Family Violence Exposure and Health Outcomes Among Older African American Women: Do Spirituality and Social Support Play Protective Roles?

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Abstract

Background: Family violence (FV), spirituality, and social support are salient psychosocial determinants of health. FV is associated with poor health among older African American women. The effect of spirituality and social support levels on the health of older African American women is unknown.

Methods: To assess the role of spirituality and social support as culturally relevant determinants of health status for older African American women independent of FV levels, we used a cross-sectional observational study. Two hundred twelve African American women, aged ≥ 50 , were interviewed in two urban primary care practices. The measures used were (1) Family Violence Against Older Women (FVOW) scale, (2) Physical and Mental Composite Scores of the Short-Form 8[®] scale, (3) Medical Outcomes of Social Support survey (MOSS), and (4) Spiritual Well-Being Scale (SWBS). Spearman correlation coefficients estimated to test associations among lifetime FV exposure, spirituality, social support, and health status outcomes and multivariate regression models were used to examine the independent effect of spirituality and social support on physical and mental health status, controlling for FV and significant demographic variables.

Results: Mean participant age was 63.9 years. Higher spirituality levels were significantly associated with better physical health status after adjusting for FV levels and demographic factors ($F = 6.17$, $p = 0.0001$). Similarly, higher levels of spirituality and social support both significantly correlated with better mental health status in the multivariate model ($F = 13.45$, $p < 0.0001$) that controlled for lifetime FV levels and demographic factors.

Conclusions: Spirituality and social support are two potentially modifiable determinants of health for older African American women. Culturally appropriate mechanisms to enhance social support and spirituality levels need to be explored as potential interventions to improve the health of those African American women who have been exposed to FV.

Introduction

SOCIAL DETERMINANTS OF HEALTH are factors in an individual's environment that contribute to or detract from her health.¹ These factors include, but are not limited to socioeconomic status (SES), transportation, housing, access to services, discrimination (e.g., by race or class), and other social or environmental stressors.¹ Family violence (FV), an important stressor, has long been known to be associated with poor physical and mental health outcomes for younger women.²⁻⁵ Recent investigations indicate that this association between FV and poor health holds true even for older women.⁶⁻⁸ For older women, poor health outcomes associated with both incident and lifetime FV exposure include worse physical and mental health status.^{7,8}

Older African American women risk experiencing worse health outcomes compared with women who are younger or Caucasian or both.^{9,10} Data from nationally representative samples reveal that African Americans are less likely than Caucasians or Asian Americans to report being in good health and that African American women are more likely to die earlier than their Caucasian counterparts; this gap in life expectancy starts at birth and persists through adulthood.^{9,10} As FV exposure over a lifetime is associated with worse physical and mental health status for older African American women,⁸ it is essential to improve our understanding of other factors that may independently enhance the health status of these at-risk women.

Social support levels and spirituality are two distinct, culturally relevant protective factors for African American survivors of FV.¹¹ In fact, they are the preferred means to deal with

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adversity, including FV exposure.^{12–15} Spirituality refers to the perception of and interaction with the transcendence and a sense of inner strength in daily life.¹⁶ Unlike religiosity, which usually refers to an institutional affiliation guided by a shared belief system,¹⁷ spirituality is thought to assist individuals through times of adversity by helping them develop a sense of meaning and purpose.¹¹ Social support refers to the availability of people to provide assistance with physical, psychological, and material needs in times of distress. The act of seeking and receiving support is an adaptive form of coping and may reduce the adverse consequences of exposure to illness or stressors.¹⁸ In studies conducted among recently abused African American women, participants who endorsed high levels of spirituality or social support appeared less likely to manifest negative mental and physical health outcomes.^{13,19–21}

The role of spirituality and social support, as culturally relevant protective factors for abused African American women, has been investigated only in the context of recent FV.¹⁵ We have reason to believe, however, that both spirituality and social support levels may enhance the health status of older African American women and, thus, have the potential to reduce the adverse health effects of lifetime FV exposure. Higher levels of spirituality are associated with better overall health among older adults.^{22–25} Social relationships are thought to be significant for preserving health and well-being for older people.^{26,27} Sherbourne et al.²⁶ demonstrated that community dwelling people with higher levels of social support are more likely to enjoy better health status; the detrimental effects of lower levels of social support were more pronounced for older adults. Further, older adults with strong social ties are able to maintain independence longer than those who are socially isolated.²⁷ Thus, both spirituality and social support are linked to better health outcomes for older people and may positively influence the health status of older African American women, including those who have been exposed to lifetime FV.

In prior work, we showed that high levels of lifetime FV exposure contribute to poor overall health for older African American women.⁸ We take our work one step further by focusing on culturally relevant factors that have the potential to buffer older African American women from the harmful effects of FV exposure on their health status. Specifically, we focus on the independent effect of spirituality and social support levels on the physical and mental health status of African American women, controlling for FV exposure, as we expect these two variables will be modifiable, culturally relevant factors amenable to a targeted intervention. In this article, we present the results of analyses conducted to address the following hypothesis: When controlled for FV level and demographic variables, higher levels of spirituality and social support are associated with better physical and mental health status in low-income, older adult African American women living in an urban environment.

Materials and Methods

Setting and participants

We interviewed 212 participants at two clinical sites (Atlanta, GA, and Philadelphia, PA) over two 12-month periods in the years 2005–2006 and 2008–2009. Participants were a convenience sample of English-speaking women who self-identified as African American, aged ≥ 50 years. We approached a total of 431 women, of whom 212 were eligible,

agreed to participate, and completed the interview (recruitment rate of 49%). Women who were not able to provide informed consent because of lack of understanding or capacity, who scored <22 on the Mini-Mental State Exam,²⁸ or who required immediate medical attention were excluded from the study. Trained research assistants (RAs) approached potential participants as they waited to be seen in the primary care practices at two inner-city hospitals. Medical records were not used to determine age or race; instead, adult women were approached sequentially in the waiting rooms at the study site. The RAs provided interested women the choice of being interviewed at the time of the visit or at a future date, which was then arranged. During the study visit, RAs obtained written informed consent and screened patients for eligibility in a private room. Caregivers and surrogates were not present during the consent and interview process, nor did we obtain consent from them. The teach back method,²⁹ adapted for informed consent, was used to determine capacity; the examiner assesses participant ability to repeat back the reason and context of the study and the implications of participation. All participants were offered either \$10 or \$20 at the end of the interview. The incentive amount was determined by study site to maintain consistency regarding research participation incentives with other ongoing projects at the study sites. We offered all women resource information for a range of agencies that provided services for women exposed to various forms of FV. The investigation was approved by the university Institutional Review Board at both sites and the Research Oversight Committee for one of the two sites.

Measures

We collected data on the following demographic variables: age, grade level attained, individual income, place of residence, marital and relationship status, employment status, insurance status and type, number of children, and whether or not they lived with their children. The predictor variables for the analyses included levels of spirituality and social support. The outcome variables for the analyses were physical and mental health status. We controlled for lifetime FV exposure in both regression models.

We used total scores on the Family Violence in Older Women (FVOW) scale to determine FV exposure levels, with higher scores representing more FV exposure.³⁰ This scale has 29 self-report items that tap the presence and severity of physical violence; emotional, financial, and sexual abuse; and neglect and coercion perpetrated by an intimate partner or family member experienced during the woman's adult life (Appendix). All items are scored on a 5-point Likert scale; responses ranged from 0 (never) to 4 (very often). The FVOW has strong internal consistency reliability (Cronbach's alpha of 0.97) and solid test-retest reliability (correlation coefficients of 0.83).³⁰

The Spiritual Well-Being Scale (SWBS)³¹ was used to determine the participants' spirituality level. This reliable and valid 20-item scale is a measure of overall spiritual well-being and has been used in wide variety of research settings.^{31–33} Each item has 6 response options anchored by Strongly disagree and Strongly agree. The positively worded items are scored from 1 to 6; negatively worded items are scored in reverse. Item scores are summed to obtain the total spirituality score. For the current sample, the internal consistency reliability of this scale was high (Cronbach's alpha 0.90).

Social support was assessed using the 19-item Medical Outcomes of Social Support survey (MOSS).²⁶ Each of the 19 items assesses one of the following forms of support: tangible, affectionate, positive interaction, and emotional/informational. Items are scored on a 5-point scale, anchored by 1 (none of the time) and 5 (all of the time). The sum of the responses represents overall social support; higher total scores represent higher levels of social support. For the current sample, the scale had excellent internal consistency reliability (Cronbach's alpha 0.96).

The outcome variables of physical and mental health status were assessed using the Short Form-8 (SF-8)³⁴ a valid and reliable brief version of the SF-36 instrument.^{35,36} The scores of the SF-8 correlate well with the scores of the SF-36.³⁴ We used the SF-8 to reduce respondent burden. The items rate the following dimensions of health: general health, physical and social function, mental health, role limitation due to physical health or emotional problems, bodily pain, and fatigue. Item responses are transformed, weighted, and aggregated according to standardized scoring procedures, resulting in two summary scores: physical (PCS-8) and mental (MCS-8) summary scores.³⁴ The outcome variables of physical and mental health status are captured by participant PCS-8 and MCS-8 scores, respectively.

Analyses

We calculated means, medians, and frequencies for all demographic variable techniques appropriate for the variable type. Next, we assessed FVOW, MOSS, SWBS, PCS-8, and MCS-8 scores for normality using boxplots and the Shapiro-Wilk test for normality. As the scores for the FVOW, MOSS, and SWBS were not normally distributed, we estimated Spearman's rho to assess the strength of association among all variables of interest.

To test our hypotheses, we constructed two separate multivariate linear regressions for each of the two outcomes (physical and mental health status). Both models included significant demographic variables and lifetime FV exposure in addition to the predictor and the outcome variables. We used a p value of 0.05 for all tests of significance and conducted analyses using SAS 9.1.3 (Cary, NC).

Results

The demographic characteristics of our participant group are presented in Table 1. Mean participant age was 63.9 years (standard deviation [SD] 9 years). Only one fourth reported that they were in an intimate relationship; 44% had not finished high school, and 53% were unemployed or on disability (not retired). Almost 80% of participants owned their own home, although their median reported personal monthly income was only \$927 (range \$0–\$13,000). The majority of the women were recruited at the Atlanta site; one quarter of the total participant pool was recruited at the Philadelphia site. The recruitment rates at the two sites were 62% and 42%, respectively. The only significant differences between participant characteristics by study site were their age and their levels of spirituality. Philadelphia participants were older, had more personal income, and reported higher levels of spirituality (data not shown).

We found significant associations between age and both PCS-8 ($\rho = 0.22, p = 0.007$) and MCS-8 ($\rho = 0.3, p = 0.0002$) as well as

TABLE 1. BACKGROUND CHARACTERISTICS OF STUDY PARTICIPANTS (N = 212)

<i>Demographic characteristic</i>	
Mean age in years (SD)	63.9 (9.3)
Median monthly income (range)	\$927 (\$0–\$13,000)
In an intimate relationship at time of interview, n (%)	54 (25.6)
Has children, n (%)	145 (74.7)**
Children living with participant, ^a n (%)	58 (32)**
Lives in own home, n (%)	169 (79.8)
Separated or divorced, n (%)	74 (35.1)
Did not finish high school, n (%)	94 (44.5)
Unemployed/disabled, n (%)	113 (53.8)
Scale scores	
Mean PCS-8 (SD)	41 (10.4)
Mean MCS-8 (SD)	47.8 (10.8)
Median FVOW score (range)	3 (0–89)
Median MOSS score (range)	82 (0–114)
Median SWBS score (range)	112 (64–120)

^aOf those with children, $n = 145$.

**FVOW, Family Violence Against Older Women; MCS-8, Mental Composite Score; MOSS, Medical Outcomes of Social Support; PCS-8, Physical Composite Score; SD, standard deviation; SWBS, Spiritual Well-Being Scale.

between income and PCS-8 ($\rho = 0.26, p = 0.002$) and MCS-8 ($\rho = 0.19, p = 0.024$). In addition, we found that home ownership and unemployment correlated with PCS-8 and MCS-8 scores. However, as these two variables were both conceptually linked and highly correlated with income, we did not include them in the multivariate models. In bivariate analyses, we found that higher levels of spirituality and social support were associated with better mental health status ($\rho = 0.46, p < 0.0001$ and $\rho = 0.42, p < 0.0001$, respectively) and that higher spirituality levels correlated with better physical health status ($\rho = 0.20, p = 0.017$) (Table 2). On the other hand, we did not find a significant association between social support levels and physical health status ($\rho = 0.07, p = 0.42$). As expected, higher FV levels correlated with worse physical ($\rho = -0.27, p = 0.0008$) and mental health status ($\rho = -0.30, p = 0.0002$).

The results of multivariate models constructed to assess the independent effect of spirituality and social support on health status are shown in Tables 3 and 4. Higher spirituality levels remained significantly associated with better physical health status after adjusting for FV levels and demographic factors ($F = 6.17, p = 0.0001$). Similarly, higher levels of spirituality and social support remained significantly correlated with better mental health status in the multivariate model ($F = 13.45, p < 0.0001$), which controlled for lifetime FV levels and demographic factors. Lifetime FV remained a significant independent correlate of both physical and mental health status in the regression models.

Discussion

In this article, we present results of analyses conducted to demonstrate the links among FV exposure, spirituality and social support, and health status among older African American women. Consistent with predictions, we confirm that higher levels of spirituality and social support are associated with better mental health status in these women. In addition, higher levels of spirituality are also linked to better physical health status. Counter to expectations, however,

TABLE 2. INTERCORRELATIONS BETWEEN VARIABLES OF INTEREST, $N=212$

	PCS-8	MCS-8	MOSS	SWBS	FVOW
PCS-8	—	—	—	—	—
MCS-8	0.16 (0.05) ^a	—	—	—	—
MOSS	0.07 (0.42)	0.42 (<0.0001)	—	—	—
SWBS	0.20 (0.02)	0.46 (<0.0001)	0.54 (<0.0001)	—	—
FVOW	-0.27 (0.0008)	-0.30 (0.0002)	-0.29 (0.0004)	-0.27 (0.0011)	—

^aSpearman's rho presented, with p values in parentheses.

social support levels do not have an independent effect on physical health status.

Our findings about the positive effect of spirituality and health status generally are congruent with prior work among both older people and abused women. Daaleman et al.,²⁵ in a study of 277 geriatric outpatients, found that spirituality levels positively correlated with self-reported good health. Meadows et al.²⁶ demonstrated that higher levels of spirituality are associated with a lower number of suicide attempts among abused African American women. Similarly, Watlington and Murphy¹³ demonstrated that abused African American women with higher levels of spirituality were less likely to report depressive symptoms. The authors assume that the explanatory mechanism for their finding was a greater use of religious coping skills among these women. However, in another investigation of 86 urban African American women conducted by Fowler and Hill,¹¹ spirituality was not linked to symptoms of depression and posttraumatic stress disorder (PTSD). The authors of that study contended that the lack of association may be explained by the inherent weakness of their instrument.¹¹ The mean age of Fowler's sample was 39 years, in contrast to the mean age of our sample of 62 years. Another reason for the difference between our findings and those of Fowler and Hill¹¹ may be the quality of our spirituality measure,³³ as well as the salience of spirituality to older African Americans.²³ It is possible that women in our sample who report higher levels of spirituality may have developed better coping responses and higher levels of resiliency over their lifetime, which may have translated into better physical and mental health status for those women who had experienced FV.

Our data about the link between social support and health status are consistent with the work of Sherbourne et al.,²⁶ who demonstrated that community-dwelling people with higher levels of social support enjoy better health status. Specific to abused women, Coker et al.²⁰ were the first to show that higher levels of social support are associated with better physical and mental health status among abused women. Further, there are data showing the association between

reduced levels of social support and psychological distress in abused inner-city African American women.³⁷ Although we did not examine the effect of social support on the health status of only abused women, we did demonstrate that there was an independent effect of social support on the mental health of older African American women, after controlling for FV exposure. We are not clear why social support levels did not have the same beneficial effect on physical health status. Indeed, one would expect that given that the measure of social support used in this study was developed among medical patients, it would have captured the domains of support associated with better physical health; thus, the finding is counterintuitive. It is possible that given the high medical comorbidity burden that these women experience,^{9,10} the differences in current levels of social support are insufficient to impact their physical health status. Social support may, however, still play a powerful role in determining mental health outcomes because social connections to, and assistance from, family and friends may be a necessary contributor to mental health functioning for older African American women.

This investigation has a few particular strengths that merit mention. First, this is one of the first studies to address psychosocial factors that may explain the FV exposure-health outcome link in older African American women. Given that older African American women exposed to FV report worse physical and mental health well-being than their counterparts without a history of such exposure,⁸ it is crucial to understand the role that social support and spirituality might play in enhancing the health of older African American women. Second, there are a number of positive aspects of the study's methodology. The sample is relatively homogeneous with regard to race and social class and, thus, offers an opportunity for more in-depth appreciation of the phenomenon in this demographic group. We used valid and reliable scales to quantify all the constructs of interest. Our FV scale is comprehensive and designed to address all forms of FV affecting older women.

As with any cross-sectional study, the results are limited by the study design. We are not able to draw firm conclusions about

TABLE 3. INFLUENCE OF SPIRITUALITY LEVELS ON PHYSICAL HEALTH STATUS

Variable	PCS-8 ^a β (SE)	t value	Pr > t
Intercept	19.744 (7.904)	2.50	0.013
FVOW score	-0.102 (0.034)	-2.92	0.004
SWBS score	0.126 (0.058)	2.14	0.033
Age, years	0.126 (0.079)	1.6	0.111
Income (\$)	0.001 (0.0005)	1.94	0.054

Controlled for FV levels, age, and income.

^a $F = 6.17$, $p = 0.0001$.

SE, standard error; FV, family violence.

TABLE 4. INFLUENCE OF SPIRITUALITY AND SOCIAL SUPPORT ON MENTAL HEALTH STATUS

Variable	MCS-8 ^a β (SE)	t value	Pr > t
Intercept	-2.972 (7.621)	-0.39	0.697
FVOW score	-0.71 (0.033)	-2.12	0.0353
MOSS	0.109 (0.046)	2.38	0.0184
SWBS score	0.255 (0.06)	3.95	0.0001
Age, years	0.241 (0.077)	3.13	0.0007
Income (\$)	0.0004 (0.0005)	0.83	0.405

Controlled for FV levels, age, and income.

^a $F = 13.45$, $p < 0.0001$.

the direction of associations observed in our sample. Because the purpose of the study was to understand the role of culturally relevant protective factors on the health of older African American women exposed to FV, we chose to focus on this at-risk, culturally distinct population. The implication of this choice is that our findings cannot be generalized to other population groups. A third weakness of the study is that the measurement tool used for health status is brief and general and, thus, did not provide a comprehensive picture of the physical or mental health of these women. One additional concern that limits our findings is the low participation rate at the Philadelphia site. Most of women who refused at this site reported a lack of interest as the main reason. Wait times at this practice site were shorter than at the Atlanta site. It is possible that dependence on relatives for transportation for a study visit may be a significant factor in their lack of willingness to participate in the study.

Results from this investigation underscore the value of medical professionals conducting a culturally relevant psychosocial assessment during their routine care of older African American women. It is necessary for attention to be paid to these women's mental health as well as physical health. Such attention is not possible without routine assessment and identification of FV in clinical practice. For low-income African American women who endorse FV exposure, it behooves clinicians to query about their levels of spirituality and their sources of social support. Further, our findings suggest that both spirituality and social support levels are potential intervention points for improving the physical and mental health for these women. Enhancing existing spiritual coping skills using such techniques as music therapy³⁸ has the potential to improve overall physical and mental health, particularly in woman exposed to FV. Engaging family, friends, and community members, as well as making referrals to community programs designed to enhance social support, will further enhance the ability of these women to cope with illness and may lead to better mental health. Our data should serve as a reminder to physicians and physicians-in-training that addressing psychosocial determinants of health during healthcare encounters with older African American women exposed to FV can ensure that the care we deliver is culturally competent and patient centered.

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Disclosure Statement

The authors have no conflicts of interest to report.

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Appendix: The Family Violence Against Older Women Scale

Someone close to me (my partner or family member) . . .

- 1 Makes me do things that I don't want to do.
- 2 Tries to hurt me or harm me.
- 3 Makes me get his/her permission before I can go anywhere
- 4 Yells or screams.
- 5 Swears or curses.
- 6 Acts abusive and mean to me when drinks/drugs.
- 7 Makes me feel uncomfortable.
- 8 Very cold (unfeeling) toward me.
- 9 Acts mean and hateful toward me.
- 10 Threatens to hurt or harm me.
- 11 Hits, slaps or kicks me.
- 12 Pushes, grabs, or shoves me.
- 13 Forces me to do sexual acts.
- 14 Throws things.
- 15 Makes me feel stupid.
- 16 Makes me feel afraid.
- 17 Insults me in front of other people.
- 18 Jealous and suspicious when I spend time with others
- 19 Complains about having to take care of me.
- 20 Makes me feel like his/her personal slave.
- 21 Orders me around.
- 22 Makes me stay at home even when I don't want to.
- 23 Makes me stay in bed even when I am not sick.
- 24 Is careless or rough with me.
- 25 Forgets or refuses to feed or take care of me.
- 26 Makes me give him/her my money.
- 27 Takes my money or my things without my permission.
- 28 Refuses to let me buy medicine or other things I need.
- 29 Refuses to let me go to the doctor or causes me to miss my appointments.