“CAN’T IS NOT IN OUR VOCABULARY. I STAY PRAYED UP.”: AN EXPLORATION OF THE MODERATING ROLES OF STRONG BLACK WOMAN IDEOLOGY AND SPIRITUALITY AMONG BLACK MOTHERS WITH HISTORIES OF CHILDHOOD SEXUAL ABUSE

AN ABSTRACT

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BY

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Abstract

Maternal experiences of childhood sexual abuse (CSA) have the potential to create deleterious intergenerational effects within families and communities. Similarly, a small but growing body of literature suggests an association between maternal experiences of racial trauma (discrimination) and emotional and behavioral health outcomes in children. Maternal experiences of CSA and lifetime exposure to racial trauma may impact the quality of the mother-child relationship. However, the co-contribution of these experiences to maternal and child mental health, as well as culture-specific risk and protective factors in intergenerational transmission, have not been examined. The aims of this study were two-fold. The first aim of this study was to examine the association between maternal CSA, maternal racial trauma, and risk factors for intergenerational transmission of vulnerability, including child behavior problems and maternal depressive symptoms. Secondly, this study is the first known study to examine culture-specific, modifiable risk (Strong Black Woman Ideology endorsement) and protective factors (spiritual coping) for maternal depressive symptoms for Black mothers in contexts of discrimination and CSA. Regression analyses revealed maternal use of spiritual coping as a protective factor associated with lower levels maternal mental health challenges among Black mothers; the impact of maternal use of spiritual coping was greater than the impact of both maternal history of childhood sexual abuse and lifetime discrimination exposure. Endorsement of Strong Black Woman Ideology was identified as a risk factor for maternal depressive symptoms. These results provide evidence of the impact of Black mothers’ intersectional identities and lived experiences on maternal mental health outcomes. Recommendations and suggestions for future research and clinical practice to
better support the needs of Black mothers and subsequently promote the health and well-being of young Black children are discussed.
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Dedication

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# Table of Contents

Dedication........................................................................................................ii

Acknowledgements.........................................................................................iii

Table of Contents..............................................................................................v

List of Tables....................................................................................................viii

List of Figures...................................................................................................ix

Introduction.......................................................................................................1

  Maternal History of CSA, Racial Trauma and Outcomes for Mothers and
  Children.........................................................................................................1

  Maternal CSA History and Depression.......................................................5

  Vulnerabilities for Black Mothers...............................................................8

  Financial Hardship/Wealth Inequities.........................................................8

  Painful Soul Ties...........................................................................................9

  Derogatory Tropes.......................................................................................10

  Culturally Specific Sources of Strength for Black Women......................12

  Spirituality/Religiosity and the Black Community......................................14

  CSA Survivors, Racial Trauma, Religion, and Spiritual Coping..................15

  Strong Black Woman Ideology.....................................................................18

The Present Study.............................................................................................25

  Hypotheses..................................................................................................25

Methods............................................................................................................26

  Participants..................................................................................................26

  Procedures.................................................................................................26
Measures

Sociodemographic Information

Maternal History of Childhood Sexual Abuse

Maternal Depressive Symptoms

Maternal Experiences of Discrimination

Strong Black Woman Ideology (SBW)

Child Behavior Problems

Analytic Plan

The First Aim of this Study

Hypothesis 1

Hypothesis 2

The Second Aim of this Study

Hypothesis 3

Hypothesis 4

Results

Sample Characteristics and Descriptive Analyses

Maternal CSA Exposure

CSA Exposure and Key Study Variables in the Analytic Sample

Hypothesis Testing

Maternal CSA, Depressive Symptoms and Child Behavior Problems

Maternal Exposure to Discrimination and Depressive Symptoms

Culture Specific Risk and Protective Factors in the Context of Maternal
List of Tables

Table 1. Time 1 and Time 2 Measures and Constructs……………………………86

Table 2. Summary of Variable Correlations, Means, and Standard Deviations Among All Mothers in Analytic Sample………………………………………87

Table 3. Summary of Variable Correlations, Means, and Standard Deviations Among Mothers Who Endorsed Histories of CSA…………………………88

Table 4. Summary of Variable Correlations, Means, and Standard Deviations Among Mothers who Did Not Endorse Histories of CSA……………………………89

Table 5 Analysis for Mediation of Maternal Depressive Symptoms at Time 1 between Maternal CSA and Time 2 Child Behavior Problems……………………………90

Table 6. Regression Analysis Summary for Main Effects and Interaction Effects of Maternal CSA History, Exposure to Discrimination, Spiritual Coping, SBW, on Maternal Depressive Symptoms at Time 2 ………………………………91
List of Figures

Figure 1: Conceptual Model.................................................................92

Figure 2: Standardized Regression Coefficients for the Relationship between
Maternal CSA History and Child Behavior Problems at Time 2 Mediated by
Maternal Depressive Symptoms at Time 1........................................93
Introduction

“Black women have resilience, whether we like it or not.” – Dr. Maya Angelou

Approximately 1 in 3 women experiences sexual abuse during childhood (Finkelhor et al., 2013). The broader quantitative findings on maternal childhood sexual abuse (CSA) history and parenting/child outcomes during early childhood highlight the associations between maternal CSA and decreased parenting self-esteem (Jaffe et al., 2012), decreased household income and increased maternal depression (Roberts, et al., 2004), parenting anxiety (Douglas, 2000), and decreased parenting efficacy (Pazdera et al., 2013; Fitzgerald et al., 2005).

Maternal History of CSA, Racial Trauma and Outcomes for Mothers and Children

There is a plethora of qualitative and quantitative literature addressing the impact of CSA on White mothers and children. The current literature is based predominantly on the experiences of White, middle- and high-income mothers. Very few studies, within the early childhood and maternal CSA literature, have explored the impact of maternal history of CSA on the parenting experiences of Black mothers during the early years of parenting. However, rates of CSA may be higher among Black American women (Elliott & Urquiza, 2006). Exposure to CSA among Black mothers has been associated with re-exposure to sexual assault in adulthood, intimate partner violence, depression, anxiety, disruption within the mother-child relationship and internalizing and externalizing behaviors in the children of CSA survivors (Barrett, 2009).

Black CSA survivors are also at risk for exposure to racial trauma. Experiences of racism can be categorized as racial trauma or race-based trauma. Racial trauma can be
defined as psychological, emotional, and physical harm caused by experiences of real and perceived covert and overt forms of racism (Bryant-Davis & Ocampo, 2005). Experiences of racism and racial discrimination through individual, institutional, and cultural exchanges may cause individuals to experience stress (Utsey, 1999). Research has shown that Black Americans have elevated levels of PTSD that cannot be explained by stressful events (e.g. natural disaster, illness, etc.) and suggests that the unaccounted-for stressors may be race-based stressors (Carter, 2007). Williams et al. (2018) posits that repeated encounters with racism/re-traumatization (e.g. driving while Black, worshipping while Black, working while Black, etc.) may cause Black Americans to present with elevated mental health symptoms. When considering racial trauma, Helms and colleagues (2012) recommended that one’s knowledge of the historical racism towards his/her group should be considered as traumatic stressors, even if his/her life has not been directly threatened by acts of racism. Additionally, racial stressors may go unaccounted for due to the tendency for Black Americans’ reluctance to discuss experiences of racism when participating in mental health treatment (Thompson et al., 2004). The race and discrimination literature has also explored the deleterious effects of maternal exposure to racism and children’s wellbeing. Parental exposure to racism prior to birth has been associated with premature birth (Rankin et al., 2011), low birthweight (Collins et al., 2004), and children’s behavioral and emotional outcomes including externalizing behaviors, socioemotional difficulties, and low self-esteem (Espinoza et al., 2016).

Within the CSA literature, the impact of structural risk factors such as racism, discrimination, prejudice, and access to resources on the intergenerational transmission of
trauma from Black female survivors of CSA to their children has not been studied. Not only are these mothers survivors of sexual abuse, but they daily navigate through American society as Black women. Black CSA survivors are striving to overcome and manage the effects of their own trauma histories while daily making the decision to combat, ignore, or internalize the negative tropes often attached to Black femininity and Black pain.

However, the harmful effects of childhood trauma, including CSA, on Black women have been explored within the broader women’s health literature. Histories of childhood sexual abuse have been associated with decreased contact with medical treatment evidenced by decreased likelihood of receiving annual women’s wellness exams and increased chronic illness including hypertension (Lawson et al., 1999). Lawson et al. (1999) found that Black women who have histories of elevated race-based social inequality more frequently sought treatment for reproductive health complications. In the United States, Black women are 3-4 times more likely to die from pregnancy related complications than White women (Howell, 2018). As of date, during this time of global crisis, Black Americans represent 14% of all COVID related deaths despite representing only 13% of the U.S. population (Hill & Artiga, 2022). Poor health outcomes and decreased engagement with health care systems may be a byproduct of systemic racism and slavery actualized through biased healthcare treatment. Many medical providers often ignore the pain of Black women. Hoffman et al. (2018) found that 40% of first- and second-year medical students believed that Black Americans experience less physical pain compared to White Americans. Being keenly aware of how society and helping professionals may view them, Black trauma survivors may be less likely to engage in
traditional help-seeking behaviors such as therapy, family counseling and psychiatric support. On May 5, 1962, during the funeral services for Ronald Stokes, a Nation of Islam follower killed by Los Angeles police, one of the greatest Black thinkers of our time, Malcolm X, stated, “The most disrespected person in America is the Black woman. The most unprotected person in America is the Black woman. The most neglected person in America is the Black woman” (Educational Video Group, n.d.).

How can we effectively explore the impact of CSA on Black mothers if we ignore the struggles and culturally specific coping and help-seeking behaviors associated with their “Blackness?” The CSA literature ignores the “and.” These mothers are Black and female and survivors of significant trauma; they are members of at least three marginalized groups. Black CSA survivors belong to multiple marginalized groups; each membership bringing with it, its own set of stigmas and stereotypes. The cumulative impact of these varying memberships on life experiences can be better understood using methods rooted in intersectionality theory. Intersectionality is the study of how multiple social identities intersect to create and maintain complex and layered systems of inequality and discrimination (Grzanka et al., 2017). Through the use of intersectional research methods, scholars can better explore the impact of CSA on the intergenerational transmission of trauma in Black families by acknowledging and examining the impact of structural racism and “anti-Blackness” on Black CSA survivors and recognizing the unique ways in which Black mothers disrupt the cycle of intergenerational transmission of trauma. Although the CSA literature has not explored the impact of racism on the coping strategies used by Black female CSA survivors in the context of early motherhood, qualitative and quantitative work has been done to provide insight into the
lasting effects of CSA, impact of CSA on maternal mental health and beliefs and strategies that promote healing in adulthood among survivors.

**Maternal CSA History and Depression**

Currently, literature on the impact of childhood sexual abuse on Black mothers and parenting during early childhood is limited and largely focused on individual-level or family-level risks while ignoring larger structural influences and cultural resources. Current research findings indicate that intergenerational transmission of stress may be imparted through individual and family-level risks such as maternal depression and harsh parenting. However, much of the literature has focused primarily on the experiences of White CSA survivors. In efforts to highlight developments in the study of maternal CSA and parenting outcomes during early childhood (age 0-5 years), related studies with at least 40% of participants identifying as Black or African American are discussed below.

Madigan and colleagues (2014) analyzed the course of depression during the transition to parenthood among teen survivors of CSA using a longitudinal design. Forty-nine percent of participants identified as Black and the mean level of educational attainment was 10th grade. Participants were initially interviewed during the second trimester of pregnancy and again at 6 and 12 months postpartum. Depression was measured using the Beck Depression Inventory Second Edition. Results of their study indicated that CSA was significantly correlated with depression at 12 months postpartum, even when controlling for histories of physical abuse and neglect. Teen mothers with histories of CSA were at an increased risk of maintaining depressive symptoms during the postpartum period.
Some studies have been able to capture data on the individual risks associated with maternal histories of CSA on parenting during early childhood among predominantly Black research samples. However, the sample pools consisted of mostly low-income participants. Pazdera et al. (2013) designed a study to examine the relationships between maternal history of childhood sexual abuse, parenting discipline practices, maternal depression, and perceived parenting competence. Seventy-three percent of participants identified as Black/African American. Eighty-one percent of participants had a high school diploma or GED. Forty percent of participants had an income of less than $15,000 annually. Pazdera et al (2013) ran analyses using data from the longitudinal Parenting Among Women Sexually Abused in Childhood Study (PAWSAIC). Findings suggested that mothers with CSA histories endorsed lower perceived parenting competency and higher levels of depressive symptoms. Path analysis indicated that the relationship between CSA and parenting stress and maltreatment was mediated by maternal depression and parenting competency (Pazdera et al., 2013). Thusly, prevention and early intervention efforts focused on parent education and maternal mental health support may disrupt the intergenerational transmission of trauma from Black CSA survivors to their children through harsh parenting. Parental depression and harsh parenting practices have been shown to mediate the relationship between parental exposure to racism and child health outcomes (Anderson et al., 2015). Early intervention for maternal mental health may be especially beneficial for Black CSA survivors who have experienced racism, as maternal depression has been shown to mediate the relationship between maternal exposure to racism and undesirable parenting practices (Anderson et al., 2015).
Schuetze and Eiden (2005) and Mapp (2006) also completed studies using the same PAWSAIC secondary data. Schuetze and Eiden (2005), investigated the associations between maternal CSA history and parenting outcomes (parenting stress, parenting competence and parenting practices). Results of their study indicated that the relationship between CSA and harsh parenting was fully mediated by maternal involvement in current intimate partner violence and maternal depression. Mapp (2006) developed a study to explore the path by which maternal history of CSA impacts the risk of perpetuating physical abuse through maternal locus of control, maternal depression, and exposure to intimate partner violence. Mapp (2006) results suggested that the relationship between childhood sexual abuse and the risk of committing physical abuse was indirect in nature and mediated by depression. Although CSA history was associated with depression, the influence of maternal locus of control was four times as influential on depression as CSA history.

Findings from studies using the (PAWSAIC) datasets help explain the mechanisms through which early maternal childhood trauma (CSA), current trauma (intimate partner violence) and individual factors (maternal depression and perceived parenting competency) contribute to low-income Black mother’s utilization of harsh parenting strategies. However, these findings blatantly disregard the compounding effect of structural risks such as race(ism) and Black mother’s use of culturally specific coping strategies on the intergenerational transmission of trauma with harsh parenting. Failure to acknowledge the influence racial trauma on Black CSA survivors prevents the development of culturally appropriate interventions that are relevant to the needs of this population.
Vulnerabilities for Black Mothers

Financial Hardship/Wealth Inequities

Black women and girls are at an increased risk for sexual abuse due to the increased likelihood that they will live in poverty and in high violence communities (DuMonthier et al., 2017). Not only are Black American women more likely to experience economic hardship that place them at risk for CSA, generally accepted negative stereotypes about Black women are perpetuated by media that place Black women at an elevated risk for violation.

Twenty percent of Black Americans live in poverty compared to 8% of White Americans (Kaiser Family Foundation, 2018). Black women are at an increased risk of living and raising families in an environment of financial hardship. Black women are paid less than black men, white men, and white women (Hooks, 2015). Black women who are born into middle-class income households are still more likely to end up near, at, or below the poverty line in adulthood (Pacific Library, 2015). Black women should not accept culpability for their societal positioning. Financial hardship experienced by Black women is yet another consequence of many carefully orchestrated systems of oppression.

Poverty places women at increased vulnerability for emotional, physical, and relational risks. This is exemplified in Maslow’s hierarchy of needs (Maslow, 1943). The foundation of Maslow’s hierarchy of needs consists of physiological needs including food, water, and warmth. Those basic needs (e.g., rent, electricity, grocery, etc.) require adequate financial stability. The second tier of the hierarchy includes safety needs including security and safety. Black women are often unable to successfully reach Maslow’s highest tier. When she is unable to provide for her physiological needs, her
safety and security is threatened, placing her at increased risk of victimization and revictimization. This is a grim reality for many Black CSA survivors.

Frias and Angel (2007) reported that women’s employment status impacts their risks of repeated violence. Women who are unemployed and lack financial stability are at an increased risk of experiencing repeated violence and are less likely to leave their abusers than women who are more financially secure (Frias & Angel, 2007).

**Painful Soul Ties**

One hundred- and fifty years post slavery, Black Americans in the United States continue to experience the negative consequences of slavery through Post Traumatic Slave Syndrome, PTSS. One of the key components of PTSS is multigenerational trauma paired with continued oppression (DeGruy, 2005); it is passed down generationally through family, community and societal mechanisms (Crawford, Nobles & DeGruy, 2003) and perpetuated by ongoing and repeated psychologically exhaustive experiences of racism and oppression (Halloran, 2019).

Within the context of Black America, sometimes the decision is made to spare the vilification of the Black male relative or protect the family name at the expense of children’s innocence (Stone, 2004). Black women are often encouraged to tolerate and celebrate the misogyny perpetuated within their communities through music and film (Pough, 2007). Particularly harmful to Black women is the devaluation and sexual objectification of Black women perpetuated through drill rap music (Clark et al., 2016; Cundiff, 2013). Black queer feminist Moya Bailey coined the term *misogynoir*, which nearly perfectly articulates the victimization of Black women at the hands of Black men.
Misogynoir conceptualizes two major threats associated with Black women’s intersectionality: anti-Blackness and sexism (Bailey & Trudy, 2018).

Collins (1998) attributed this intracommunal self-destructive behavior to the trauma bonds shared between Black men and women to this country’s history of repeated criminalization and figurative and literal lynching of Black men. Consequently, Black male and female victims of childhood sexual abuse often suffer in silence. Thomas et al. (2008) reported that some Black women have learned to manage and cope with distress through suppressing and avoiding rather than problem-solving, potentially stemming from feelings of powerlessness and betrayal linked with experiences of childhood sexual trauma (Finkelhor & Browne, 1985).

**Derogatory Tropes**

Negative stereotypes about Black women place them at increased risk for maltreatment and abuse in and outside of the Black community. The internalization of mainstream beliefs about femininity and stereotypes about Black women have been associated with negative psychological outcomes in Black women (Tolman et al., 2006). There are three prominent stereotypes about black women that permeate American culture: Mammy, Sapphire, and Jezebel (West, 1995). The Mammy stereotype is often depicted as a fat, self-sacrificing caregiver; her only role is to serve and ensure that those in her charge are well-taken care of. She is the entertainment, the sturdy shoulder to cry on, and always available wise friend and confidant. Most importantly, Mammy is not a sexual being. Sapphire is depicted as the “angry Black woman.” Sapphire emasculates and belittles Black men. Sapphire is uncouth, loud, and obnoxious. The Jezebel is “Ms.
I’m gone steal yo’ man.” Jezebel’s power lies within her sexuality. Jezebel is presented as overtly sexual and as a woman who uses her sexuality to control men.

Jezebel places the entirety of the Black woman’s value in her physical, reproductive, and sexual attributes. Girls do not have control over how their bodies develop or the age at which rounded hips, breasts, and thighs begin to develop. However, too often when allegations of CSA arise within Black households, someone echoes, “Well, you know she always been fast,” or “She kept tempting him.” According to Epstein et al. (2017) national (United States) survey data shows that adults view Black girls as less innocent and more adult-like compared to White peers, especially girls within the 5-14 age range; more specifically respondents reported the belief that Black girls were more knowledgeable about sex compared to White girls and were more likely to take on adult roles. These beliefs and sentiments place Black women and girls at risk for victimization and re-victimization, especially if abused women begin to find and place their self-esteem and self-worth in their sexuality (West, 1995). Research has shown that endorsement of the Jezebel stereotype among adolescent Black girls has been positively associated with endorsement of colorism, and rejection of Black beauty standards, and likelihood of engaging in early unprotected sex (Townsend et al., 2010).

Sadly, these stereotypes are immortalized in mainstream media and pornography, which may embed them in the psyches of collective society and Black girls. 

Metastereotype awareness among Black women, or Black women’s awareness that others endorse negative stereotypes about them, has been shown to predict negative mental health outcomes including depression, anxiety, and hostility which predict decreased self-care practices and maladaptive coping through the use of drugs and
alcohol (Jerald, Cole, Ward & Avery, 2017). Jerald, Ward, Moss, Thomas and Fletcher (2017) found that media (music videos and movies) contribute to the endorsement of traditional gender ideologies and stereotypes about Black women among young Black women. Internalized racism occurs when Black women accept and adopt the societal stereotypes about Black Americans or glorify White American cultural ideals. If internalized, these negative beliefs may cause Black women and girls to believe that their sexual abuse and exploitation is justified, conclude that something within them is broken, or that they somehow brought the abuse upon themselves.

The maternal CSA literature has not explored the relationship between the metastereotype awareness, experiences of covert and overt racism, help-seeking behaviors, and parenting practices of Black CSA survivors. Potential research objectives are two-fold: (a) increasing understanding of the mediating effect of metastereotype awareness on help seeking behaviors among Black CSA survivors who are mothers of young children and the relationship between metastereotype awareness and maternal mental health outcomes (b) exploration of the relationship between internalized racism and parenting practices of Black mothers during the early years of motherhood. Endorsement of stereotypes about Black women can be measured using Thomas et al. (2004) Stereotypic Roles for Black Women Scale (SRBWS). Utilization of the SRBWS and measures of ethnic identity in the CSA literature may provide the opportunity to assess the intersectional influences of historical trauma, institutional racism, gender, and ethnic identity on parenting and mental health outcomes among Black CSA survivors.

**Culturally Specific Sources of Strength for Black Women**
On May 25, 2020, George Floyd, a 46-year old Black Houston native was murdered in front of a crowd of his peers in Minneapolis, Minnesota. As George Floyd lay dying, with his neck crushing under the weight of a police officer’s knee, he called out for help. George Floyd did not call out to Jesus, Allah, or Yahweh. In the last moments of his life, he called out for his mother. As he painfully succumbed to his unjust demise he cried, “Mama! Mama I’m through!”

Who is she this giver of life, teacher of right and wrong and just versus unjust, healer of scrapes and bruises, protector from the perverted and evil? Do we call her Mama, Mommy, Maw-Maw, Mother, Madear, Meme or Masa? She holds the answers to all questions. When little ones question her authority, her response, “Because I said so,” is often enough to quiet a curious child. She is the Black mother.

Black families and communities often look to the Black matriarch as the peacemaker, provider, mobilizer, and source of comfort and affirmation. Who does the Black mother look to support her during her times of need? What persons, entities, or networks do Black mothers lean on/into when they are feeling exhausted by the weight placed upon them by society and their communities? From an early age, Black girls are taught they have to work twice as hard as White children to be considered passing. This is manifested in adulthood when some Black women feel that they must succeed and excel at everything (Jones & Shorter-Gooden, 2003). For Black American CSA survivors who work and live in close proximity to White Americans, the burden of constantly shifting/code-switching and hypervigilance while navigating “professional” spaces can be overwhelming. Therefore, it is imperative that childhood trauma researchers attempt to
understand how Black female survivors of CSA manage and cope with the aftermath of trauma while successfully navigating parenthood, within a society that largely does not value their humanity. Academic discourse has often overlooked the value of culturally specific coping mechanisms used by Black survivors of CSA to achieve and sustain, despite their trauma histories and recurring experiences of marginalization.

**Spirituality/Religiosity and the Black Community**

Since the arrival of enslaved Africans in the Americas, religion and spirituality have served as coping mechanisms used to endure the uncertainties of life. During the 1800s, churches served as safe havens and stations along the Underground Railroad, as enslaved Black individuals escaped the grips of bondage. The Black church served as the epicenter of the Montgomery Bus Boycott and other pivotal events during the Civil Rights Movement. Any smart politician hoping to gain the support of Black voters, knows that she must stop by the most prominent Black churches within her community.

The benefits of spirituality and participation in religious activities for Black Americans has been documented in the literature. The Black American Church still functions as an entity that often provides physical, financial, and emotional support to members. Members of the congregation who worship together often form church families (Graham, 2016).

Faith often facilitates survival for Black people. Spiritual and religious involvement are forms of self-preservation and self-care for many Black people (Bacchus & Holley, 2004). Black women use spiritual coping to survive amid oppressive circumstances related to their intersectionality (Floyd-Thomas, 2006). Black Americans pray more often and have more steadfast religious beliefs compared to White Americans.
(Taylor et al., 1999). Black Americans who attend church at least once a week live 14 years longer than Black Americans who do not attend church (Hummer et al., 1999). Compared to non-religious Black Americans, religious Black Americans, have improved mental health and have lower levels of substance abuse, suicide, depression, and higher levels of life satisfaction (Ball et al., 2003). High endorsement of spirituality among Black young adults has been shown to mitigate the impact of racial trauma on physiological outcomes and overall health (Bowen-Read & Harrell, 2002).

Across the United States, more than 80% of Black women describe religion as highly important and nearly 60% of Black women attend church on a weekly basis (Pew Research Center, 2009). On any given Sunday, in most Black American churches, it is very likely that the observed majority of individuals in the church will be women and children. Generations of Black women weekly fill wooden and stiffly cushioned church pews. Most revered are the church mothers, the honorary grandmothers of entire congregations - the revered matriarchal leaders. It is not uncommon for Black men and women to attribute their survival to their grandmother’s prayers. Black grandmothers are often the spiritual and literal backbones of their families (Gibson, 2002).

**CSA Survivors, Racial Trauma, Religion, and Spiritual Coping**

Research has shown that spiritual and religious coping provides support for survivors of sexual abuse and racial trauma. Qualitative studies have identified spirituality and belief of a Higher Power as a source of strength and sustainment among ethnically diverse groups of adult male and female childhood sexual abuse survivors (Draucker et al., 2011) and female sexual assault survivors (Ahrens et al., 2010). Decreases in spirituality have been associated with decreases in well-being among female
Black and Hispanic sexual assault survivors (Kennedy et al., 1998). Black sexual assault survivors are more likely to use both positive (e.g., praying, spending time with other members of faith organization, and activities that promote connectedness with God) and negative (e.g., questioning belief system) religious coping strategies more than survivors from other ethnicities (Ahrens et al., 2010). Much of the sexual trauma literature that explores the benefits of spiritual and religious coping focuses on the experiences of sexual assault survivors.

Painful experiences such as abuse and maltreatment may cause survivors to distance themselves from religious communities. Singh and colleagues (2013) completed a qualitative study to explore sources of healing for Black female CSA survivors. Participants in their study highlighted the complex relationships they had with religious institutions; some described churches as places that earlier on in life, hushed their experiences of CSA and discouraged exploration of sexuality and eventually transformed into safe supportive spaces in later adulthood.

Similarly, within the racial stress and trauma literature, spirituality and perceived connectedness to a Higher Power is a frequently used culture specific coping mechanism that assists Black Americans in finding strength and hope when exposed to racial trauma. Among Black women, experiences of gendered racism have been positively associated with psychological distress (Thomas et al., 2008) and Black women cope with gender and race related stress through the use of resistance strategies that include finding rest in faith, relying on prayer and spirituality and harnessing strength from African American ancestors (Shorter-Good, 2004). Spirituality and an active prayer life rather than rote participation in religious activities (e.g., church attendance, church involvement and early
religious involvement) are associated with optimism in Black women; the perceived possession of a supportive and loving relationship with God predicts optimism (Mattis et al., 2003).

Black individuals experience racism in nearly every aspect of their lives (academic, professional, public, and private realms). Frequent exposure to racism and racial stress may lead to detrimental physical and mental health outcomes. Cardiovascular reactivity and resting systolic and diastolic blood pressure, are some one of the primary early indicators of risk for heart disease. Cooper and colleagues (2014) found that Black women who endorse higher use of prayer as a coping mechanism to address racism have decreased levels of resting systolic and diastolic blood pressure and lower resting heart rate variability. Furthermore, the same group of women also have lower diastolic blood pressure and increased heart variability after being asked to recall racial trauma when compared to women who do not use prayer or infrequently use prayer. These findings demonstrate the power of spirituality and prayer to moderate the impact of exposure to racial trauma on physiological indicators of stress and predictors of heart disease.

Bowen-Reid and Harrell (2002) examined the associations between exposure to racism, racial stress, mental health outcomes, and spirituality among Black college students. Within their study, 95% of participants endorsed experiences of racism within the past twelve months and those experiences of perceived racism were associated with negative psychological health symptoms including somatization, depression, anxiety, hostility, and paranoia. Spirituality was identified as a culture specific protective mechanism; spirituality moderated the relationship between racial stress and poor mental health symptoms.
Based upon the extant literature, religious involvement, spirituality, and prayer present as critical sources of support for many Black women and sexual assault survivors. Research suggests that the use of prayer as a coping mechanism to combat exposure to racism may provide cardiovascular health benefits for Black women. However, the associations between experiences of racism and discrimination, spiritual coping, and maternal depressive symptoms among Black mothers of young children has not yet been explored.

**Strong Black Woman Ideology**

Black girls are socialized about what it means to be Black women by their mothers, grandmothers, aunties, cousins, teachers, friends, and the media. Often Black mothers bring up their daughters using the parental-child model in which mothers rely on young girls to manage some responsibilities. Within this model, mothers give daughters responsibilities to provide them with armor to protect them from the harmful effects of stereotyping and aggressions related to their intersectionality (race, gender, and class; Edmondson Bell & Nkomo, 1998). Further bolstering Black girls’ armor against the demeaning tropes (mammy, jezebel, and sapphire) used to characterize Black women, an ethnocentric ideology has emerged within the Black community and subsequently appeared time and time again within mainstream media - the Strong Black Woman Schema, SBW. SBW has also been referred to as the Superwoman Schema (Woods-Giscombe, 2010), Sojourner Truth Syndrome (Mullings, 2000), and Sisterella Complex (Shorter-Gooden, 2003).

Abrams et al. (2014) conducted a qualitative study, with an economically, educationally, and spiritually diverse group of Black women ranging in age from 18 to 91
years of age to better operationalize the Strong Black Woman schema. The following strength-oriented subthemes arose from that study: Embodies and Displays Multiple Forms of Strength, Possesses Self/Ethnic Pride in Spite of Intersectional Oppression, Embraces Being Every Woman, and Anchored by Religion/Spirituality.

The first main theme to arise from Abrams, Maxwell, Pope and Belgrave (2014) qualitative study was the identification of strength as a positive attribute that was often described by participants as a badge of honor and courage rather than as a burden. The first subtheme to arise was Embodies and Displays Multiple Forms of Strength. Women frequently described independence and strength as their ability to, without assistance from others, provide for herself, family, and community. Key defining aspects of this theme included resilience and matriarchal leadership. The authors described resilience as “overcoming various challenges and being able to regain composure in the midst of adversity” (Abrams et al., 2014, p. 509). Participants described the possession of resilience as a mandatory and non-negotiable trait required for survival for all Black women. The second major theme to arise from the study was matriarchal leadership. Participants described matriarchal leadership as instilling wisdom and providing guidance to children, younger generations, and the community. The matriarchal leadership theme acknowledges the multigenerational consequences of chattel slavery and the mass incarceration of Black men on the Black experience. By reason of historical and ongoing systematic racism and prejudice, Black women have been forced to serve as nurturers, protectors, and political voices for the Black collective and community.

The second subtheme to emerge was Possesses Self/Ethnic Pride in Spite of Intersectional Oppression. The ability for Black women to recognize their own beauty in
the absence of external validation was a key concept used to describe the possession of self-pride. The third subtheme to emerge was Embraces Being Every Woman. This theme referred to the often-never-ending responsibilities balanced by the Strong Black Woman; it depicts not only the Black woman’s ability to manage those responsibilities but living each day with the perpetual desire or need to exceed and surpass expectations associated with her many obligatory pursuits. The subtheme of Embraces Being Every Woman references the provision of self-sacrificial care to others. A participant stated, “By definition a Strong Black Woman is to deny her own needs” (Abrams et al., 2014, p. 511). Participants often expressed feeling consumed by their numerous responsibilities and the negative impact of having to be everything for everybody on their own wellness. The fourth and final subtheme to emerge was the Anchored by Religion/Spirituality. Focus group responses suggested that Strong Black Women can continue on in spite of difficulty and challenges through religion or spirituality. Participants believed that they could harness guidance and strength by their relationships with a Higher Power and religious organizations (Abrams et al., 2014). This subtheme emphasizes the role of spirituality/religiosity as a coping mechanism used by Black women during stressful times.

Abrams et al. (2014), recommended that future studies explore the expression of the SBW in demanding relationships such as parenting. This is especially important during early childhood, when mothers and children are creating the foundations for children’s self-regulation systems and future relationships.

The proposed study will uniquely contribute to the current literature by examining pathways between SBW ideology, maternal depression, and early childhood behavior.
outcomes among Black CSA survivors. Findings will shed light on the mechanisms that promote or deter the intergenerational transmission of trauma in Black families.

Some Black women’s endorsement of the SBW ideology may explain why Black Americans are able to “better” cope with stressful life events compared to White Americans (Assari, 2016). However, how well are Black women really coping with stressful life events? At what cost? The emphasis on self-reliance and unwavering determination embodied within SBW ideology may potentially harm Black Women.

SBW emphasis on strength and self-reliance may inhibit help-seeking behaviors and contribute to declines in physical and emotional health of Black mothers. Despite experiencing comparable rates of depression and anxiety symptomology, Black women are less likely to engage in mental health treatment compared to the general population (Abrams et al., 2019). Hall and colleagues (2021) facilitated focus groups with Black women to better understand the association between SBW ideology and mental health treatment utilization. Some women shared their beliefs that seeking mental health treatment was an indicator of low cultural pride (Black Pride). One participant shared “Our parents taught us that being “strong,” not allowing yourself to be overcome by racism and sexism are symbols of pride that represent our culture. Going to therapy would be an insult to our race” (Hall et al., 2021, p. 6). Her statement suggests that some Black women have been taught to self-silence in order to cope with struggles related to their salient intersecting identities.

When Black women continuously respond to stress with self-reliance, caregiving, and emotional suppression, they are put at risk for a plethora of health challenges (Kwate et al., 2003) including increased risk of Type II diabetes (CDC, 2014), hypertension
(Mozfarrian et al., 2015), and stroke (Howard et al., 2013); all of which are directly or indirectly related to stress, stress management and obesity.

SBW emphasis on caring for other’s even to the extent of neglecting personal needs taps into the core assumptions of Mammy stereotype. The foundation of Mammy’s performative existence and unwavering strength is rooted in self-silencing. Self-silencing includes four behaviors that map perfectly onto the Mammy archetype: (1) silencing the self and not directly making personal needs and wants known, (2) divided self-presenting publicly as submissive, while internally experiencing anger, (3) putting the needs of others before her own and (4) evaluating self based on external standards (Jack & Ali, 2010). The relationship between women’s perceived obligatory outward manifestations of strength and depressive symptomology is mediated by self-silencing (Abrams et al., 2019). Through self-silencing, Black women, notably those with histories of trauma, are placed at an increased risk for complicated physical and mental health outcomes.

Harrington et al. (2010) examined the relationships between SBW ideology, trauma, and binge eating. They explored the mediating role of SBW ideology, emotional inhibition and eating for psychological purposes on binge eating symptoms. Findings of their study suggested that women with histories of trauma may have a greater internalization of SBW ideology compared to women without histories of trauma. More specifically, findings indicated that SBW ideology mediated the relationship between trauma exposure and emotional inhibition (self-silencing). Emotional inhibition mediated the relationship between SBW ideology and eating for psychological purposes; subsequently eating for psychological purposes then impacted patterns of binge eating among Black trauma survivors.
The literature has created a polarizing view of Black women’s endorsement of SBW ideology. Watson and Hunter (2016) utilized interviews to gain insight into potential tensions experienced by Black women who endorsed the SBW ideology. The following tensions were emphasized by participants: Be Psychologically Durable yet Do Not Engage in Behaviors That Preserve Psychological Durability, Be Equal yet Be Oppressed, Be Feminine yet Reject Feminine Attributes. Within each tension, expectations and positive and negative consequences were identified.

Watson and Hunter (2016) first tension, Be Psychologically Durable yet Do Not Engage in Behaviors That Preserve Psychological Durability had two opposing expectations: remain mentally strong in spite of multiple stressors and remain mentally strong without seeking psychological help and neglecting self-care. Negative consequences associated with this tension included perceived negative impacts on physical and emotional health. Positive consequences including disproving societal expectations that Black women will not succeed and gaining respect from others. Watson and Hunter (2016) second tension, Be Equal yet Be Oppressed had two counter intuitive expectations. Black women are expected to challenge harmful stereotypes of Black womanhood that perpetuate the marginalization of Black women while simultaneously tolerating struggles such as classism that perpetuate the marginalization of Black women. The negative consequences associated with this tension included increased psychological distress related to pressure to challenge stereotypes about black women. Positive consequences associated with this tension included earning respect from others and developing a perceived sense of self-efficacy needed to navigate current systems of oppression.
Watson and Hunter (2016) third tension, Be Feminine yet Reject Traditional Feminine Attributes has the expectation that Black women conform to traditional gender roles and at the same time, exemplify traditionally masculine traits such as independence. The negative consequence of this tension is the perceived undermining or emasculation of heterosexual Black men within romantic relationships. The positive consequence was identified as the perceived ability to be successful with limited opportunities and resources or “make a way out of no way.”

Donovan and West (2015) quantitatively explored the impact of the SBW embodiment of strength on women’s stress and depressive symptoms. The findings of their study revealed that SBW endorsement exacerbated the association between stress level and depressive symptoms; women who reported the highest levels of stress and SBW endorsement reported the highest levels of depressive symptoms compared to women who reported lower levels of SBW endorsement.

These findings accentuate the complex duality of SBW ideology endorsement. Although SBW stands in juxtaposition to demeaning stereotypical depictions of Black women, the literature suggests that endorsement of SBW may serve as a culture specific risk to Black women’s health, particularly stress, stress management, and depressive symptomology.

Ultimately, SBW may represent a culture- and context-specific vulnerability for Black mothers in contexts of childhood trauma history and high exposure to racial trauma. To date no research has examined the associations among maternal histories of racial trauma, SBW, and depressive symptoms.
The Present Study

Taking an intersectional frame that considers Black mothers in the contexts of both their experiences of CSA as well as racial trauma, this study will extend literature in a number of ways. This study will longitudinally examine risks and culture-specific protective mechanisms experienced by Black mothers with histories of CSA and racial trauma, as previous studies have not (1) examined both maternal exposure to racial trauma and CSA, (2) examined endorsement of SBW ideology impact on depressive symptomology among mothers exposed to both childhood and racial trauma, and (3) explored the role of spiritual coping among mothers of young children.

Hypotheses

This study consists of two aims and four hypotheses. The first aim is to examine the association between maternal CSA, maternal racial trauma/discrimination, and risk factors for intergenerational transmission of vulnerability, including child behavior problems and maternal depressive symptoms. I hypothesize that among participants who endorse histories of CSA, mothers’ self-report of depressive symptoms will be associated with child behavior problems, and the association between maternal CSA and children’s behavior problems will be mediated by maternal depressive symptoms. Secondly, I predict that maternal exposure to racial trauma/discrimination will be associated with maternal depressive symptoms above and beyond CSA endorsement. The second aim of this study is to examine culture-specific risk and protective factors for maternal depressive symptoms in Black mothers. I predict that mothers who endorse histories of racial trauma or CSA and also report endorsement of SBW ideology will report higher levels of depressive symptoms. Finally, I hypothesize that among mothers who report
histories of racial trauma or CSA, those who endorse spiritual coping will report lower depressive symptoms compared to mothers who do not endorse spiritual coping.

**Methods**

**Participants**

The present study employed secondary analysis of data collected as part of the Parent and Child Coping Study (PI: Sarah A. O. Gray, Ph.D.), a longitudinal, multi-method examination of early exposure to adversity, parenting, and developmental outcomes in early childhood. Data collection occurred at two timepoints (Time 1 and Time 2). At Time 1, Participants included 158 mothers (Mage = 29.89, SD = 5.42) and their preschool-aged children (Mage = 51.45 months, SD = 8.97 months; 51.3% female). Most mothers self-identified as Black or African American (82.9%) and non-Hispanic (72.8%). Most mothers had at least a high school education (88.5%) and were employed at least part-time (59.5%). All mothers qualified for need-based federal assistance for families living near or below the poverty line (≤130% federal poverty line). All mothers were within 185% of the federal poverty limit. The first wave of data collection (Time 1) occurred from September 2015 to February 2019. The second wave of data collection (Time 2) occurred between early October 2020 and early April 2021; during this time, 58% of mothers from Time 1 participated. Sixty-nine of these mothers self-identified as Black or African American and will be included in these analyses.

**Procedures**

During Time 1, initial screenings took place at four Head Start programs in the greater New Orleans area and at one pediatric clinic. Mothers who qualified for income-related assistance and mothers who were referred by mothers who previously participated
in the study were eligible to participate. Mothers completed a screener packet, which consisted of family sociodemographic information and child and caregiver exposure to life events on the Life Events Checklist (Gray et al., 2004). Mothers were purposefully sampled across a range of exposure to family violence; however, mothers who reported exposure to interpersonal trauma in themselves or their child were intentionally oversampled. Exclusionary criteria for participation in Time 1 and Time 2 included (1) respondent was not the child’s biological mother, (2) mother could not complete interviews in English, and (3) parent reported that child had diagnosis of pervasive developmental delay (e.g., autism spectrum disorder). Only mothers of children between the ages of 3 and 5 were invited to participate. Participation in Time 1 consisted of two visits with mother and child; each visit was approximately two hours long and took place either in the family’s home or at our office, according to mothers’ preference. Two trained, graduate-level research assistants collected data at each visit. Mothers were compensated for their time with a $50 gift card for each visit, and children received a book and small toys.

During Time 1, data were collected by research lab members during both visits. Visits were facilitated by six graduate research assistants and two lab managers. Of the six graduate research assistants, three identified as White women, one identified as a Black woman, one identified as a Latina woman, and one identified as a White male. Two of the graduate research assistants were natives of the Greater New Orleans area, two graduate research assistants were both natives to the Southern United States - Mississippi and Alabama, and two graduate research assistants were from the
Northeastern United States. Both lab managers identified as White women; one was raised in the Midwest United States and the other in the Northeastern United States.

All mothers who completed both visits during Time 1 were invited to participate in a remote follow up visit in Time 2. The average length of time between Time 1 and Time 2 was approximately 4 years. During Time 2, mothers remotely completed a survey by phone or internet per parent preference that included information about maternal depressive symptoms, stereotypical roles and beliefs about Black/African American women (Black/African American mothers only), maternal experiences of discrimination, and a family resilience measure that included an open-ended coping prompt. Inclusion criteria for Time 2 included all mothers who completed both in-person visits in Time 1 and who provided permission for follow-up contact. Ninety-one mothers participated in Time 2. Forty-one mothers were lost to follow up due to incorrect phone numbers and email addresses. Eight mothers declined invitations for participation in remote follow up visit (Time 2). Seven mothers partially completed remote follow up visit (Time 2). Parents were compensated $50 for their participation in the remote survey. The parent study was approved by the Tulane University Social-Behavioral Institutional Review Board.

During Time 2, data were collected by lab members during remote follow-up visits. Remote visits were facilitated by two graduate research assistants, one lab manager, and three undergraduate students. The lab manager identified as a White female Canadian National. One of the graduate research assistants identified as a Black woman and the second research assistant identified as a White woman. Two of the undergraduate research assistants identified as White women and the third research assistant identified
as woman of South Asian descent. The senior graduate research assistant was a native of Mississippi and the junior graduate research assistant was raised in California. The regional background of the undergraduate research assistants at Time 2 is unknown.

Prior to participating in research data collection, all lab managers, graduate/undergraduate research assistants, and volunteers completed 8 hours of training on ethics and were required to complete The Collaborative Training Initiative (CITI Program) training on standards in research, ethics, and compliance training. Each research assistant, lab manager, and volunteer were trained separately on consent, physiology, interviewing, and additional lab assessments. All undergraduate research assistants and volunteers participated in training on the APA guidelines for Psychological Practice for People with Low-Income and Economic Marginalization (LIEM) which was designed to promote culturally competent research approaches and interpretation of findings.

Throughout the course of data collection during Time 1 and Time 2, all graduate research assistants, undergraduate research assistant, and lab managers participated in weekly lab meetings. Each week, undergraduate research assistants (1) presented articles that specifically explored the experiences of Black low-income families, (2) engaged in reflective activities to encourage the examination of personal privilege, bias, and intersectionality, and (3) facilitated conversations that promoted lab members’ understanding and appreciation of local community beliefs, values, and norms. Lab meetings also served as a time to identify barriers and ways to balance both the implementation of rigorous research methodology and the provision of trauma-informed and culturally sensitive engagement with our mother-child dyads and their household
members. For example, in efforts to increase the validity of data collection and attend to
the real needs of many participants within this study, undergraduate research assistants
provided free childcare within the home or lab space during Visits 1 and 2 at Time 1.

Measures

See Table 1 for visualization of the timing of collection of study variables.

Sociodemographic information. At Time 1, mothers completed a screening
packet in which they self-reported information such as maternal age, race, ethnicity,
educational attainment, as well as child age and sex. Maternal race was examined at Time
1 with the question, “Which group below most accurately describes your race?”
Response options were coded as 0 for American India/Alaska Native, 1 for Asian, 2 for
Black or African American, 3 for Native Hawaiian or other Pacific Islander, and 4 for
White. Maternal age was assessed at Time 1 with the question, “How old are you?”; at
Time 2, it was addressed with the question “How old are you today?” Maternal education
was examined at Time 1 with the question, “What is the highest education level you have
completed?” Responses were coded as 0 for 8th grade or less, 1 for 1-3 years of high
school, 2 for high school diploma/GED, 3 for vocational school/other non-college, 4 for
1-3 years of college, 5 for Associates degree, 6, for college degree (B.A, B.S., etc.), 7 for
Master’s degree (e.g. M.A., M.B.A., M.S.) and 8 for professional degree (e.g., E.G., MD.,
JD, PhD). Child age was coded in months. Child sex was assessed with the question,
“What is your child’s sex?” and coded as 0 for girl and 1 for boy.

Maternal history of childhood sexual abuse. At Time 1, Mother history of child
abuse and neglect was measured retrospectively by self-report using the Adverse
Childhood Experiences (ACE) Survey (Felitti et al., 1998). The ACE Survey is a 10-item measure that evaluates experiences of adversity that occurred prior to age 18. Maternal history of childhood sexual abuse exposure was assessed with a yes/no question, “Did an adult or person at least 5 years older than you ever (1) Touch or fondle you or have you touch their body in a sexual way? OR (2) Attempt or actually have oral, anal, or vaginal intercourse with you?”

**Maternal depressive symptoms.** At Time 1 and Time 2, maternal depressive symptoms, experienced during the past week, were measured using the Center for Epidemiologic Studies Depression Scale-Revised (CESD-R). The CESD-R is a 20-item self-report measure of depression and measures nine different depression subscales as identified by the American Psychiatric Association Diagnostic and Statistical Manual, fifth edition (DSM-5): Sadness (Dysphoria), Loss of Interest (Anhedonia), Appetite, Sleep, Thinking/Concentration, Guilt (Worthlessness), Tired (Fatigue), Movement (Agitation) and Suicidal Ideation. CESD-R internal consistency (Cronbach’s $\alpha = 0.92$ to 0.93) and has moderate convergent validity with measures of anxiety and negative affect ($rs = 0.58$ to 0.74) and divergent validity with a measure of positive affect ($r = -0.26, p <.01$) in community and student samples (Van Dam, & Earleywine, 2011). Total CESD-R Scale scores range from 0 to 60, with higher scores indicating more depressive symptomatology and scores of 16 or higher indicating significant depressive symptoms. Among samples of low-income African American and Hispanic American mothers, the CESD-R has reflected internal reliability ranging from .92 to .95 (Thomas et al., 2019). Within the current analytic sample, the CESD-R has good internal consistency (20 items; $\alpha = .95$).
**Maternal experiences of discrimination.** During Time 2, Mothers completed a modified version of the Intersectional Day-to-Day Discrimination Index (InDI-D). The InDI-D is a 9-item measure that is used to evaluate experiences of discrimination based upon intersectional identities across the lifetime and within the past year (Scheim & Bauer, 2019). Previously, the InDI-D has been identified as strongly and positively correlated ($r = 0.50$) with the Williams et al. (1997;2008) Everyday (EDS) and Major Discrimination (MDS) measures. Scheim & Bauer (1999) study included North American participants utilizing oversampling for ethnic/racial and gender/sexual diversity and observed test-retest reliability of 0.70. Lifetime day-to-day items were coded as 1 for yes if they occurred during the lifetime versus 0 if they never occurred. Day-to-day discrimination was addressed as person-specific sociological phenomena; each prompt began with “Because of who you are, have you” A sample item read as “Because of who you are, have you been called names or heard/saw your identity used as an insult?” Items that addressed experiences over the past year were coded as 0 for never, 1 for yes but not in the past year, 2 for once or twice in the past year, and 3 for many times in the past year. The sum of lifetime day-to-day items range from 0-9 and the sum of past year experiences range from 0-27. If mothers completed at least 80% of items, missing item values were imputed to “no/never”; if not, sum scores were not calculated. Within the present analytic sample, the INDI-D demonstrated strong internal consistency (9 items; $\alpha = .90$).

**Strong Black Woman Ideology (SBW).** At Time 2, Mothers’ beliefs about stereotypical roles of Black women were measured using a revised version of Thomas, Witherspoon and Speight (2004) Stereotypic Roles for Black Women Scale (SRBWS).
The SRBWS is a 34-item measure designed to assess attitudes that align with Mammy, Sapphire, Jezebel, and Superwoman stereotypes. Harrington, Crowther and Shipard (2010) revised version of the SRBWS was used to assess caretaking and strength components of the Strong Black Woman (SBW) ideology by utilizing the five-item Mammy stereotype subscale (e.g., “I often put aside my own needs to help others”) and the 11-item Superwoman stereotype subscale (e.g., “Black women have to be strong to survive”) of the SRBWS. A 5-point likert scale (strongly disagree to strongly agree) was used to rate agreement with each item. On the Mammy stereotype subscale, scores can range from 5 to 25. On the Superwoman stereotype subscale, scores can range from 11 to 55. SBW endorsement was measured using Total scores (the sum of Superwoman and Mammy subscales). Higher total scores suggest greater endorsement of the targeted stereotypical image. Within this analytic sample, Mammy and Superwoman subscales of the SRBWS were highly correlated with good internal consistencies (Mammy 5 items; α = .72) and (Superwoman 11 items; α = .86).

**Child behavior problems.** At Time 2, mothers completed the Child Behavior Checklist 6-18 (CBCL; Achenbach & Rescorla, 2001), a 120-item checklist that measures child internalizing and externalizing symptoms during the past 6 months on a 3-point Likert scale (not true to very/often true). Internalizing items addressed behavior problems such as crying, social fears, feelings of worthlessness and excessive worry. Externalizing items addressed behavior problems including swearing, fire setting, arguing, fighting, screaming, and teasing others. The total problems score, a summation of responses to all internalizing items (21 items; α = .87) and externalizing behavior items (35 items; α = .89) was used to assess child problem behaviors. Within the current
analytic sample, the CBCL 6-18 total problems score has good internal consistency (56 items; $\alpha = .92$).

**Spiritual Coping.** At Time 2, mothers completed the Walsh Family Resilience Questionnaire (WFRQ), a measure that allowed mothers to self-report on their family resilience and how their family deals with crises and ongoing challenges, at Time 2. The WFRQ consists of 32 items that are defined on a 5-point Likert scale (1= rarely; 5= usually) and one optional open-ended question that asks mothers to specify any other aspects that helped them to overcome a crisis (Walsh, 2003). The latter was coded as 1 if mothers indicated spiritual engagement (e.g., relying on a Higher Power, God, prayer, meditation, or listening to religious music) and 0 if mothers’ responses did not include spiritual engagement. Mothers also completed the Coping with Discrimination Measure NSAL Study (Abbreviated), adapted from McNeily and colleagues (1996) and Krieger (1990). The abbreviated Coping with Discrimination Measure consists of 7 items. Each item is scored as 1 for a lot, 2 for some, and 3 for not at all. The last item lists prayer as a coping strategy. Maternal use of prayer was assessed using mothers’ responses to this item. Mothers who endorsed use of spiritual engagement (e.g., praying, trusting God, emphasis on Higher Power) as a coping mechanism on the WFRQ or who endorsed using prayer a lot on the Coping with Discrimination Measure were categorized as spiritual copers.

**Analytic Plan**

Data analyses were conducted using IBM SPSS Version 27.0. Preliminary bivariate correlations among independent and dependent variables were examined along
with descriptives. Reliability for all measures were evaluated and normality assumptions were supported. Potential covariates including child age, maternal age, and maternal education were explored; maternal age at Time 2 was the only covariate significantly associated with outcome variables and was included in analyses (see Tables 1 & 2).

The first aim of this study was to examine the association between maternal childhood sexual abuse, maternal racial trauma, and risk factors for intergenerational transmission of vulnerability, including child behavior problems and maternal depressive symptoms.

Hypothesis 1 posited that maternal depressive symptoms reported at Time 1 would mediate the association between maternal endorsement of CSA and child behavior problems at Time 2. Hayes’s PROCESS Macro was utilized to analyze indirect effects of maternal depressive symptoms at Time 1 between maternal CSA status and total child behavior problems at Time 2 using a bootstrapped linear regression model.

Hypothesis 2 proposed that maternal exposure to racial trauma (discrimination) would uniquely predict maternal depressive symptoms reported at Time 2, above and beyond maternal history of childhood sexual abuse. These relationships were examined using multiple linear regression analysis. In stepwise regression analyses, maternal CSA status, and experiences of discrimination (sum score of InDI-D Lifetime Day-to-Day score) were entered as predictors. Time 2 maternal depressive symptoms (CESD-R scores) were examined as an outcome variable.

The second aim of this study was to examine culture-specific risk and protective factors for maternal depressive symptoms in Black mothers.
Hypothesis 3 predicted that endorsement of SBW ideology would serve as a culture-specific risk factor for depressive symptoms in the context of maternal trauma history. Specifically, I hypothesized that SBW ideology (Mammy and Superwoman combined sum scores) would moderate the associations between racial trauma / CSA and maternal depressive symptoms, such that mothers with histories of racial trauma or CSA who endorsed SBW would report higher levels of depressive symptoms at T2.

Hypothesis 4 posited that maternal use of spiritual coping would moderate the association between maternal history of discrimination / CSA and depressive symptoms reported at Time 2, such that mothers who reported discrimination / CSA and also endorsed spiritual coping would report lower depressive symptoms at Time 2.

To test Hypothesis 3 and Hypothesis 4, one stepwise linear regression was run to test the main effects and interactions effects with maternal depressive symptoms at T2 as the outcome variable. In step one, variables assessing maternal history of trauma (CSA and lifetime discrimination exposure) and covariate (maternal age at T2) were entered. In step 2, variables assessing maternal history of trauma (maternal CSA history and lifetime discrimination exposure), maternal modifiable risk (SBW ideology endorsement) and protective (spiritual coping), and covariate (maternal age at T2) were entered. In step 3, variables assessing maternal history of trauma (maternal CSA history and lifetime discrimination exposure), maternal modifiable risk (SBW ideology endorsement) and protective (spiritual coping), interaction terms (CSA X SBW, InDI-D X SBW, CSA X SC, and InDI-D X SC), and the covariate (maternal age at T2) were entered. Before creating interaction terms, continuous variables were centered to aid in interpretation and reduce multicollinearity. Missing data were addressed using listwise deletions.
Results

Sample Characteristics and Descriptive Analyses

At Time 1, participants included 158 mothers ($M_{age}=29.89$ years, $SD=5.42$ years) and their preschool-aged children ($M_{age}=51.45$ months, $SD=8.97$ months; 51.3% female). Of the 158 mothers who participated in Time 1, 129 (81.6%) identified as Black/African American and were eligible for these analyses. Of these 129 Black/African American mothers, 69 participated at Time 2; 16 others declined to participate, 35 mothers were lost to follow up due to inability to contact, and 6 mothers initiated but did not complete Time 2 measures, yielding insufficient data for this set of analyses. When comparing eligible mothers who only participated in Time 1 (T1) to eligible mothers who provided complete data at both Time 1 and Time 2 (T1NT2), the groups were relatively similar with regards to child sex, with 50% of T1 children identified as female and 49% of T1NT2 children identified as female. There were no significant differences in maternal age between T1 ($M=30.06$, $SD=4.88$) and T1NT2 ($M=30.12$, $SD=5.43$) mothers: $t(127)=-0.06$, $p=.95$; educational attainment between T1 ($M=3.16$, $SD=1.53$) and T1NT2 ($M=3.42$, $SD=1.57$) mothers: $t(127)=-0.97$, $p=.33$; or maternal depressive symptoms at T1 between T1 ($M=8.58$, $SD=8.08$) and T1NT2 ($M=10.42$, $SD=11.85$) mothers: $t(124)=-1.01$, $p=.31$. Chi-square tests of independence were performed to examine endorsement CSA in T1 and T1NT2 mothers. The frequency of endorsement of CSA was not statistically different between T1 and T1NT2 mothers, $X^2(1)=.00$, $p=.97$.

Maternal CSA Exposure Among eligible Black mothers who participated during Time 1 (T1), 40 mothers endorsed histories of CSA and 89 mothers did not endorse
histories of CSA. Independent sample t-tests were conducted to compare mean differences of maternal depressive symptoms, maternal age, and child age between T1 mothers who did and did not endorse histories of CSA. There was a significant difference in the maternal depressive symptom scores at T1 for CSA ($M=12.83$, $SD=12.63$) and NON-CSA ($M=8.12$, $SD=8.56$) mothers; $t(127)=-2.47$, $p = .015$. Results suggests that among eligible participants at Time 1, mothers who endorsed CSA history reported greater levels of depressive symptoms at Time 1 compared to mothers who did not report a history of CSA.

There were no significant differences in child age at T1 between CSA ($M= 50.55$ months, $SD= 9.00$ months) and NON-CSA ($M=51.89$ months, $SD= 9.14$ months) mothers: $t(129) =0.77$, $p = .44$; maternal age between CSA ($M=30.38$ years, $SD=5.42$ years) and NON-CSA ($M=29.90$ years, $SD=5.06$ years) mothers who participated during Time 1: $t(129) =-0.48$, $p =.63$; or maternal education for CSA ($M=3.20$, $SD = 1.63$) and NON-CSA ($M=3.35$, $SD=1.63$) mothers: $t(129)= .51$, $p=.61$.

**CSA Exposure and Key Study Variables in the Analytic Sample**

For the analytic sample of T1NT2 mothers who provided full information on key study variables and were included in hypothesis testing ($n = 69$), we examined group differences between mothers who endorsed histories of CSA ($n = 22$) and those who did not ($n = 47$) on key study variables, including maternal depressive symptoms, child behavior problems, lifetime experiences of discrimination, maternal spiritual coping, endorsement of Strong Black Woman ideology, child sex, and demographic variables of maternal educational attainment, child age at Time 2 and maternal age at Time 2.
There was a significant difference in the maternal depressive symptom scores at T1 between CSA-endorsing ($M=14.46, SD=15.55$) and NON-CSA ($M=8.30, SD=9.03$) mothers; $t(67)=2.08, p=.04$. Results suggest that among participants in the analytic sample, as in the sample of all 129 T1 mothers, mothers who endorsed CSA history reported greater levels of depressive symptoms at T1 compared to mothers who did not report a history of CSA.

There were no significant differences observed in maternal depressive symptom scores at T2 for CSA ($M=18.74, SD=18.88$) and NON-CSA ($M=16.95, SD=16.41$) mothers: $t(61)=0.38, p=.71$; maternal depressive symptoms at T2 were elevated above the clinical cut-off score of 16 among both CSA and NON-CSA mothers, whereas at Time 1, scores for both CSA ($M=14.54$) and NON-CSA ($M=8.29$) mothers fell below the CESD-R cutoff score of 16. These increases in self-reporting of maternal depressive symptoms may have been attributed to confounding national and global crises that were ongoing during data collection at Time 2. Despite increases in self-reporting of maternal depressive symptoms at Time 2, maternal reports of child behavior problems at Time 2 fell within the normal range, below the CBCL 6-18 clinical cutoff.

No group differences were observed in: maternal educational attainment between CSA ($M=3.14, SD=1.36$) and NON-CSA ($M=3.47, SD=1.65$) mothers: $t(67)=0.82, p=0.42$; total child behavior problems between children of CSA ($M=19.79, SD=20.85$) and NON-CSA ($M=20.63, SD=18.21$) mothers: $t(60)=-0.16, p=0.87$; lifetime discrimination exposure between CSA ($M=2.72, SD=2.70$) and NON-CSA ($M=3.00, SD=3.07$) mothers: $t(58)=-0.33, p=0.74$; endorsement of Strong Black Woman
ideology for CSA ($M = 61.78, SD = 11.43$) and NON-CSA ($M = 56.12, SD = 13.01$) mothers: $t(58) = 1.60, p = 0.12$; child age for CSA ($M = 91.59$ months, $SD = 14.75$ months) and NON-CSA ($M = 96.55$ months, $SD = 20.29$ months) mothers: $t(67) = 1.02, p = .31$; and maternal age for CSA ($M = 32.14$ years, $SD = 8.45$ years) and NON-CSA ($M = 33.26$ years, $SD = 6.49$ years) mothers: $t(67) = 0.61, p = .55$.

Chi-square tests of independence were performed to examine the relationship between maternal history of CSA, maternal use of prayer, and child sex. The relation between maternal history of CSA and maternal spiritual coping, $X^2(1) = .83, p = .36$ and child sex $X^2(1) = .87, p = .35$ were not statistically different between CSA and NON-CSA mothers.

See Table 2 for correlations between variables of interest in the complete analytic sample ($n = 69$), as well as Tables 3-4 for correlations stratified by CSA exposure status. Among the full sample, depressive symptoms at T2 were significantly and positively associated with previous depressive symptoms at T1, as well as with mothers’ endorsement of experiences of discrimination and Strong Black Woman Ideology, as well as with child behavior problems. Mothers’ usage of spiritual coping was significantly negatively associated with depressive symptoms at T1, but not T2. Children’s behavior problems were significantly associated with mothers’ endorsement of experiences of discrimination.

Among mothers who endorsed a history of sexual abuse, there were significant positive correlations between maternal depressive symptoms at Time 1 and maternal depressive symptoms at Time 2, $r = .66, n = 19, p = .002$; child behavior problems at Time
2 and maternal lifetime discrimination exposure, $r = .50, n=18, p=.04$; and significant negative correlations between child behavior problems at Time 2 and maternal use of spiritual coping, $r = -.48, n= 19, p = .04$; and maternal age at Time 2 and maternal depressive symptoms at Time 2, $r = -.40, n= 19, p = .05$.

Among mothers who did not endorse a history of sexual abuse, there were significant positive correlations between maternal depressive symptoms at Time 1 and maternal depressive symptoms at Time 2, $r = .43, n=44, p = .004$; maternal lifetime discrimination exposure and maternal depressive symptoms at Time 2, $r=.36, n=42, p = .02$; maternal endorsement of Strong Black Woman Ideology and maternal depressive symptoms at Time 1, $r=.34, n= 42, p = .03$; maternal endorsement of Strong Black Woman Ideology and maternal depressive symptoms at Time 2, $r=.54, n= 42, p < .001$; maternal endorsement of Strong Black Woman Ideology and maternal lifetime discrimination exposure $r=.37, n=42, p = .02$; maternal depressive symptoms at Time 1 and total child behavior problems at Time 2, $r = .31, n= 43, p = .04$; maternal depressive symptoms at Time 2 and total child behavior problems at Time 2, $r=.44, n= 43, p = .003$.

Maternal age was significantly negatively associated with maternal depressive symptoms at T2 and was thus included as a covariate in hypothesis testing. Given that other potential demographic covariates (child sex, child age, and maternal education) were not associated with any outcomes of interest, they were not included as covariates in hypothesis testing in order to preserve power.
Hypothesis Testing

The first aim of this study was to examine the association between maternal childhood sexual abuse, maternal discrimination exposure, and risk factors for intergenerational transmission of vulnerability, including child behavior problems and maternal depressive symptoms. Aim 1 was addressed by Hypotheses 1 and 2. The second aim of this study is to examine culture-specific risks and protective factors for maternal depressive symptoms in Black mothers. Aim 2 was addressed with Hypotheses 3 and 4.

Maternal CSA, Depressive Symptoms and Child Behavior Problems

Hypothesis 1 posited that maternal depressive symptoms reported at Time 1 would mediate the association between maternal CSA history reported at Time 1 and child behavior problems at Time 2. As described above, maternal CSA exposure was not associated with the outcome of child behavior problems. Additionally, as illustrated in Tables 3 and 4, maternal depressive symptoms at T1 were significantly associated with child behavior problems at T2 among mothers who did not endorse histories of CSA (r = .31, p < .05), but not among mothers who endorsed histories of CSA (r = .04, p = .89). We used Hayes’ PROCESS Macro to formally test direct and indirect effects (see Table 5). The findings revealed that maternal CSA history and maternal depressive symptoms at T1 explained 7% of the variance in child behavior problems at Time 2 with $R^2 = .07$, $F(1, 60) = 4.39, p = .04$. Maternal endorsement of CSA was significantly associated with T1 maternal depressive symptoms ($\beta = .56, p = .04$); however, neither maternal depressive symptoms at T1 ($\beta = .18, p = .62$) nor maternal CSA endorsement ($\beta = -.14, p = .19$) predicted child behavior problems at T2, and both direct (effect = -2.72, 95% CI [-13.52, 8.09]) and
indirect effects (effect=1.88, 95%CI [-1.35, 5.67] were not significant. The results of this analysis do not provide support for Hypothesis 1.

**Maternal Exposure to Discrimination and Depressive Symptoms**

Hypothesis 2 predicted that maternal lifetime discrimination exposure reported at T2 would uniquely predict maternal depressive symptoms reported at Time 2, above and beyond maternal history of childhood sexual abuse. A linear regression was conducted to examine this hypothesis, with maternal depressive symptoms at Time 2 as the outcome, and maternal CSA exposure and maternal lifetime discrimination exposure as predictors of interest (see Table 6), covarying maternal age. In linear regression analyses, maternal CSA history, and lifetime discrimination exposure (sum score of InDI-D Lifetime Day-to-Day score) were entered as predictors. Maternal age at Time 2 was included as a covariate. Consistent with Hypothesis 2, maternal lifetime discrimination exposure predicted maternal depressive symptoms at Time 2 ($\beta = .33, p = .01$) above and beyond maternal history of CSA ($\beta = .04, p = .73$). Covariate maternal age at Time 2 predicted maternal depressive symptoms at Time 2 ($\beta = -.31, p = .01$). The predictors and the covariate together explained 23% variance in maternal depressive symptoms at Time 2, $R^2 = .23, F(3,56) = 5.41, p = .002$.

**Culture Specific Risk and Protective Factors in the Context of Maternal Trauma History (CSA History and Discrimination)**

Hypothesis 3 posited that endorsement of SBW ideology would serve as a culture-specific risk factor for depressive symptoms in the context of CSA, and Hypothesis 4 posited that maternal spiritual coping would serve as a culture-specific protective factor
in contexts of CSA. Specifically, it was hypothesized that SBW ideology (SRBWS Mammy and Superwoman combined sum scores) would moderate the association between CSA/discrimination and maternal depressive symptoms, such that mothers with histories of CSA/discrimination who endorse SBW would report higher levels of depressive symptoms than mothers with histories of CSA who did not endorse SBW; similarly, I predicted that maternal usage of prayer would be associated with lower depressive symptoms, specifically in the context of maternal CSA and discrimination. To test Hypothesis 3 and Hypothesis 4, one stepwise linear regression was ran to test the contributions of maternal CSA and lifetime discrimination exposure (InDI-D) and context-and culturally specific hypothesized risk and protective factors of Strong Black Woman ideology (SBW) and spiritual coping (SC) to maternal depressive symptoms, we ran a bootstrapped stepwise linear regression with main effects and interactions effects with maternal depressive symptoms at T2 as the outcome variable. In Step 1, variables assessing maternal history of trauma (CSA and lifetime discrimination exposure) and covariate (maternal age at T2) were entered. In Step 2, variables assessing maternal history of trauma (maternal CSA history and lifetime discrimination exposure), maternal modifiable risk (SBW ideology endorsement) and protective (spiritual coping), and covariate (maternal age at T2) were entered. In Step 3, variables assessing maternal history of trauma (maternal CSA history and lifetime discrimination exposure), maternal modifiable risk (SBW ideology endorsement) and protective (spiritual coping), interactions terms (CSA X SBW, InDI-D X SBW, CSA X SC, and InDI-D X SC), and covariate (maternal age at T2) were entered.
Table 6 shows the main and interaction effects of maternal history of trauma (CSA and discrimination), culture-specific risk (SBW) and protective factors (spiritual coping). In Step 1, maternal history of CSA, lifetime discrimination exposure and maternal age, explained 22% of the variance in maternal depressive symptoms, $R^2 = .22$, $F(3, 56) = 5.13$, $p < .05$. We observed the main effect of lifetime discrimination exposure ($b = 1.95$, $p < .05$, 95% CI [.62, 3.23]), such that maternal experiences of discrimination were associated with higher depressive symptoms. No main effect of maternal CSA history was observed ($b = 1.54$, $p = .73$, 95% CI [-6.89, 11.15]). However, covariate, maternal age was negatively associated with maternal depressive symptoms.

In Step 2, the $R^2$ value of .40 revealed that maternal history of CSA, lifetime discrimination exposure, spiritual coping, and endorsement of SBW explained 40% of the variance in maternal depressive symptoms with $F(5, 54, ) = 7.18$, $p < .001$. These findings revealed that when spiritual coping ($b = -8.90$, $p < .05$, 95% CI [-17.77, -1.16]), and SBW endorsement ($b = .55$, $p < .001$, 95% CI [.25, .88]) were included within the model, both maternal history of CSA ($b = -2.37$, $p = .56$, 95% CI [-10.89, 6.76]) and lifetime discrimination exposure ($b = 1.22$, $p = .06$, 95% CI [-.15, 2.47]) had no main effects on maternal depressive symptoms. The $\Delta R^2$ of .18 revealed that the additional predictors of SBW endorsement and spiritual coping explained an additional eighteen percent of the variance in maternal depressive symptoms, $\Delta F (2, 54) = 8.25$. Main effects of maternal spiritual coping and SBW endorsement were revealed, and main effects of maternal age remained in Model 2.

In Step 3, the $R^2$ value of .44 revealed that maternal history of CSA, lifetime discrimination exposure, spiritual coping, endorsement of CSA and interaction terms
(CSA X SBW, InDI-D X SBW, CSA X SC, and InDI-D X SC) explained 44% of the variance in maternal depressive symptoms with $F(9,50) = 4.32, p < .001$. The $\Delta R^2$ of .04 revealed that the addition of the interaction terms explained an additional 4% of the variance in depressive symptoms $\Delta F(4,50) = .86$. All interaction terms were non-significant: CSA X SBW ($b = -.70, p = .07, 95\% CI [-1.63, .27]$), InDI-D X SBW ($b = .01, p = .82, 95\% CI [-.08, .12]$), CSA X SC ($b = -1.59, p = .86, 95\% CI [-29.56, 21.74]$) and InDI-D X SC ($b = -.32, p = .82, 95\% CI [-3.57, 3.31]$). Thus, the main effects model (Step 2) is the best fit to this data.

The aforementioned results do not provide support for the conditional effects of the risk and protective factors that were hypothesized in hypotheses 3 and 4. Within this sample, maternal endorsement of Strong Black Woman ideology was positively associated with maternal depressive symptoms. Additionally, maternal age was significantly and negatively associated with maternal symptoms of depression, indicating that as maternal age increased, severity of maternal depressive symptoms decreased; younger mothers reported more depressive symptoms compared to older mothers. Although maternal spiritual coping was negatively associated with maternal depressive symptoms, maternal CSA history and maternal lifetime discrimination exposure were not significantly associated with maternal depressive symptoms when maternal age, SBW endorsement, and spiritual coping were included in the model.

**Discussion**

The present study examined the pathways between maternal endorsement of Strong Black Woman Ideology, maternal lifetime discrimination exposure, maternal use of spiritual coping, maternal depression, and early childhood behavior outcomes among
Black mothers with and without histories of childhood sexual abuse and their children. Haye’s PROCESS Macro was used to formally test direct and indirect effects of Maternal CSA history and depressive symptoms on early childhood behavior problems. Linear regression analyses were used to test the predictive power of both maternal history of CSA and lifetime discrimination exposure on maternal depressive symptoms. A bootstrapped stepwise linear regression analysis was conducted to identify main and interaction effects of maternal trauma exposure (CSA and lifetime discrimination) and modifiable coping strategies (maternal endorsement of SBW or utilization of spiritual coping) on maternal depressive symptoms.

It was hypothesized that: (1) maternal depressive symptoms would mediate the association between maternal history of CSA and childhood behavior problems, (2) racial trauma (maternal lifetime discrimination exposure) would predict maternal depressive symptoms above and beyond childhood sexual abuse, (3) SBW ideology endorsement would positively moderate the associations between maternal CSA history and lifetime discrimination exposure and (4) maternal use of spiritual coping would moderate the associations between maternal CSA status and racial trauma such that mothers who reported histories of CSA or racial trauma and spiritual coping would report lower depressive symptoms. The results of this study did not provide evidence of the intergenerational effects of maternal experiences of childhood sexual abuse. Results generally indicated that culturally specific, modifiable risk (SBW endorsement) and protective (maternal use of spiritual coping) factors had a greater impact on maternal depressive symptoms than maternal CSA and racial trauma. The present study represents one of the first known explorations of the impact of Strong Black Woman ideology
endorsement on mental health outcomes among mothers who have histories of childhood and racial trauma.

**Impact of COVID-19 and Black Lives Matter Summer 2020**

It is imperative that the results of this study be examined within the unique context in which the second wave (Time 2) of data collection occurred. The second wave of data collection occurred between early October 2020 and early April 2021. A month into the beginning of the second wave of data collection, the novel coronavirus SARS-CoV-2 (COVID-19) had claimed the lives of 250,000 Americans (Tierney & Meko, 2020) and the first dosages of COVID-19 vaccines would not become widely available for public use for another five months (American Journal of Managed Care, 2021). In the second half of Time 2 data collection (February 2021), the U.S. COVID-19 death toll would reach 500,000. As of October 2020, many American parents, including the participants of this study, had experienced repeated school closures and reopenings (Goldman et al., 2022), virtual learning - with and without adequate internet access (Oster et al., 2021), social distancing and disconnection from familial and community sources of spiritual and emotional (DeSouza et al, 2021) support for over six months. The city of New Orleans, typically known for its world-class tourism, jazz music, celebrations, and impromptu second lines had become a ghost town, with many laid off service, hospitality and gig workers relying on unemployment assistance while facing unprecedented housing insecurity (Murphy, 2020).

Shortly following state-wide COVID-19 restrictions and lockdowns, the U.S. media began presenting continuous coverage of violent police and civilian sanctioned
killings of Black Americans. Three cases that gained regular nationwide media coverage during this time included the murders of Breonna Taylor, Amhad Arbery, and George Floyd. Protests erupted across the United States under the cadence of “Black Lives Matter.” Many peaceful protests were sabotaged by individuals who utilized the gatherings as opportunities to loot stores and burn down public service buildings (Reid & Craig, 2021). A White American adolescent drove across state lines to serve as “medic” during a protest in which his shot and killed two unarmed protestors (Correia & Wall, 2021); the shooter was later acquitted of all charges (Krishnamurthi & Salib, 2022). In the fall of 2020, Aliah Sheffield, posted her now infamous song “Earth is Ghetto” onto YouTube, and her lyrics became an underground anthem for the year 2020 and the COVID-19 pandemic. Sheffield (2020) verse two lyrics read:

Earth is ghetto
I wanna leave
They got their hungry starving
nothing to eat
The homeless living
out on the street
And the sick are dying
Crooked police
Politicians lying
Criminals on the street
I got five on fuel if you need it from me
I’ll sit in the back if we riding too deep
Better lock the doors, these people lie steal and cheat

Roll the windows up, so we can ride off in peace.

succinctly describe the distressing and incomprehensible phenomenon that was the year 2020.

Minority and low-income communities across the nation were devastated by COVID-19. COVID-19 created not only health-related stress but also exacerbated employment and educational gaps. Issues related to occupational segregation and labor market inequality became increasingly apparent during the COVID-19 pandemic. Womanist scholars have found that Black women are overrepresented in hospitality and restaurant industries, both of which experienced disproportionate job losses during the COVID-19 crisis (Holder et al., 2021). COVID-19 psychosocial stress and pre-existing psychosocial stressors may have resulted in higher occurrences of maternal mortality and morbidity rates among Black women (Carvalho et al., 2021). More specifically, Adesogan and colleagues (2021) found that among Southern Black Americans, overall health markers including sleep disturbances and depressive symptoms worsened after the onset of the COVID-19 pandemic and that increased pre-existing stressors including financial stress, racial discrimination, and chronic stress were associated with exposure to COVID-19 related stressors and health markers during the pandemic. Similarly, within the current study’s analytic sample, during the second wave of data collection, there was a significant increase in maternal depressive symptoms among mothers who did not endorse histories of childhood sexual abuse; both CSA and NON-CSA mothers indorsed levels of depressive symptoms that exceeded or nearly exceeded clinical cut offs at Time 2.
Amid an international health crisis, social upset, and civil unrest, many Black churches closed their doors as they slowly and reluctantly transitioned onto online platforms (DeSouza et al., 2021) or parking lot services (Kidder & Hucks, 2020). Many parishioners lost the ability to engage in regular social support and fellowship with other worshipers. As the number of COVID-19 related deaths continued to rise, many Black families were forced to grieve in isolation, at small graveside burials, or postpone traditional celebration of life ceremonies until unspecified dates when it was considered safer to gather together (Moore et al., 2022). During COVID-19, for Black families that previously leaned on corporate worship for support, the importance of individual spiritual connections such as prayer may have become a more central source of resilience.

The COVID-19 pandemic has also significantly impacted maternal mental health outcomes more broadly and may have presented unique risks mothers to mothers of preschool-aged children, especially considering daycare closures during the early months of the COVID-19 pandemic (Carlson et al., 2021). Cameron et al. (2020) found that within the context of COVID-19, maternal depressive and anxiety symptoms of mothers of children between the ages of 0 and 8 years, were elevated compared to previously reported symptoms. The COVID-19 literature has also demonstrated the potential risk/protective role of socioeconomic status in maternal mental health outcomes during the pandemic, Doan et al. (2022) found that as maternal income increased, maternal depressive symptoms decreased. As the need for access to mental health services and support increased during the pandemic, Black, Asian, and Hispanic/Latina women were more likely to experience barriers in access to healthcare services when compared to White American women (Masters et al., 2021).
Therefore COVID-19 has presented as a public health crisis that has the potential to double as a mental health crisis among low-income Black mothers of young children. As such, it has the potential to have lasting intergenerational effects on the next generation of Black children and families. Although, within the current study, maternal depressive symptoms did not mediate the relationship between maternal history of trauma and child behavior outcomes, maternal depressive symptoms were positively associated with child behavior problems.

**Different Intergenerational Associations for CSA and NON-CSA Mothers**

Contrary to Hypothesis 1, maternal depressive symptoms at Time 1 (Pre-COVID) did not mediate the association between maternal CSA status and child behavior problems at Time 2 (During COVID). Maternal CSA status was not significantly associated with child behavior problems at Time 2; this was surprising considering that the previous literature has provided evidence for links between maternal CSA history and child behavior difficulties (Barrett, 2009). The discrepancy between our results and findings within the existing literature may be attributed to inconsistencies in how CSA is defined, resulting in inadequate representation of the scope and magnitude of the issue and intergenerational effects. The age limits placed upon the classification of sexual abuse as childhood sexual range from abuse that occurred prior to age 14 (Zvara et al., 2017; Zvara et al., 2015), at or prior to age 16 (Barrett, 2009) prior to age 18 (Schuetze & Eiden, 2005; Pazdera et al., 2013), or age at time of high school graduation (Madigan et al., 2014). Some articles only consider sexual abuse as penetrative in nature, whereas other articles include non-penetrative acts such as exposure or forced participation in
child pornography. Unfortunately, some articles only consider sexual acts with minors as sexual abuse when genital contact or penetration has occurred more than 10 times. Contrasting, other authors have defined childhood sexual abuse in very broad terms including behaviors such as unwanted hugs (Matthews & Collin-Vezina, 2019). To address issues related to CSA operationalization, future studies should adhere to the World Health Organization’s operationalization of childhood sexual abuse which defines CSA “as the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society” (Murray et al., 2014, p. 1-2).

Few studies have explored the impact of maternal CSA history on maternal depressive symptoms among Black mothers of young children and intergenerational outcomes. There is some research that suggest that the elevated levels of depression experienced by Black CSA survivors during pregnancy, are likely to remain consistent through the postpartum period and into the early years of motherhood (Madigan et al., 2004). The extant literature has primarily explored the potential intergeneration impact of maternal depression on child behavior outcomes through CSA survivors’ use of harsh parenting practices and parenting. Additionally, maternal depression has been shown to mediate the relationship between maternal CSA history and parenting stress and CSA history and child maltreatment (Pazdera et al., 2013) and the relationship between maternal CSA and parenting outcomes may be dependent upon current trauma exposure. Schuetz and Eiden (2005) found that the association between maternal CSA history and harsh parenting practices was fully mediated by current involvement in intimate partner
violence. The current study differs from previous research in two ways: (1) exploring the relationship between CSA, maternal depression and child behavior problems within an all-Black sample and (2) exploring the direct association between maternal CSA history, maternal depression, and child behavior problems without directly examining perceived parenting stress or harsh disciplinary practices.

However, within the current study, significant associations between maternal risk/protective factors and child behavior problems were revealed. Associations between maternal risk/protective factors and child behavior problems differed between mothers based upon maternal CSA status. Among mothers with histories of CSA, maternal use of spiritual coping was significantly and negatively associated with child behavior problems. Although there is a shortage of literature that explores the direct relationship between maternal spiritual coping strategies and child behavior problems among Black trauma exposed mothers of young children, there is some existent literature that suggests a relationship between parenting satisfaction, parental use of prayer, and child behavior problems. Henderson et al. (2016) explored relationships between parental religious involvement and parental satisfaction among a group of young parents aged 24-34 using data from the National Longitudinal Study of Adolescent to Adult Health; within their sample, they found positive associations between parental use of prayer and parenting satisfaction. Berry (1992) literature review discussed the association between lower parenting satisfaction among adoptive parents and higher levels of reported behavior problems.
Among mothers who did not endorse a history of CSA, maternal depressive symptoms pre-COVID-19 (Time 1) and during COVID-19 (Time 2) were positively and significantly associated with child behavior problems. This finding is in alignment with previous research that has examined the relationships between maternal depression and child behavior problems among Black low-income women primary caregivers and preschool aged children. When examining the relationship between depressive symptoms among maternal caregivers (mothers, grandmothers, and aunts) and Head Start children, Koblinsky et al. (2006) found that maternal depression arose as a significant risk factor; women caregivers with more depressive symptoms endorsed higher preschooler behavior problems and the relationship between maternal depressive symptoms and preschooler internalizing behavior problems was mediated by increased maternal use of psychological aggression.

**Racial Trauma (Discrimination) and Mother and Child Outcomes.**

As anticipated with Hypothesis 2, maternal lifetime history of discrimination exposure predicted maternal depressive symptoms above and beyond maternal childhood sexual abuse history. Even when CSA was included in the model, maternal discrimination still predicted maternal depressive symptoms, highlighting the impact of Black mother’s intersectional identities (i.e. being women, mothers, Black, and of low socio-economic status). These findings are supported by studies that have suggested that repeated exposure to racism may cause Black Americans to present with higher levels of mental health challenges (Anderson, 2015) and chronic illnesses including breast cancer (Taylor et al., 2007) and hypertension (Cozier et al., 2007). Gendered discrimination,
which encompasses two components of Black women’s intersectionality, has also been
linked to increases in psychological distress (Thomas et al., 2008). The intersectionality
of Black mothers places them at risk for repeated exposure to discrimination throughout
the lifetime, in comparison to childhood trauma which is confined developmentally.

In addition to maternal discrimination’s association with maternal depressive
symptoms, within this sample, it was also positively and significantly associated with
child behavior problems. These findings are in line with previous research that has shown
that parental exposure to racism is associated with higher levels of parental depression
which subsequently impacts child health outcomes (Anderson et al., 2015). Therefore,
when providers are conducting needs assessments, maternal racial trauma (lifetime
discrimination exposure) should be examined, especially when providing wrap around or
intensive services to Black mothers and children.

**Main Effects: Spiritual Coping – Culture Specific Protective Factor**

A key finding of the present study revealed that maternal use of spiritual coping
had a greater impact on maternal depressive symptoms than both maternal childhood
(CSA) and racial (lifetime discrimination exposure) trauma histories, despite not
providing support for Hypothesis 4 and the moderating role of maternal use spiritual
coping in the relationship between maternal trauma history and depressive symptoms.
Rather than the conditional effects we hypothesized, wherein spiritual coping was
specifically protective for mothers with CSA or racial discrimination histories, we instead
observed powerful main effects for maternal use of spiritual coping for maternal
depressive symptoms. The protective role of Black mothers’ use of spiritual coping with
prayer has been previously identified as a source of healing for Black CSA survivors (Singh et al., 2013) and associated with decreased levels of maternal parenting stress among trauma exposed mothers (Lamis et al., 2014) and child behavioral and emotional maladjustment (Christian and Barbarin, 2001). The CSA literature has not previously simultaneously explored the impact of racial trauma and spiritual coping strategies of Black mothers who are CSA survivors and mothers of young children. However, within the domestic violence literature, among Black female intimate partner violence survivors, higher levels of spirituality and religious involvement have been associated with lower levels of depression (Watlington & Murphy, 2006) and PTSD symptoms (Staton-Tindall et al., 2013). However, among a community sample of predominantly White American trauma survivors, increased spirituality was associated with higher levels of PTSD symptoms (Connor et al., 2003). The opposing results emphasize the importance of exploring culture-specific risk factors for Black mothers. This study significantly contributes to the CSA literature by examining both CSA and racial trauma exposure and spiritual coping strategies utilized by Black mothers.

**Main Effects: Strong Black Woman Ideology – Culture Specific Risk Factor**

Within this study, Strong Black Woman Ideology endorsement emerged as a culture-specific risk factor for maternal depressive symptoms. This finding was expected considering that maternal endorsement of Strong Black Woman Ideology has previously been associated with markers of increased emotional dysregulation including stress, depressive symptoms (Donovan & West, 2015; Leath et al., 2021), anxiety (Leath et al., 2021), and binge eating (Harrington et al., 2010). Maternal endorsement of Strong
Black Woman Ideology has also been linked with maternal hesitation to engage in mental health programming (Woods-Giscombe et al., 2016) which may also pose as a risk for the intergenerational transmission stress within Black families.

An unexpected result of this study was the absence of significant interaction effects between maternal trauma history and modifiable culture-specific risks and protective factors. Previous research has suggested that exposure to discrimination exacerbates stress levels among women who endorse Strong Black Woman. In contrast to Hypothesis 3, which posited that mothers who endorsed histories of racial or CSA trauma and Strong Black Woman ideology would report higher levels of depressive symptoms, maternal endorsement of Strong Black Woman ideology did not moderate the relationship between maternal trauma history (CSA and discrimination) and maternal depressive symptoms. These findings were surprising considering that the SBW literature has demonstrated evidence of Black women’s endorsement of SBW and elevated depressive symptoms (Donovan and West, 2015). The one known research article that has addressed Black women’s childhood trauma, endorsement of Superwoman Schema and mental health outcomes found significant associations between Superwoman Schema endorsement and maternal mental health outcomes (Leath et al., 2021). Specifically, Leath and colleagues (2021) observed that among Black women who endorsed multiple ACES, stronger determination to succeed was associated with anxiety symptoms and internalized beliefs about presenting images of strength were associated with elevated stress.
In the present study, Strong Black Woman Ideology was defined within the context of maternal endorsement of Mammy and Superwoman schema traits which include characteristics such as self-reliance, remaining strong, decreased use of help-seeking behaviors, and prioritization of the well-being of others over oneself. The externalization rather than internalization of these stereotypical characteristics of Black women by Black CSA survivors within Woods-Giscombe and colleagues (2016) study was identified as a healing mechanism in overcoming childhood sexual abuse. Wingo et al. (2010) examined the moderating role of resiliency in the relationship between childhood abuse and depressive symptoms in adulthood among a sample akin to that of current study and found that resilience, measured using the Connor-Davidson Resilience Scale, moderated the relationship between childhood abuse history and depressive symptoms in adulthood. Some of the items on the Connor-Davidson Resilience Scale (Connor & Davidson, 2003), including self-reliance, remaining strong to help others, and strong work ethic which mirror constructs on the Stereotypical Roles of Black Women Scales Mammy and Superwoman subscales (Thomas, Witherspoon & Speight, 2004). Some of those same characteristics (e.g., self-reliance and strength) have historically functioned as survival mechanisms for Black families facing race-related stressors (Woods-Giscombe, 2010). Like Wingo et al. (2010) findings, Donovan and West (2015) suggested that Black women who endorsed higher levels of stress and internalization of SBW ideology reported elevated levels of depressive symptoms. There is some literature that has suggested that Black women’s beliefs about being perceived as strong is dependent upon context (e.g., perceived positively within the Black community and workplace and perceived negatively in settings occupied by predominantly non-Black
others) (Jones et al., 2020). Similarly, a participant in Dow (2015, p.47) qualitative analysis of SBW among middle class Black women described her endorsement of SBW as:

“I think it is important to role model for my daughter being a strong woman and being a career woman. Sometimes my job gets in the way with me being the type of mom I want to be, but I think it is important for her to see that. I think the term ‘Strong Black Woman’ is a good term. I think in certain settings strong black women are thought of as aggressive women, and it is thought of negatively . . . [but] to me it is a positive thing . . . it means unwavering values, goal-oriented, tenacious, good things. You don’t let situations prevent you from going after what is important.”

This study uniquely contributes to literature in demonstrating the predictive power of modifiable culture-specific risk and protective factors for Black mothers above and beyond that of maternal trauma history. Additionally, findings revealed that although maternal history of CSA predicted maternal depressive symptoms at Time, it did not predict maternal depressive symptoms at Time 2. Maternal history of CSA and lifetime discrimination exposure lost its predictive power when more proximal predictors including maternal lifetime exposure to discrimination, maternal use of prayer as spiritual coping, and maternal endorsement of Strong Black Woman Ideology were included within regression models. Within the context of a global pandemic and racially charged political climate, it appears that for low-income Black mothers, culturally specific risks and protective factors rather than history of childhood sexual trauma, have a more salient impact on maternal mental health outcomes. More specifically, these findings suggest that these culture-specific risks may have a greater impact on younger low-income Black
mothers considering that, within this sample, the severity of depressive symptoms at Time 2 where higher among younger mothers and appeared to decrease with age.

**Strengths, Limitations, and Implications/Future Directions**

This study serves as an important contribution to the women’s health and resiliency literature through its exploration of culture specific risks (SBW) and protective factors (spiritual coping), maternal racial (discrimination) and early childhood (CSA) trauma, and maternal mental health outcomes (self-reported depressive symptoms) within one study. By exploring risks and protective factors simultaneously, we were able to observe the protective power of spiritual coping, which exceeded the impact of maternal trauma exposure. Spiritual coping served as a protective factor for all mothers, regardless of trauma history. Within the context of a global pandemic and heightened stress, Black mothers’ resilience appears to have been rooted in their spiritual belief systems.

However, there are some limitations to this study. Firstly, this study only examined the experiences of Black mothers who live near or below the poverty line. Due to the overrepresentation of low-income mothers within our sample, we were unable to examine the impact of poverty and limited access to mental health resources and community supports on the culture specific risks and protective factors identified within the study. Previous research has shown that socioeconomic status impacts access to services and the ability to successfully engage with community resources (Silverstein et al., 2008) while also potentially increasing risks for exposure to discrimination (Hoyt D’Anna et al., 2018).
Secondly, this study was not able to examine the intergenerational transmission of vulnerability from non-biological mothers to children; this is a significant limitation considering that within many Black households, grandmothers, Godparents (nannies and parrains), aunts (teedys), and other trusted adults may serve as primary caregivers in addition or adjacent to biological mothers (Cross, 2018).

Thirdly, the present study did not specifically measure the content of prayers, meditation, or music utilized by mothers identified as spiritual copers. Assessment of the content of prayers is especially important among low-income mothers who have been identified as spiritual copers considering that, according to Baker (2008), Black Americans and those from lower socioeconomic backgrounds are more likely to utilize prayer as a coping mechanism by making petitions and expressing concerns (e.g., health and financial concerns) to God and individuals from lower-income backgrounds are also more likely to seek spiritual comfort through praying about one’s personal relationship with God. Within the current study, we were unable to assess how Black mothers of young children utilized spiritual coping to deal with life’s hardships. Previously, spiritual coping in Black women has been explored qualitatively and the following functions of spiritual coping were identified 1) coming to terms with reality vs. escapism, 2) developing the courage to surrender concerns to a Higher Power, 3) acknowledging one’s own limitations and allowing a Higher Power to provide, 4) identifying and grappling with existential life lessons, 5) finding purpose and destiny in life, 6) living a life led by spiritually informed principals, and 7) personal growth and transformation (Mattis, 2002).

Furthermore, the use of intercessory prayer (i.e., having others pray or petition God on another’s behalf) in bolstering personal strength has been qualitatively identified as a
source of spiritual coping for Christian Black women (Skipper et al., 2018). Future studies should qualitatively explore how Black mothers have used spirituality and other mechanisms to cope during the COVID-19 pandemic.

A significant methodological limitation of this study is that child behavior problems were assessed as a single-rater outcome, there was no independent assessment of children’s behavior through observation or using multiple raters such as teachers or other caregivers. Future studies that address maternal depressive symptoms and child behavior problems should explore child behavior problems using parent and teacher reports of child behavior. Additionally, future studies should utilize oversampling of Black mothers who endorse histories of CSA to increase statistical power and more comprehensively examine its intergenerational impact; preliminary correlations within the current analytic sample suggest the potential for differences in risk and coping strategies experienced by mothers who did and did not endorse histories of childhood sexual abuse.

In efforts to promote the development of trauma informed and culturally sensitive interventions that reflect the intersectionality of Black women, future studies should continue to explore culture-specific and modifiable risks and strengths for Black mothers with histories of childhood sexual abuse and other adverse childhood experiences. It is also recommended that future studies examine SRBW subscales (e.g., Mammy, Superwoman, Sapphire, and Jezebel) individually to identify the protective of harmful effects of each schema on parenting and mental health outcomes among Black mothers who endorse varying levels of childhood trauma exposure and socioeconomic privilege.
or hardship. Additionally, future studies should specifically examine the moderating role of maternal age in the relationship between early trauma exposure, modifiable risks/protective factors, maternal depressive symptoms, and child outcomes in an economically diverse sample of Black mothers. Lastly, the exploration of the relationship between maternal endorsement of Strong Back Woman Ideology and harsh parenting practices fell beyond the scope of the current study. Future studies should explore the moderating role of Strong Black Woman ideology endorsement in the association between maternal discrimination exposure and harsh parenting practices considering that harsh parenting practices have been shown to mediate the relationship between parental exposure to racism and child health outcomes (Anderson et al., 2015).

Clinically, in endeavors to decrease feelings of mistrust among Black low-income mothers toward mental health providers (Leis et al., 2011), providers should work to incorporate client (a) spiritual and religious beliefs, (b) attitudes, beliefs and concerns related to ethnic-racial identity and gender/sexuality, (c) ability and access to financial and community resources, and (d) history of trauma and/or resilience into all aspects of treatment. Providers should also initiate conversations related to sensitive issues (e.g. parenting stress, financial stress, experiences of raced and gender -based discrimination) and provide accessible community-based referrals for assistance, as some Black mothers may be hesitant to bring up these issues as potential risks related maternal mental health with their healthcare providers. Maternal use of spiritual coping and endorsement of Strong Black woman ideology are both modifiable. Healthcare providers should work with clients to incorporate beneficial components of client belief systems into treatment planning and provide psychoeducation on the harmful effects of over self-reliance while
providing referrals to community agencies that offer culturally sensitive parenting and socio-emotional support to Black mothers and families.

Still, a profession-wide commitment to training mental health professionals in culturally sensitive practices is not enough to undo decades of mistrust between Black women and mental health care providers. To better address Black women’s mistrust and limited access to mental health services, the cultural mismatch between many mental health providers and Black women, and the modifiable risks (endorsement of SBW) and protective factors (spiritual coping) identified within the present study, it is recommended that culture-specific mental health interventions designed for Black women, be offered in more accessible spaces that are created for and by Black women. Mbilishaka (2018) has posited that “PsychoHairapy” be utilized to meet the psychological, emotional, and spiritual needs of Black women considering that Black women, on average, visit the hair salon at least once every four to eight weeks and appointments last between one to five hours (Linnan and Ferguson, 2007). Black women have historically created “safe spaces” within Black owned hair salons by promoting Black beauty standards and cultural values (Gill, 2010). Within “PsychoHairapy,” like thAIRapy (Ashley & Brown, 2015), haircare professionals work in collaboration with Black community leaders and mental health professionals to facilitate interventions (e.g., group therapy and provision of psychoeducation materials) within the salon setting (Mangum and Woods, 2011).

Similar to beauty salons, Black churches and places of worship, Black sororities, and Black civic/social organizations (e.g., bike clubs, fitness clubs etc.) can also function as systems in which therapeutic activities and resources can be offered in collaboration
with mental health professionals. All of these organizations are more easily accessible (i.e., physical and financial proximity) to more Black women than a clinician's office.

**Conclusion**

The present study provided insight into the impact of Black mothers’ lived experiences and the influence of their intersectional identities on mental health outcomes by exploring culture-specific risk and protective factors. Black mothers’ use of spiritual coping emerged as a modifiable culture-specific protective mechanism for Black mothers’ mental health. Spiritual coping implies a personal relationship with God or some other supernatural source or entity. Regardless of the proven/disproven existence of Black women’s’ chosen Higher Power(s), reliance on it and belief that it cares about their well-being serves as an identified protective mechanism for Black mothers, in spite of the current global pandemic, ongoing racial discrimination, and histories of childhood trauma. Maternal endorsement of Strong Black Woman Ideology arose as a culture-specific modifiable risk to Black mothers’ mental health outcomes, regardless of maternal history childhood sexual trauma or race-based trauma (discrimination). Through the provision of psychoeducation and targeted culture-specific intervention, Black mothers can develop insight into more adaptive ways to cope with life’s challenges and develop the tools needed to seek help through natural (e.g., community, family, friends) and/or professional supports rather than feeling pressured to bear the weight of the world on their shoulders with impossible God-like strength.
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### Table 1

*Time 1 and Time 2 Measures and Constructs*

<table>
<thead>
<tr>
<th>Measures</th>
<th>Constructs</th>
<th>Time 1</th>
<th>Measures</th>
<th>Constructs</th>
<th>Time 2</th>
</tr>
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<tbody>
<tr>
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<td>Maternal history of childhood sexual abuse</td>
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<td>CESD-R</td>
<td>Maternal depressive symptoms</td>
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</tr>
<tr>
<td>CESD-R</td>
<td>Maternal depressive symptoms</td>
<td></td>
<td>INDI-D</td>
<td>Maternal lifetime discrimination exposure</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SRBWS</td>
<td>Maternal endorsement of Strong Black Woman ideology</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CBCL 6-18</td>
<td>Child behavior problems</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>WFRQ</td>
<td>Maternal spiritual coping</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CDM-NSAL</td>
<td>Maternal spiritual coping</td>
<td></td>
</tr>
</tbody>
</table>

*Note.* CESD-R, Center for Epidemiologic Studies Depression Scale-Revised; INDI-D, Intersectional Day to Day-to-Day Discrimination Index; SRBWS, Stereotypic Roles for Black Women Scale; WFRQ, Walsh Family Resilience Questionnaire; CDM-NSAL, Coping with Discrimination Measure NSAL Study (Abbreviated); CBCL 8-16, Child Behavior Checklist 6-18.
Table 2

Summary of Variable Correlations, Means and Standard Deviations Among All Mothers in Analytic Sample (n = 69)

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>M(or%)</th>
<th>SD</th>
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</tr>
<tr>
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<td></td>
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<td></td>
<td></td>
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<td>.05</td>
<td>.36**</td>
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<td></td>
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<td></td>
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<td>.34**</td>
<td>.46**</td>
<td>.25</td>
<td>1</td>
<td></td>
<td></td>
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<td></td>
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<td>.26*</td>
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<td>-.23</td>
<td>-.08</td>
<td>.05</td>
<td>-.21</td>
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<tr>
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<td>.02</td>
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<td>.03</td>
<td>-.01</td>
<td>-.05</td>
<td>.05</td>
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<td></td>
<td></td>
<td></td>
<td>49.30</td>
<td></td>
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<tr>
<td>9. Mat Edu</td>
<td>-.10</td>
<td>.09</td>
<td>.15</td>
<td>.17</td>
<td>.11</td>
<td>-.06</td>
<td>-.01</td>
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<td>-.15</td>
<td>-.34**</td>
<td>-.07</td>
<td>-.04</td>
<td>.04</td>
<td>-.04</td>
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<td>1</td>
<td></td>
<td>32.90</td>
<td>7.12</td>
</tr>
<tr>
<td>11. Child Age</td>
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<td>-.12</td>
<td>-.11</td>
<td>.03</td>
<td>-.11</td>
<td>-.24</td>
<td>.09</td>
<td>-.10</td>
<td>-.23</td>
<td>.11</td>
<td>1</td>
<td>94.97</td>
<td>18.74</td>
</tr>
</tbody>
</table>

Note. N=69. CSA, maternal history of childhood sexual abuse (0=no, 1=yes); CESD T1, Center for Epidemiologic Studies Depression Scale-Revised Time 1 sum; CESD T2, Center for Epidemiologic Studies Depression Scale-Revised Time 2 sum; InDI-D, Intersectional Day to Day Discrimination Index Sum of Lifetime day-to-day scores; SBW Strong Black Woman Score, total of Mammy and Supervmman scores; SPC, mothers endorsement of prayer or spiritual engagement on WFRQ or CDM-NSAL (Abbreviated) (0=does not endorse use of prayer, 1=does endorse use of prayer); CBCL, Child Behavior Checklist 6-18 total problems score; Child Sex, Child Sex (0=girl, 1=boy); Mat Edu, maternal educational attainment level; Mat Age, maternal age (in years) at Time 2; Child Age, child age (in months) at Time 2.

*p < .05, **p < .01
Table 3

Summary of Variable Correlations, Means and Standard Deviations Among Mothers Who Endorsed Histories of CSA

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>( \bar{x} ) (or%)</th>
<th>SD</th>
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<tbody>
<tr>
<td>1. CESD T1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td>14.46</td>
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<td>2. CESD T2</td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>18.74</td>
<td>18.88</td>
</tr>
<tr>
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<td></td>
<td></td>
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<td></td>
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</tr>
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<td>6. CBCL</td>
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</tr>
<tr>
<td>7. Child Sx</td>
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<td>.27</td>
<td>-.18</td>
<td>-.12</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>50.00</td>
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</tr>
<tr>
<td>8. Mat Edu</td>
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<td>.24</td>
<td>-.18</td>
<td>.15</td>
<td>-.32</td>
<td>-.12</td>
<td>.31</td>
<td>1</td>
<td></td>
<td></td>
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<tr>
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<td>91.59</td>
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</table>

Note. \( N=29 \). CESD T1, Center for Epidemiologic Studies Depression Scale-Revised Time 1 sum; CESD T2, Center for Epidemiologic Studies Depression Scale-Revised Time 2 sum; InDI-D, Interpersonal Discrimination Index; SBW, Sum of lifetime day-to-day scores; SPC, Sarbin Person-Self-Community Scale; CBCL, Child Behavior Checklist; Child Sx, Child Sex (0=girl, 1=boy); Mat Edu, Maternal Educational Attainment Level; Mat Age, Maternal Age (in years) at Time 2; Child Age, Child age (in months) at Time 2.

*p < .05, **p < .01
Table 4

Summary of Variable Correlations, Means and Standard Deviations Among Mothers Who Did Not Endorse Histories of CSA.

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
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<th>5</th>
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<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>M (or%)</th>
<th>SD</th>
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<tbody>
<tr>
<td>1. CESD T1</td>
<td>1</td>
<td></td>
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<td></td>
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<td>9.03</td>
</tr>
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<td></td>
<td>56.12</td>
<td>13.01</td>
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<td>5. SPC</td>
<td>-.24</td>
<td>-.13</td>
<td>.00</td>
<td>.22</td>
<td>1</td>
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<td></td>
<td></td>
<td></td>
<td>66.00</td>
<td></td>
</tr>
<tr>
<td>6. CBCL</td>
<td>.31*</td>
<td>.44**</td>
<td>.16</td>
<td>.23</td>
<td>.07</td>
<td>1</td>
<td></td>
<td></td>
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<td></td>
<td>20.63</td>
<td>18.21</td>
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<tr>
<td>7. Child Sx</td>
<td>-.09</td>
<td>-.14</td>
<td>.14</td>
<td>-.10</td>
<td>.16</td>
<td>.02</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>48.90</td>
<td></td>
</tr>
<tr>
<td>8. Mat Edu</td>
<td>.11</td>
<td>.13</td>
<td>.27</td>
<td>.14</td>
<td>.10</td>
<td>.04</td>
<td>.18</td>
<td>1</td>
<td></td>
<td></td>
<td>3.47</td>
<td>1.65</td>
</tr>
<tr>
<td>9. Mat Age</td>
<td>.09</td>
<td>.25</td>
<td>.09</td>
<td>.15</td>
<td>.15</td>
<td>.06</td>
<td>.06</td>
<td>.02</td>
<td>1</td>
<td></td>
<td>33.26</td>
<td>6.48</td>
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<tr>
<td>10. Child Age</td>
<td>-.08</td>
<td>-.22</td>
<td>.03</td>
<td>.09</td>
<td>.15</td>
<td>.25</td>
<td>-.01</td>
<td>-.30*</td>
<td>.04</td>
<td>1</td>
<td>96.55</td>
<td>20.29</td>
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</tbody>
</table>

Note. N=47. CESD T1, Center for Epidemiologic Studies Depression Scale-Revised Time 1 sum; CESD T2, Center for Epidemiologic Studies Depression Scale-Revised Time 2 sum; InDI-D, Intersectional Day to Day-to-Day Discrimination Index Sum of Lifetime day-to-day scores; SBW, Strong Black Woman Score, total of Mammy and Superwoman scores; SPC, mothers endorsement of prayer or spiritual engagement on WFRQ or CDM-NSAL(Abbreviated) (0= does not endorse use of prayer, 1= does endorse use of prayer); CBCL, Child Behavior Checklist 6-18 total problems score; Child Sex, Child Sex (0=girl, 1=boy); Mat Edu; maternal educational attainment level; Mat Age, maternal age (in years) at Time 2; Child Age, child age (in months) at Time 2.
*p<.05; **p<.01
Table 5

Analysis for Mediation of Maternal Depressive Symptoms at Time 1 between Maternal CSA and Time 2 Child Behavior Problems

<table>
<thead>
<tr>
<th>Predictors</th>
<th>On Mat Dep T1</th>
<th>On Child Behav Prob</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>β</td>
<td>SE</td>
</tr>
<tr>
<td>Constant</td>
<td>1.71</td>
<td>.00</td>
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<tr>
<td>CSA</td>
<td>.56</td>
<td>3.09</td>
</tr>
<tr>
<td>Mat Dep T1</td>
<td>.18</td>
<td>.22</td>
</tr>
<tr>
<td>R²</td>
<td>.07*</td>
<td>.04</td>
</tr>
<tr>
<td>F</td>
<td>4.39</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Effect</th>
<th>SE</th>
<th>t</th>
<th>p</th>
<th>95%CI</th>
<th>BootSE</th>
<th>Boot95%CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Effect</td>
<td>-.84</td>
<td>5.24</td>
<td>-.16</td>
<td>.87</td>
<td>[-11.33,9.65]</td>
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<td></td>
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<tr>
<td>Direct Effect</td>
<td>-2.72</td>
<td>5.40</td>
<td>-.50</td>
<td>.62</td>
<td>[-13.52,8.09]</td>
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<tr>
<td>Indirect Effect</td>
<td>1.88</td>
<td></td>
<td></td>
<td>1.74</td>
<td>[-1.35,5.67]</td>
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</table>

Note. CI= confidence interval. N=62. CSA, maternal history of childhood sexual abuse (0=no, 1=yes); Mat Dep T1, Center for Epidemiologic Studies Depression Scale-Revised Time 2 sum; Child Behav Prob, Child Behavior Checklist 6-18 total problems score. *p < .05.
Table 6

Regression Analysis Summary for Main Effects and Interaction Effects of Maternal CSA History, Exposure to Discrimination, Spiritual Coping, SBW, on Maternal Depressive Symptoms at Time 2

<table>
<thead>
<tr>
<th>Variable</th>
<th>b</th>
<th>95% CI</th>
<th>SE b</th>
<th>β</th>
<th>( R^2 )</th>
<th>( Δ R^2 )</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1</strong></td>
<td></td>
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</tr>
<tr>
<td>Maternal Age</td>
<td>-70*</td>
<td>[-1.22, -.23]</td>
<td>.28</td>
<td>.29</td>
<td>.22</td>
<td>.22</td>
</tr>
<tr>
<td>CSA</td>
<td>1.54</td>
<td>[-6.89, 11.15]</td>
<td>4.40</td>
<td>.04</td>
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<td></td>
</tr>
<tr>
<td>Mat Exp Dis</td>
<td>1.95*</td>
<td>[.63, 3.22]</td>
<td>.69</td>
<td>.34</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
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<td></td>
<td>.40</td>
<td>.18</td>
</tr>
<tr>
<td>Maternal Age</td>
<td>-68*</td>
<td>[-1.25, -.17]</td>
<td>.25</td>
<td>-.28</td>
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<td></td>
</tr>
<tr>
<td>CSA</td>
<td>-2.36</td>
<td>[-10.89, 6.7]</td>
<td>4.04</td>
<td>-.06</td>
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<tr>
<td>Mat Exp Dis</td>
<td>1.22</td>
<td>[-.15, 2.47]</td>
<td>.64</td>
<td>.21</td>
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<td></td>
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<tr>
<td>SBW</td>
<td>.55**</td>
<td>[.25, .87]</td>
<td>.15</td>
<td>.41</td>
<td></td>
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<tr>
<td>SC</td>
<td>-8.89*</td>
<td>[-17.77, -.16]</td>
<td>4.01</td>
<td>-.24</td>
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<tr>
<td><strong>Step 3</strong></td>
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<td>.44</td>
<td>.04</td>
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<tr>
<td>Maternal Age</td>
<td>-.82*</td>
<td>[-1.51, -.20]</td>
<td>.27</td>
<td>-.34</td>
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<tr>
<td>CSA</td>
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<td>[-17.17,26.08]</td>
<td>7.65</td>
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<tr>
<td>Mat Exp Dis</td>
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<td>[-2.19,4.33]</td>
<td>1.13</td>
<td>.19</td>
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<tr>
<td>SBW</td>
<td>.73**</td>
<td>[.38,1.11]</td>
<td>.18</td>
<td>.54</td>
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<tr>
<td>SC</td>
<td>-10.13</td>
<td>[-21.48,84]</td>
<td>5.06</td>
<td>-.27</td>
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<tr>
<td><strong>Interaction Terms</strong></td>
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<td></td>
</tr>
<tr>
<td>CSA X SBW</td>
<td>-.70</td>
<td>[-1.63,.27]</td>
<td>.38</td>
<td>-.26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>INDI X SBW</td>
<td>.01</td>
<td>[-.08,.12]</td>
<td>.05</td>
<td>.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CSA X SC</td>
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<td>[-29.56,21.74]</td>
<td>9.01</td>
<td>-.04</td>
<td></td>
<td></td>
</tr>
<tr>
<td>INDI X SC</td>
<td>-.32</td>
<td>[-3.58,3.31]</td>
<td>1.36</td>
<td>-.05</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note. N=60; CI= confidence interval; Maternal CSA, Maternal history of childhood sexual abuse (0=no, 1=yes), Mat Exp Dis, Maternal Intersectional Day to Day-to-Day Discrimination Index Sum of Lifetime day-to-day scores; SBW, maternal endorsement of Strong Black Woman ideology, total of Mammy and Superwoman scores; SC, mothers endorsement of prayer or spiritual engagement on WFRQ or CDM-NSAL(abbreviated) (0= does not endorse use of prayer, 1= does endorse use of prayer); Maternal Age, maternal age at Time 2
a. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples.
b. Based on 999 samples
*p < .05. **p < .001.
Figure 1

*Conceptual Model*

*Note.* Maternal CSA, maternal history of childhood sexual abuse (0=no, 1=yes); Maternal Depressive Symptoms, Center for Epidemiologic Studies Depression Scale-Revised sum (assessed at Time 1 and Time 2); Maternal Discrimination Exposure, Intersectional Day to Day-to-Day Discrimination, Index Sum of Lifetime day-to-day scores; Maternal SBW, maternal endorsement of Strong Black Woman Ideology, sum of Mammy and Superwoman subscale scores; Maternal Spiritual Coping, mothers endorsement of prayer or spiritual engagement on WFRQ or CDM-NSAL (Abbreviated) (0= does not endorse use of prayer, 1= does endorse use of prayer); Child Behavior Problems T2, Child Behavior Checklist 6-18 total problems score.
Figure 2

Standardized Regression Coefficients for the Relationship between Maternal CSA History and Child Behavior Problems at Time 2 Mediated by Maternal Depressive Symptoms at Time 1

Note. The regression analysis shows the relationship between maternal history of CSA and child behavior problems at Time 2, with maternal depressive symptoms at T1 entered as a moderator. Maternal Depressive Symptoms at T1 did not mediate the relationship between maternal history of CSA and child behavior problems at Time 2. Coefficients presented are standardized linear regression coefficients.
Biography

Prior to completing her PhD in School Psychology at Tulane University, Chloe Pickett obtained a Bachelor of Science in Psychology from Alabama State University in Montgomery, Alabama as well as a Master of Science in Clinical Psychology from Virginia State University in Petersburg, Virginia. Chloe’s commitment to serving children and families was instilled in her by her mother, Bridget Delores Taylor Pickett, who worked as a First Steps Early Intervention Service Coordinator and licensed social worker for over 25 years. During her third year of practicum training at Tulane University, while under the supervision of Dr. Bonnie Nastasi and Dr. Allisyn Swift, Chloe first acknowledged that she was indeed “called” to complete school-based work. Chloe is currently completing her predoctoral internship with the National Psychology Training Consortium in Columbus, Indiana. Chloe is excited to return to New Orleans in Fall 2022 to work toward licensure during her first year of employment as a district-level school psychologist with Crescent City Schools.