidemiological Studies Depression (CESD; Lewinsohn, Seeley, Roberts, & Allen, 1997) is designed to assess depressive symptoms. The CESD is a 20-item questionnaire that examines dysphoria (i.e., sadness), anhedonia (loss of interest), suicidal ideation, and loss of sleep or appetite. This scale has been tested and confirmed for its validity (Eliassen, 2013; Lewinsohn, Seeley, Roberts, & Allen, 1997). The CESD showed good internal consistency in the present sample (α = .87).

Analytic Plan

Analyses were conducted in the Statistical Package for the Social Sciences (SPSS). We used Multivariate Analysis of Variance (MANOVA) analyses to examine mean differences in continuous study variables by gender, ethnicity, and their interaction. We also used MANOVA to examine mean differences in study variables by emotional abuse status. We used Pearson bivariate correlations to determine the relationship between childhood experiences and current

mental health outcomes. Specific measures of effect size by analysis type with Cohen's (1992) criteria as follows: For mean differences, we used Cohen's d: .20 (small effect), .50 (medium effect), and .80 (large effect). For correlations, we used Pearson's r: .10 (small effect), .30 (medium effect), and .50 (large effect).

We used chi-squared analyses to determine whether there were differences in the frequency of endorsed emotional abuse items based on gender and ethnicity. For individuals who endorsed emotional abuse in childhood on the ACES (i.e., ACE item 1 and/or 4), we tested for moderated moderation using the Hayes Process Macro (version 3.0, Model 3; Hayes, 2013). For our predictor variable, harsh emotion parenting for individuals who endorsed emotional abuse, we used the HEP composite score. We had two outcome variables (anxiety and depression) and two categories of moderators: religious support (religious social support or negative religious interactions) and contextual diversity related factors (gender, ethnicity, and gender*ethnicity interaction term). Please see Figure 1.

Results

First, MANOVA analyses were used to determine whether continuous study variables varied by gender, ethnicity, and the interaction of gender*ethnicity. Regarding emotion parenting experienced during childhood, there was a main effect for ethnicity [$F(2, 385) = 3.68$, $p = .03$] such that African American participants reported higher levels of parental distress reactions ($p = .03$) and harsh emotion parenting ($p = .007$) compared to European American participants. There were no significant differences on emotion parenting variables due to gender [$F(2, 385) = 1.00$, $p = .37$] or gender*ethnicity [$F(2, 385) = .26$, $p = .77$]. Regarding religious support received during childhood, there was a main effect of ethnicity [$F(2, 420) = 6.42$ $p = .002$] such that African American participants reported higher levels of religious social support

(p = .006) and marginally higher levels of negative religious interactions than European American participants (p =.06). There were no significant differences on religious support variables due to gender [$F(2, 420) = 2.00$, $p = .14$] or gender*ethnicity [$F(2, 420) = 1.62$, $p = .20$]. Regarding anxiety and depression, there were no significant mean differences in internalizing symptoms due to gender [$F(2, 373) = 2.53$, $p = .08$], ethnicity [$F(2, 373) = 2.17$, $p = .12$], or gender*ethnicity [$F(2, 371) = .43$, $p = .65$]. See Table 2 for mean, standard deviation, and effect sizes related to mean differences due to ethnicity.

Next, MANOVA analyses were used to determine whether continuous study variables varied by whether or not participants indicated that they experienced emotional abuse in childhood. In the current sample, we had 382 participants who completed the ACEs measure, 65% of whom endorsed no emotional abuse, 19% who endorsed one of the two emotional abuse items, and 16% who endorsed both emotional abuse items. Combined, 35% of the sample endorsed some form of emotional abuse in childhood. Regarding emotion parenting experienced during childhood, there was a significant effect of emotional abuse group status [$F(2, 362) = 30.31$, $p < .001$] such that participants who endorsed emotional abuse in childhood reported higher levels of parental distress reactions ($p < .001$) and harsh emotion parenting ($p < .001$) compared to participants who did not endorse emotional abuse in childhood. Regarding religious support received during childhood, there was a significant effect of emotional abuse group status [$F(2, 359) = 21.77$, $p < .001$] such that participants who endorsed emotional abuse in childhood reported lower levels of religious social support ($p < .001$) and higher levels of negative religious interactions ($p < .001$) compared to participants who did not endorse emotional abuse in childhood. Regarding internalizing symptoms, there was a significant effect of emotional abuse group status [$F(2, 358) = 24.52$, $p < .001$] such that participants who endorsed emotional abuse

in childhood reported higher levels of depression ($p < .001$) and anxiety ($p < .001$) compared to participants who did not endorse emotional abuse in childhood. See Table 2 for mean, standard deviation, and effect sizes related to mean differences due to emotional abuse status.

Next, Pearson bivariate correlations between all variables was utilized to determine the relationship between childhood experiences and current mental health outcomes for the entire sample. As seen in Table 2, all correlations between study variables were in the expected direction. Religious social support in childhood was associated with fewer depression and anxiety symptoms in adulthood, whereas negative religious interactions in childhood were associated with greater depression and anxiety symptoms in adulthood. Harsh emotion parenting in childhood was associated with greater depression and anxiety symptoms in adulthood.

Next, Chi-squared analyses were utilized to determine rates of endorsed emotional abuse based on gender and ethnicity. ACEs items 1 and 4, which reflect emotional abuse, were analyzed in relation to gender and ethnicity to see if there were any significant differences in frequency based on groups by gender, ethnicity, or the interaction of gender and ethnicity. Results of Chi-squared analyses indicated that there were no significant differences in the frequency of endorsed emotional abuse for ACEs item 1 based on gender [$\chi^2(1, N = 119) = .75, p = .78$], ethnicity [$\chi^2(1, N = 122) = 0.40, p = .53$], or the interaction of gender and ethnicity [$\chi^2(1, N = 199) = 2.97, p = .40$] and for ACEs item 4 on gender [$\chi^2(1, N = 83) = 2.14, p = .14$], ethnicity [$\chi^2(1, N = 84) = 1.70, p = .19$], or the interaction of ethnicity and gender [$\chi^2(1, N = 83) = 3.50, p = .32$]. Of note, there were far more European American participants than African American participants. Due to this lack of diversity across participants, power to draw conclusions is lessened (see Table 3).

Lastly, moderated moderation was used to predict whether religious social support moderated symptoms of anxiety and depression associated with emotional abuse using Hayes Process Macro. Only participants who endorsed ACEs items 1 and/or 4 were included in analysis (n = 134). To test hypothesis 1, that religious social support in childhood would lessen the negative outcomes associated with emotional abuse, we tested 4 moderation models using Process Model 1: X = HEP, W = Religious social support or Religious negative interactions, Y = Anxiety or Depression. Significant moderation would be indicated by a 2-way interaction between X and M ($p < .05$, confidence interval does not include zero). Results did not indicate significant moderated moderation for any of the models tested.

To test hypothesis 2, that religious social support will have the strongest effect in moderating internalized symptoms associated with emotional abuse in African American women in the context of intersectionality, we tested 4 moderation models, using Process Model 3: X = HEP, W = Religious social support or Religious negative interactions, Z = Gender*Ethnicity, Y = Anxiety or Depression. Significant moderated moderation would be indicated by a 3-way interaction between X, M, and Z. Results did not support moderated moderation for any of the models tested.

Discussion

Emotional abuse is the most common, yet least studied type of childhood abuse. The current study aimed to shed light on how emotional abuse and religious social support in childhood impacts current mental well-being. More specifically, this project examined the questions “is religious support in childhood a protective factor against early emotional abuse?” and “how does the intersectionality of gender and ethnicity impact whether and how religious social support serves as a protective factor?” Overall, the findings did *not* support the notion that

religious social support acts as a protective factor in the link between childhood emotional abuse and internalizing symptoms in adulthood. Despite the non-significant moderation findings, study results support the existing literature on the relationship between emotional abuse in childhood and mental health outcomes in adulthood. In addition, it was interesting that emotional abuse during childhood was endorsed at similar rates regardless of one's gender or ethnicity; however, our sample was comprised predominately of European American female participants, thus limiting our ability to detect findings due to intersectionality of gender and ethnicity. Despite this limitation, the results corroborate and add to the literature on emotional abuse, religious social support, and mental health outcomes.

One goal of this study was to investigate the impact of gender and ethnicity on religious social support as a moderator; however, our sample was predominately comprised of individuals who identified as European American females. As such, our power to find moderating effects due to intersectionality of ethnicity and gender was limited. Despite this limitation, we were able to investigate whether the proportion of individuals who endorsed emotional abuse in childhood differed due as a function of ethnicity, gender, and their interaction. Our results suggest emotional abuse endorsement rates were similar across groups regardless of one's of gender and/or ethnicity. Overall, 35% of the sample endorsed some form of emotional abuse in childhood. Of note, the average rate of emotional abuse in our sample is higher than the rate for adults in TN (25%; CDC, 2012). It is also interesting that visual inspection of frequency rates (see Table 3) suggests that regardless of ethnicity or gender, more individuals endorsed experiencing ACEs item 1 ("Did a parent or other adult in the household often ... Swear at you, insult you, put you down, or humiliate you? Or Act in a way that made you afraid that you might be physically hurt?") than ACEs item 4 ("Did you often feel that ... No one in your family loved

you or thought you were important or special? Or Your family didn't look out for each other, feel close to each other, or support each other?"). It would be interesting for future research to examine whether these two different experiences of emotional abuse have similar or unique implications for developmental outcomes. Put together, our findings suggest that emotional abuse in childhood is a relatively common experience regardless of one's ethnicity or gender.

Our findings also highlight that the experiences one has in childhood, both positive and negative, have implications for mental health symptoms in adulthood. Regarding emotion parenting, HEP was positively correlated with symptoms of anxiety and depression, meaning that as HEP increase, symptoms of anxiety and depression increase. This is consistent with past research that has shown when parents respond to children's emotions in a punitive or minimizing way, that increases risks for maladaptive outcomes (Kendler et al., 2011; Spinazzola et al., 2014; Van Vugt, Lanctot, Paquette, Collin-Vezina, & Lemieux, 2013). Through emotion socialization, parents directly and indirectly teach children both positive and negative ways to regulate emotions. If parents continually practice harsh emotion parenting over supportive emotion parenting, children will develop unhealthy ways to cope and regulate emotions. For instance, if a parent constantly berates a child for responding appropriately for a situation (e.g., in tears over breaking their bike), the child might develop the belief that it is "bad" to show negative emotions and develop a tendency to internalize their feelings of sadness. It is noteworthy that African American participants reported higher levels of harsh emotion parenting reactions from childhood (both in terms of parental distress reactions and minimizing/punitive reactions). Previous literature suggests that emotion socialization behaviors in childhood were linked for Black and White participants, such that low expression of positive emotions in families during childhood were related to negative outcomes (e.g., depression and anxiety; Morelen, Suveg,

Jones, & Thomassin, 2013; Nelson et al., 2012). Of note, there were no ethnic group differences in levels of anxiety or depression symptoms, suggesting that the higher levels of HEP in African American families might not directly translate to higher levels of mental health problems. Future research should examine whether ethnicity moderates the link between HEP and internalizing symptoms.

Regarding religious experiences from childhood, religious social support was negatively related to depression and anxiety whereas negative religious interactions was positively related to depression and anxiety. In order words, as religious social support increases, symptoms of anxiety and depression decrease. Additionally, as negative religious interactions increase, symptoms of anxiety and depression increase. The data suggest that although aspects of religion can be beneficial, negative interactions can be harmful as well. For example, positive implications of religion can include having a sense of unity and belonging. In addition, some studies have found that highly religious people are more likely to rely on advice from religious leaders and were more involved with family than not highly religious participants, indicating that social relations in religion are valued (Pew Research Center, 2016). On the contrary, some findings confirm that negative religious interactions and social negativity appear to foster or exacerbate distress in individuals over time, correlating to poorer psychological outcomes than those who had positive religious interactions (e.g., self-esteem; Ellison, Zhang, Krause, & Marcum, 2009). Results of the current study support our hypothesis relating to whom religious social support is most beneficial; African American participants reported higher levels of religious social support and lower levels of negative religious interactions in childhood compared to European American participants. Literature indicates that these differences may be due to the collectivistic nature of African American culture versus the individualistic nature of European

American culture, such that collectivistic cultures are more likely to seek out social support than self-reliant individualistic cultures (Higginbotham & Weber, 1992).

For the current study, results regarding moderated moderation were insignificant, meaning religious social support did not help lessen symptoms of anxiety or depression. Further, results for moderated moderation did not differ depending on gender and ethnicity, therefore we cannot validate our hypothesis. However, the lack of findings does not necessarily mean that religious social support isn't enough to buffer the major adversity of emotional abuse on one's developing self and well-being. To reiterate, the lack of moderated moderation may be explained by the nature of the small sample size for this study. Future studies should look at other variable such as supportive social networks at school (e.g., peers, teachers) and caring adults outside the family who can serve as role models or mentors as possible moderators of mental health outcomes.

Limitations and Future Directions

Collectively, this study adds to our understanding of the experience of emotional abuse in young adults attending college in the Appalachian region of TN. Findings suggest that emotional abuse rates are generally consistent regardless of whether one identifies as African American or European American, male or female. Further, unsupportive experiences from childhood (i.e., harsh emotion parenting, negative religious interactions) may heighten risk for internalizing symptoms in young adulthood whereas positive religious support in childhood may lower risk for internalizing symptoms in adulthood. When considering these findings, it is important to hold certain study limitations in mind. For instance, there are limitations to retrospective reports of experiences from childhood. Since this is a retrospective study, there is a possibility of inaccurately recalling past information. For example, individuals with more depressive

symptoms might remember the past through a more negative lens then individuals with fewer depressive symptoms. Future research would benefit from longitudinal designs that follow children across time to better understand the temporal nature of these relations and whether and how religious social support may be a buffer for emotional abuse experienced in childhood. Another limitation of the current study is that there were fewer African American participants than European American participants, thus lowering power and making it challenging to draw a strong conclusion from the lack of a significant moderation. Additional data is being collected to have a more diverse sample size to be able to increase power. Future studies should strive to minimize these limitations through means of different data collection, and with other populations.

In addition to the limited sample, we also acknowledge that ethnicity, as measured by a single item on a demographic questionnaire, is an oversimplified proxy for cultural experiences. Further, we approached ethnicity as a binary construct for the sake of statistical analyses yet acknowledge that there is a wide variety of ethnic backgrounds. In fact, a subscale of our sample (n = 58, 10%) identified as having an ethnicity other than European American or African American. Future research should include measures of attitudes, beliefs, and experiences to be able to more richly capture aspects of one's ethnic identity, as well as investigate across ethnicities. Similarly, we approach gender as a binary construct as well, while acknowledging that gender identify is not binary. In fact, a subscale of our sample (n = 7, 1%) identified as having a gender identity other than male or female. We hope that with a larger sample size, we'll have more power to explore the role of ethnic identity and gender identity will be more broadly defined.

To summarize, emotional abuse is a significant topic to study, as it is prevalent in our society, it is under researched, and it is linked to internalizing symptoms such as anxiety and depression as indicted by this study and previous studies. It is also important to consider potential protective factors that could help lessen these symptoms and more research should be conducted to uncover moderators for emotional abuse.

Figure 1

Moderated Moderation Model for the Current Study

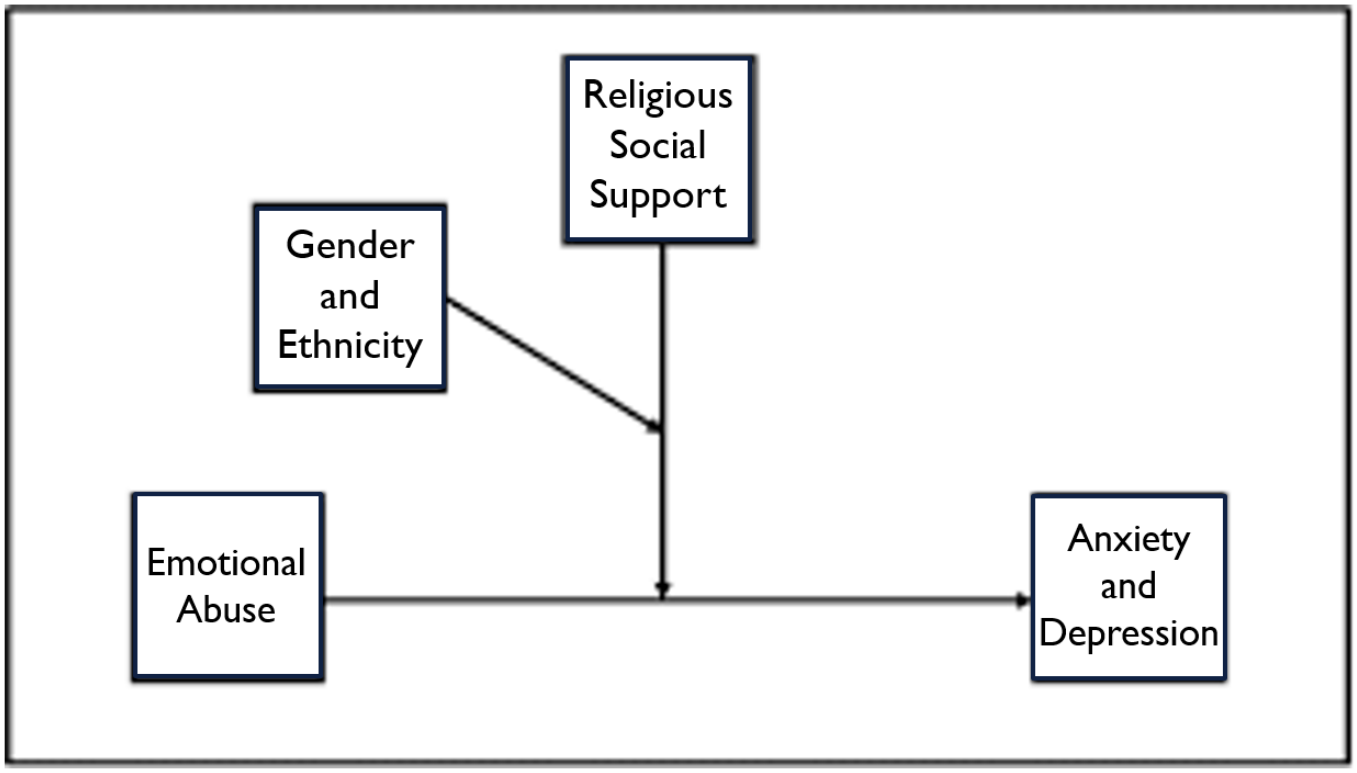

Table 1

Means and Standard Deviations of Study Variables by Ethnicity and Childhood Emotional Abuse Status

Construct	**Variable**	Ethnicity		P value and Cohen's d	Emotional Abuse Status		P value and Cohen's d
		African American	European American		No	Yes	
Childhood Harsh Emotion Parenting	DR	*n* = 37, *M* = 3.88, *SD* = .81	*n* = 353, *M* = 3.50, *SD* = .89	*p* = .03* d = .45	*n* = 242, *M* = 3.27, *SD* = .75	*n* = 123, *M* = 3.99, *SD* = .98	*p* < .001* *d* = -.83
	HEP	*n* = 37, *M* = 4.25, *SD* = 1.37.	*n* = 353, *M* = 3.66, *SD* = 1.07	*p* = .007* *d* = .48	*n* = 242, *M* = 3.47, *SD* = .99	*n* = 123, *M* = 4.17, *SD* = 1.20	*p* < .001* *d* = -.64
Childhood Religious Social Support	RSS	*n* = 55, *M* = 2.22, *SD* = .70	*n* = 370, *M* = 1.79, *SD* = .95	*p* = .006* *d* = .52	*n* = 241, *M* = 2.02, *SD* = .89	*n* = 121, *M* = 1.49, *SD* = .93	*p* < .001* *d* = .58
	RNI	*n* = 55, *M* = 1.04, *SD* = .95	*n* = 370, *M* = .85, *SD* = .88	*p* =.063* *d* = .21	*n* = 241, *M* = .72, *SD* = .82	*n* = 121, *M* = 1.12, *SD* = .90	*p* < .001* *d* = -.46
Adult Internalizing Symptoms	Depression	*n* = 38, *M* = 29.16, *SD* = 13.83	*n* = 340, *M* = 7.12, *SD* = 6.35	*p* = .052 d = 2.05	*n* = 236, *M* =21.91, *SD* = 1.84	*n* = 125, *M* =30.78, *SD* = 12.55	*p* < .001* *d* = -.99
	Anxiety	*n* = 38, *M* = 8.32, *SD* = 7.09	*n* = 340, *M* = 24.74, *SD* = 12.58	*p* = .26 *d* = -1.61	*n* = 236, *M* = 5.61, *SD* = 5.93	*n* = 125, *M* = 10.06, *SD* = 6.10	*p* < .001* *d* = -.74

Note. DR = Distress Reactions; HEP=Harsh Emotion Parenting, RSS = Religious Social Support; RNI = Religious Negative Interactions

*p ≤ .05

Table 2

Pearson Bivariate Correlations for Entire Sample

Variable	1	2	3	4	5	6
1. Depression	30.46 (12.34) α = .87					
2. Anxiety	.81*	10.1 (6.19) α = .92				
3. RSS	-.23*	-.24*	1.48 (.95) α = .78			
4. RNI	.35*	.32*	-.14*	1.09 (.90) α = .75		
5. DR	.32*	.27*	-.19*	.27*	4.01 (.98) α = .70	
6. HEP	.56*	.24*	-.12*	.26*	.78*	4.17 (1.21) α = .91

Note. Measure means (SD), and alpha listed on the diagonal. RSS = Religious Social Support; RNI = Religious Negative Interaction; DR = Distress Reactions; HEP=Harsh Emotion Parenting

*$p \leq .05$

Table 3

Results of Chi-square Test and Frequencies of Endorsed Emotional Abuse Items from the ACEs

Variable		African American		European American	
ACEs Item	Response	Female	Male	Female	Male
1	No	75% (n=18)	53% (n = 8)	69% (n = 177)	73% (n = 72)
	Yes	25% (n=6)	47% (n = 7)	31% (n = 80)	27% (n = 26)
4	No	86% (n = 19)	87% (n = 14)	76% (n = 198)	83% (n = 84)
	Yes	14% (n = 3)	13% (n = 2)	24% (n = 61)	17% (n = 17)

ACEs Item 1: Did a parent or other adult in the household often ... Swear at you, insult you, put you down, or humiliate you? Or Act in a way that made you afraid that you might be physically hurt?

ACEs Item 4: Did you often feel that ... No one in your family loved you or thought you were important or special? Or Your family didn't look out for each other, feel close to each other, or support each other?

Note. Numbers in parentheses indicate number of participants for each category.

*$p < .05$

References

Abraham, K. G. (1982). Influence of significant others' perceived voting behaviors on children's political socialization. Perceptual and Motor Skills, 54(3), 995–1001. https://doi.org/10.2466/pms.1982.54.3.995

Afifi, T. O., & MacMillan, H. (2011). Resilience following child maltreatment: A review of protective factors. *Canadian Journal of Psychiatry, 56*(5), 266-272. doi:10.1177/070674371105600505

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychological Association, 58*(5), 377-402. doi:10.1037/0003-066X.58.5.377

American Society for the Positive Care of Children. (2017). Emotional child abuse. *America SPCC,* 2017. Retrieved from: http://americanspcc.org/child-abuse-statistics/

Brewer, G., Robinson, S., Sumra, A., Tatsi, E., & Gire, N. (2015). The influence of religious coping and religious social support on health behavior, health status, and health attitudes in British Christian sample. *Journal of Religion and Health*, *54*(6), 2225-2234. doi:10.1007/s10943-014-9966-4

Bronfenbrenner U, & Ceci, S. J. (1994). Nature-nurture reconceptualized in developmental perspective: A bioecological model. *Psychological Review, 101*(4), 568–586. doi:10.1037/0033-295X.101.4.568.

Carleton, R. A., Esparza, P., Thaxter, P. J., & Grant, K.E. (2008). Stress, religious coping sources, and depressive symptoms in an urban adolescent sample. *Journal for Scientific Study of Religion, 47*(1), 113-121. doi:10.1111/j.1468-5906.2008.00395.x

Carson, C., Lapsansky-Werner, E. J., & Nash, G. B. (2012). The struggle for freedom: A history of African Americans. *Prentice Hall, 1*.

Causadias, J. M. (2013). A roadmap for the integration of culture into developmental psychopathology. *Development and Psychopathology, 25*, 1375-1398. doi:10.1017/S0954579413000679

Centers for Disease Control and Prevention (CDC). (2012). Behavioral Risk Factor Surveillance System Survey Data. *U.S. Department of Health and Human Services*, Centers for Disease Control and Prevention.

Choleris, E., Galea, L. A. M., Sohrabji, F., & Frick, K. M. (2018). Sex differences in the brain: Implications for behavioral and biomedical research. Neuroscience and Biobehavioral Reviews, 85, 126–145. https://doi.org/10.1016/j.neubiorev.2017.07.005

Cohen, J. (1992). A power primer. *Psychological Bulletin 112*(1), 155-159. http://dx.doi.org/10.1037/0033-2909.112.1.155

Cornelius, J. D. (1999). Slave missions and the black church in the antebellum south. *University of South Carolina Press, Columbia*.

Desrosiers, A. (2012). Relational spirituality in adolescents: Exploring associations with demographics, parenting style, religiosity, and psychopathology. *The Sciences and Engineering*. *73*(1-B), 612.

Durik, A. M., Hyde, J. S., Marks, A. C., Roy, A. L., Anaya, D., and Schultz, G. (2006). Ethnicity and gender stereotypes of emotion. *Sex Roles, 54*(7-8), 429-445. doi:10.1007/s11199-006-9020-4.

Eliassen, A. H. (2013). Religious Coping and Depression in Young Adulthood: Effects of Global Stress and Pre-Teenage Religious Service Attendance. *Review of Religious Research, 55*(3), 413-433. doi:10.1007/s13644-013-0110-9.

Ellison, C. G., Zhang, W., Krause, N., & Marcum, J. P. (2009). Does negative interaction in the church increase psychological distress? Longitudinal findings from the presbyterian panel survey. *Sociology of Religion, 70*(4), 409–431. https://doi.org/10.1093/socrel/srp062

Fabes R. A., Eisenberg N., Bernzweig J. (1990). Coping with Children's Negative Emotions Scale (CCNES): Descriptions and scoring. Tempe: Arizona State University.

Fabes R., Poulin R., Eisenberg N., Madden-Derdich D. (2002). The Coping with Children's Negative Emotions Scale (CCNES): Psychometric properties and relations with children's emotional competence. *Marriage & Family Review, 34*(3–4), 285–310.

Felitti, V.J., Anda, R.F., Nordenberg, D, Williamson, D.F., Spitz A.M., Edwards, V.K., Koss, M.P., and Marks, J.S., (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventative Medicine, 14(4), 245-258. doi:10.1016/j.chiabu.2015.11.017

Fetzer Institute. (1999). Brief multidimensional measurement of religiousness and spirituality. Fetzer Institute. Retrieved from: https://www.gem-beta.org/public/DownloadMeasure.aspx?mid=1155

Finkelhor, D., Shattuck, A., & Turner, H. (2013). Improving the adverse childhood experiences study scale. JAMA Pediatrics, 167(1), 70-75. doi:10.1001/jamapediatrics.2013.420

Foster, D. W., Young, C. M., Steers, M., Quist, M. C., Bryan, J. L., and Neighbors, C. (2014). Tears in your beer: Gender differences in coping drinking motives, depressive symptoms, and drinking. *International Journal of Mental Health and Addiction*, *12*(6), 730-746. doi:10.1007/s11469-014-9504-3

Harney, P. A. (2008). Resilience process in context: Contributions and implications of Bronfenbrenner's person-process-context model. *Journal of Aggression, Maltreatment & Trauma*, *14*(3), 73-87. doi:10.1300/J146v14n03_05

Harrell, Z. A., & Powell, K., (2014). The relationship between parent and student religious coping and college alcohol use. *Religion and Health, 53*(3), 895-903. doi:10.1007/s10943-013-9683-4

Hayes, A. F. (2013). An introduction to mediation, moderation, and conditional process analysis: A regression-based approach. New York: Guilford Press

Higginbotham, E., and Weber, L. (1992). Moving up with kin and community: Upward social mobility for black and white women. *Gender and Society*, *6*(3), 416-440. doi:10.1177/089124392006003005

Hill, T. D., Kaplan, L. M., French, M. T., and Johnson, R. J. (2010). Victimization in early life and mental health in adulthood: An examination of the mediating and moderating influences of psychosocial resources. Journal of Health and Social Behavior, 51(1). doi:10.1177/0022146509361194

Janas, D. M. (2013). Impact of spiritual/religious beliefs on incidents of trauma symptoms in firefighters. *Dissertation Abstracts International, 74* (3-B).

Kendler, K. S. Eaves, L. J., Loken, E. K., Pedersen, N. L., Middeldorp, C. M., Reynolds C., Boomsma, D., Lichenstein, P. Silberg, J., and Garder, C. O. (2011). The impact of environmental experiences on symptoms of anxiety and depression across the life span. *Psychological Science, 22*(10), 1343-1352. doi:10.1177/0956797611417255

Kessler, R. C., and Magee, W. J. (1994). Childhood Family Violence and Adult Recurrent Depression. *Journal of Health and Social Behavior, 35*(1).

Krause, N., Ellison, C. G., Shaw, B. A., Marcum, J. P., & Boardman, J. D. (2001). Church-bases social support and religious coping. *Journal for Scientific Study of Religion, 40*(4), 637-656. doi:10.1111/0021-8294.00082

Lewinsohn, P.M., Seeley, J.R., Roberts, R.E., & Allen, N.B. (1997). Center for Epidemiological Studies-Depression Scale (CES-D) as a screening instrument for depression among community-residing older adults. Psychology and Aging, 12, 277- 287. doi:10.1037/0882-7974.12.2.277

Labella, M. H. (2018). The sociocultural context of emotion socialization in African American families. *Clinical Psychology Review, 59*, 1–15. https://doi.org/10.1016/j.cpr.2017.10.006

Maciejewski, P. K., & Mazure C. M. (2006). Fear of Criticism and Rejection Mediates an Association Between Childhood Emotional Abuse and Adult Onset of Major Depression. *Cognitive Therapy and Research, 30.* doi:10.1007/s10608-006-9012-2

Mckim, A. E. (1995). The roles of religious and social support in the relation of stress and well-being: A cross-cultural study of university students in Botswana and the United States. *The Sciences and Engineering, 56*(5-B), 2876.

Morelen, D., and Thomassin. (2013). Emotion socialization and ethnicity: An examination of practices and outcomes in African American, Asian American, and Latin American families. *Yale Journal of Biology and Medicine, 86*, 168-178.

Nelson, J. A., Leerkes, E. M., Perry, N. B., O'Brien, M., Calkins, S. D., and Marcovitch, S. (2012). European-American and African-American mothers' emotion socialization practices relate differently to their children's academic and social-emotional competence. *Social Development 22*(3). https://doi.org/10.1111/j.1467-9507.2012.00673.x

O'Connell, H. A. (2012). The Impact of Slavery on Racial Inequality in Poverty in the Contemporary U.S. South**.** *Oxford University Press, 90*(3), 713-734. doi:10.1093/sf/sor021

O'Connell, M. E., Boat, T., & Warner, K. E. (2009). Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities. *U.S. Department of Health and Human Services*.

Pew Research Center. (2016). Religion in everyday life. Retrieved April 8, 2018, from http://www.pewforum.org/2016/04/12/religion-in-everyday-life/

Roberts, W. L., & Strayer, J. (1987). Parents' responses to the emotional distress of their children: Relations with children's competence. Developmental Psychology, 23(3), 415–422. https://doi.org/10.1037/0012-1649.23.3.415

Spinazzola, J., Hodgdon, H., Ford, J. D., Briggs, E. C., Liang, L. J., Layne, C. M., Pynoos, R., Stolbach, B., and Kisiel, C. (2014). Unseen wounds: The contribution of psychological maltreatment to child and adolescent mental health and risk outcomes. *Psychological Trauma*, *6*(1), 18 –28. doi:10.1037/a0037766

Spitzer,R. L., Kroenke, K., Williams, J. B., & Lowe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. Archives of Internal Medicine, 166, 1092-1097. doi:10.1001/archinte.166.10.1092

Sternthal, M. J., Williams, D. R., Musick, M. A., and Buck, A. C. (2010). Depression, anxiety, and religious life: A search for mediators. *Journal of Health and Social Behavior*, *51*(3). doi:10.1177/0022146510378237

Swinson, R. P. (2006). The GAD-7 scale was accurate for diagnosing generalized anxiety disorder. Evid Based Med, 11(6), 184. doi:10.1136/ebm.11.6.184

Sue, D. W., and Sue, D. (2008). Counseling the culturally different, 5th ed. New York, *John Wiley*, 576.

U.S. Department of Health and Human Services. (2014). Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. Child Maltreatment. Retrieved from: https://www.acf.hhs.gov/sites/default/files/cb/cm2014.pdf

Van Vugt, E., Lanctot, N., Paquette, G., Collin-Vezina, D., and Lemieux, A. (2013). Girls in residential care: From child maltreatment to trauma-related symptoms in emerging adulthood. *Child Abuse and Neglect*, *38*(1), 114-122. doi:10.1016/j.chiabu.2013.10.015

Whitlock, J. (2010). Review of "Adolescent girls in crisis: Intervention and hope". *Journal of the American Academy of Child & Adolescent Psychiatry*, *49*(9), 966-967. http://dx.doi.org/10.1016/j.jaac.2010.05.010

Williams, D. R., Mohammed, S. A., Leavell, J., & Collins, C. (2012). Race, socioeconomic status and health: Complexities, ongoing challenges and research opportunities. *Ann NY Acad Sci, 1186*, 69-101. doi:10.1111/j.1749-6632.2009.05339.x

World Health Organization. (2016). Child maltreatment. *World Health Organization*. Retrieved from: http://www.who.int/topics/child_abuse/en/

Yeoman, K. Safranek, T., Buss, B., Cadwell, B. L., and Mannino, D. (2013). Adverse childhood experiences and adult smoking. Preventing Chronic Disease, 10. doi:10.5888/pcd10.130009

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