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Neighborhood Disorder, Spiritual Well-Being, and Parenting Stress in African American Women

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Abstract

Using a culturally-informed risk-protective framework, the purpose of this study was to examine spiritual well-being (existential, religious) as a moderator (protective factor) in the relation between neighborhood disorder (risk factor) and parenting stress in among a high risk sample of low-socioeconomic status (SES), African American women (N = 144). These women, who were primary caregivers of children aged between 8 and 12 reported on disorder in their existential and religious well-being, neighborhoods, and three types of parenting stress. Women who perceived more disorder in their neighborhood had more parenting stress, and women who reported more existential and religious well-being had less parenting stress. Existential (characterized by a sense of purpose in life), but not religious (characterized by a sense of life in relationship with God) well-being, moderated the relation between neighborhood disorder and all types of parenting stress such that women with medium or high levels of existential well-being had low levels of parenting stress at low levels of neighborhood disorder, but higher levels of parenting stress at higher levels of neighborhood disorder. No moderation effects were found at low levels of existential well-being. Results are framed in a context that emphasizes their relevance to incorporating family interventions that bolster culturally relevant resilience factors, such as spirituality, pertinent to low-SES African American families.

This study tests a risk-protective model in which spiritual well-being, a protective factor, is examined as a moderator of the relation between neighborhood disorder, a risk factor, and parenting stress in a high risk sample of low socioeconomic status (SES) African American women. The study is important for African American families because they are more often

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low SES and live in poor and risky neighborhoods, and these socioeconomic factors contribute to high levels of parenting stress (U.S. Bureau of the Census, 2010). Poor neighborhoods are riskier due to higher crime rates and less access to supportive resources. Given these risk factors, studies of African American families have tended to approach parenting from a deficit perspective. Thus, our focus on spirituality as a protective factor in the face of risky environments is valuable, especially as theory and empirical work are turning to factors that support positive development for minority children (Cabrera & The SRCD Ethnic and Racial Issues Committee, 2013).

Parenting Stress

Parenting stress, stress related to fulfilling the parenting role (Abidin, 1995), can be understood as the negative emotional reactions individuals experience vis-à-vis the demands of being a parent (Deater-Deckard, 2004). It is associated in a transactional fashion with individual-level variables in mothers, such as depression (Renner & Boel-Studt, 2013), as well as with internalizing and externalizing emotional and behavioral problems in 8-12 year old children (Neece, Green, & Baker, 2012). At the family level, it is linked to parenting difficulties and is associated with harsher and more inconsistent parental discipline and less parental warmth (Anthony et al., 2005; Deater-Deckard, 2004). Parenting stress impacts associations between family-level stressors, such as divorce and intimate partner violence (IPV), and negative child outcomes (Anthony et al., 2005; Hakvoort, Bos, Van Balen, & Hermanns, 2012; Renner & Boel-Studt, 2013). Moreover, it is correlated with contextual factors, such as neighborhood conditions and processes (Franco, Pottick, & Huang, 2010; Guterman, Lee, Taylor, & Rathouz, 2009).

There is limited information with regard to parenting stress in the African American community. Higher of levels of parental distress among African American mothers with a history of IPV are associated with higher levels of maternal mental health symptoms, child emotional and behavioral problems, and parenting difficulties (Hughes & Huth-Bocks, 2007). Moreover, paternal levels of parenting stress predict more mismanagement of children's behavior, which in turn is associated with children's increased behavior problems (Mitchell & Cabrera, 2009).

Risk-Protective Model of Parenting Stress

A risk-protective factor model (Rutter, 1987) offers a valuable frame for understanding factors that contribute to parenting stress. Risk factors increase vulnerability to negative outcomes; they are markers, correlates, and causes of negative events in the future. Protective factors buffer individuals and families from adversity and alter outcome status. They modify and compensate for risk and moderate the association between risk factors and negative outcomes. Individuals or families who have positive outcomes despite heightened risk are resilient.

Data on risk factors for parenting stress suggest that maternal psychological functioning, child health and behavior, parent-child interactions, family poverty, and negative life events predict parenting stress in at-risk populations (Leigh & Milgrom, 2008; McPherson, Lewis, Lynn, Haskett, & Behrend, 2009; Saisto, Salmela-Aro, Nurmi, & HalmesmAki, 2008). The

more risk factors women experience, the more they report parenting stress (Nair, Schuler, Black, Kettinger, & Harrington, 2003; Raikes & Thompson, 2005). The only protective factors that have gained empirical support are maternal self-efficacy and high self-esteem, social support, and adaptive social strategies (Raikes & Thompson, 2005; Saisto et al., 2008).

Risk-Protective Model Relevance to Low Income African American Families

Historically, research has focused on pathology rather than resilience, particularly in low income African American families. However, the risk-protective factor model has been increasingly applied to individuals and families of color (Cauce, Cruz, Corona, & Conger, 2011). By selecting culturally-relevant factors, the risk-protective framework offers testable hypotheses to enhance our understanding of parenting stress in low-income African American families.

Recent years have witnessed attention to the positive traits of African American families; doing so supports positive functioning and empowers families to solve their problems. Strengths commonly found in these families include strong kinship bonds, optimistic worldview, strong work orientation, and adaptability (Hill, 2003; Taylor, Larsen-Rife, Conger, Widaman, & Cutrona, 2010). This perspective is consistent with an emphasis on protective factors in a family resilience framework, in which positive traits are emphasized as critical to optimal functioning, particularly in the face of risk (Masten, 2001).

Neighborhood Disorder: Culturally Relevant Risk Factor

Neighborhood disorder is a culturally relevant risk factor for low-income families, including those who are African American, that contributes to stress in general and may influence parenting stress. It encompass physical (abandoned buildings, vandalism) and social (crime, substance abuse) factors (Ross & Mirowsky, 2001). Mothers in disordered neighborhoods are reluctant to let their children spend time outside because of exposure to violence and drugs (Furstenberg, Cook, Eccles, Elder, & Sameroff, 1999). Rather than relying on neighborhood resources to provide support in child-rearing, mothers in these areas often disengage from the neighborhood to cope with its dangers. Residing in a neighborhood with high levels of disorder may make it difficult to parent effectively, which contributes to parenting stress and more frustrated or angry reactive parenting behaviors (Deater-Deckard, 2004). Neighborhood disorder is associated with negative parenting outcomes, such as ineffective parenting practices, involvement, and monitoring (Chung & Steinberg, 2006; Waanders, Mendez, & Downer, 2007). However, data are limited on the relation between neighborhood disorder and parenting stress (Franco et al., 2010), including in African American families.

Spiritual Well-Being: Culturally Relevant Protective Factor

Spirituality, a protective factor in the African American community (Boyd-Franklin, 2010), serves as a survival strategy for triumphing over adversity and developing positive social bonds (Boyd-Franklin, 2010). It assists African American women in meaning making and coping (Mattis, 2002). Spiritual well-being encompasses existential (purpose and meaning in

life) and religious (relationship with God) aspects (Paloutzian & Ellison, 1982). Among African Americans, existential and religious well-being combined and independently have been linked to adjustment (Douglas, Jiminez, Lin, & Frisman, 2008; Kaslow et al., 2002; Mitchell et al., 2006; Watlington & Murphy, 2006). Existential well-being has been associated with better quality of life (Dalmida, Holstad, Dilorio, & Laderman, 2011). Spiritual well-being mediates the relation between intimate partner violence and parenting stress in African American mothers (Mitchell et al., 2006). These findings suggest that the unique contributions of existential and religious well-being should be investigated in the context of risk-protective models.

Neighborhood Disorder, Spiritual Well-Being, and Parenting Stress

There is a dearth of information on the unique ways that existential and religious well-being buffer against risk factors, such as neighborhood disorder, on parenting stress levels. Although the mechanisms for these associations are not well understood, the relational view of spirituality, which suggests that higher levels of spirituality facilitate improved relationships within the family, may elucidate these relations (Mahoney, 2013).

Research with African American women has found that spiritual engagement may promote inter- and intra- personal functioning, which leads to improved family relationships (Banks-Wallace & Parks, 2004). Among African American fathers living in disadvantaged neighborhoods, those more spiritually engaged endorsed higher levels of parental monitoring and were more likely to instruct their children on safety and self-protection strategies than fathers reporting lower levels of spirituality (Letiecq, 2007). Research on parenting in neighborhoods marked by high levels of violence has highlighted the role of spirituality in bolstering parents' confidence in their ability to ward off dangerous neighborhood conditions (Newlin, 2002). It is unclear if relations between spirituality and parental engagement and confidence translate to spiritual well-being as a protective factor against parenting stress.

Purpose

This is the first study to explore existential and religious well-being as moderators of the neighborhood disorder - parenting stress link in low-income, African American women. A moderator affects the strength/direction of the relation between an independent (risk factor) and dependent variable (Rose, Holmbeck, Coakley, & Franks, 2004). Existential and religious well-being are conceptualized as moderators because they are protective factors that influence the association between neighborhood disorder and parenting stress. Conceptualizing these constructs as moderators is in keeping with a small body of research on spirituality and religious/spiritual coping as moderators between life stress and psychological adjustment (Lee, 2007; Young, Cashwell, & Shcherbakova, 2000). The purpose of this study, which is guided by a culturally-informed risk-protective factor framework, is to ascertain if existential and religious well-being moderate the association between neighborhood disorder and parenting stress in mothers of 8-12 year old African American children. This is a developmental period when neighborhood disorder may evoke parenting stress; children increasingly spend time outside the home in school activities and

with peers (Hofferth & Sandberg, 2001). Compared to earlier points in development, these children are more likely to be exposed to neighborhood dangers to and from school and when socializing with peers (Finkelhor, Ormrod, & Turner, 2009). Many low-income parents experience more parenting stress during this developmental period, as they are less likely than their higher income counterparts to be able to provide sufficient monitoring and supervision due to work hours that do not correspond well with children's school day.

We hypothesized that: 1) neighborhood disorder would be positively associated with parenting stress; 2) existential and religious well-being would be negatively associated with parenting stress; and 3) both existential and religious well-being would moderate the relation between neighborhood disorder and parenting stress such that high levels of existential and religious well-being would protect against the negative effect of neighborhood disorder on parenting stress. This work has the potential to advance our understanding of parenting stress in a culturally-relevant risk-protective factor framework. If existential and religious well-being moderate the neighborhood disorder-parenting stress link, they can serve as useful protective factor intervention targets with low-income African American mothers of school aged children.

Method

Participants

This study was part of a larger investigation of female mother-child dyads recruited for the project(Gabalda, Broth, Thompson, & Kaslow, 2009; Gabalda, Thompson, & Kaslow, 2010; Kaslow & Thompson, 2008; Mitchell et al., 2006; Owen, Thompson, & Kaslow, 2006; Owen et al., 2008; Owen, Thompson, Shaffer, Jackson, & Kaslow, 2009). Trained and supervised weekly by the principal investigator, team members (undergraduates, graduate students, and postdoctoral fellows) (n = 32, 25 of whom were female and 17 of whom self-identified as African American) recruited participants from: (1) medical and emergency care clinics in the general hospital and associated children's hospital and (2) local women's shelters. Families recruited from the hospital were approached about participation after the identified patient was medically stable. Those recruited from shelters were given the option to meet with a research team member. Potential participants provided their contact information to the research team member.

Study inclusion criteria consisted of the mother being in a relationship during the past year, having legal guardianship of a child ages 8 to 12 years old living with her currently and for at least half of the time during the past year, and being willing to attend an assessment with her child. Participants were 144 African American women, ages 22– 52 (M = 32.46, SD = 6.86) who were the mothers of at least one 8 to 12 year-old child (M = 10.02, SD = 1.44). This includes all but five of the mothers in the larger investigation; they did not have complete data on the measures of interest. It includes 81% of the individuals who completed the screening protocol; the remainder did not meet inclusion criterion. Women were considered to have reported significant IPV in the prior year if they scored above the cut-point as suggested by developers of the Index of Spouse Abuse (ISA; 10 on the Physical subscale and/or at least 25 on the Nonphysical subscale) (Hudson & McIntosh, 1981); 61 women (42%) met these criteria The women were then categorized into one of the two

groups and the dichotomous variable was inserted into all analyses as a covariate. Ten percent had received treatment for substance abuse, 12% for psychiatric reasons, and 38% had a medical problem. The women were financially stressed; 66% were unemployed, 13% were homeless; 20% were on disability; and 97% had average monthly incomes less than $2000 (3%). Their education in years ranged from 8 to 19 (M = 11.92, SD = 1.91). Twenty-nine percent were single and never married, 19% were married, 16% were separated or divorced, 19% had a partner with whom they were not living, and 17% were living with a partner. To select a target child if there were multiple children in the age range, the oldest child in the age range was invited to participate for odd numbered participants, and the youngest child in the age range was selected for even numbered participants. Participants had on average three children.

Procedure

This investigation was undertaken in the Southeastern United States at a large, comprehensive, university-affiliated, urban public health system that provides healthcare for a low socioeconomic status, predominantly African American population. Prior to data collection, approvals were obtained from the university institutional review board and the hospital's research oversight committee.

Screening—The Project Coordinator contacted women who expressed interest to schedule the mother and her child at a mutually acceptable time for a 3-hour interview. Dyads were excluded during this stage if the women's responses revealed that they self-identified as being of a racial/ethnic group other than African American/Black or were medically unstable, cognitively impaired, or experiencing acute psychotic symptoms. Responses on the Demographic Data Form (DDF) determined race/ethnicity and medical stability. The Mini Mental State Exam (MMSE) (Folstein, Folstein, McHugh, & Fanjiang, 2001) and the Rapid Estimate of Adult Literacy in Medicine (REALM) (Williams et al., 1995) ruled out women with cognitive limitations that would interfere with completing the protocol - MMSE scores < 24 if literate or < 22 if illiterate (MMSE author recommendations) (Folstein et al., 2001). A psychotic symptom screening questionnaire eliminated actively psychotic women.

Assessment—An in-depth protocol was administered in concurrent assessments to mothers and children. For this report, only mother's data were included. Assessments were administered verbally given the low functional literacy levels found in adults served by this health system (Williams et al., 1995). Dyads were compensated $50, transportation costs were covered, the child was provided a toy, and the mother and child received a snack.

Measures

Demographic Data Form (DDF)—Designed for this project, the DDF obtained background information related to age, socioeconomic factors (education, homelessness status, income level, disability status); family environment (relationship status, history of past year IPV, child gender/age); and medical/psychiatric problems and treatment, all of which have been shown to be associated with parenting stress and were used as covariates in all analyses (McConnell, Brietkreuz, & Savage, 2011; Mitchell et al., 2006; Reitman, Currier, & Stickle, 2002; Taylor, Washington, Artinian, & Lichtenberg, 2007).

Parenting Stress Index—Short Form (PSI–SF)—The 36-item PSI-SF (Abidin, 1995) gauges stress in the parent–child system. Mothers rated each item on a 5-point scale ranging from strongly disagree (1) to strongly agree (5). The measure has three subscales related to specific facets of parenting stress. The Parental Distress subscale addressed distress specific to parenting responsibilities and general distress without a specified source (“I often have the feeling that I cannot handle things well,” “Since having this child, I feel that I am almost never able to do things that I like to do”). The Difficult Child subscale assessed the mothers’ perception of their children's emotional and behavioral problems compared with other children and how distressing these behaviors are to the caregiver (“My child gets upset easily over the smallest thing,” “My child's sleeping or eating schedule was much harder to establish than I expected”). The Parent–Child Dysfunctional Interaction subscale focuses on problems relevant to mothers’ relationships with their children (“Most times I feel that my child does not like me and does not want to be close to me”, “My child smiles at me less than expected”), The measure has good internal consistency reliability, stability, and concurrent and convergent validity in other samples of low-income, African American mothers (Hutcheson & Black, 1996). Cronbach alphas ranged from .79 to .83 for the three subscales.

Perceived Neighborhood Disorder Scale (PNDS)—The 15-item PNDS (Ross & Mirowsky, 1999) measured physical and social disorder as one construct. Physical disorder related to the physical appearance of the neighborhood (“There is a lot of graffiti in my neighborhood”, “There are a lot of abandoned buildings in my neighborhood”). Social disorder assessed factors such as fighting, panhandling, and drug and alcohol use. Sample items included “there is a lot of crime in my neighborhood” and “I’m always having trouble with my neighbors.” Each item was rated on a scale of strongly disagree (1), disagree (2), agree (3), and strongly agree (4). This scale had high reliability and external validity in previous studies (Gapen et al., 2011; Ross & Mirowsky, 1999). The Cronbach alpha for the current sample was .96.

The Spiritual Well-Being Scale (SWBS)—The SWBS (Paloutzian & Ellison, 1991) has examined spirituality well-being in various populations. This 20-item Likert scale has two subscales: existential well-being (EWB; 10 items) and religious well-being (RWB; 10 items), with each item having six response options anchored by strongly agree (1) and strongly disagree (6). Higher scores indicated higher well-being. Given that a recent validity study (Gow, Watson, Whiteman, & Deary, 2011) found that both subscales had high internal consistencies, were validly separable, and reflected different constructs, we used the EWB and RWB subscales in all analyses. EWB measured the perception that one's life has meaning and tapped the existential notions of life purpose, life satisfaction, and positive or negative life experiences (“I feel very fulfilled and satisfied with life”, “I believe there is some real purpose for my life”). The RWB subscale, which focused on the affirmation of life in relationship with God, measured the degree to which one perceives and reports the well-being of his or her spiritual life in relation to God (“I believe that God loves me and cares about me”, “I have a personally meaningful relationship with God”). Previous studies have found good validity and internal consistency reliability with the coefficient alpha for

EWB between .78 and .86 and for RWB between .82 and .94 (Gow et al., 2011). In this study, the internal consistency reliability was .84 and .82 for EWB and RWB.

Plan of Analysis

Missing data were handled using listwise deletion for missing covariate cases (5%). Available item analysis was used for item-level missingness (Parent, 2013). The main analysis was guided by stepwise hierarchical regressions predicting parenting stress dependent variables. In step 1, covariates (child age and gender, and parent age, income, education, disability status, employment status, psychiatric hospitalization, medical problems, substance abuse treatment, homelessness, relationship status, and past year IPV) were added. To examine the main effect of predictor variables on each parenting stress dependent variable, step 2 included neighborhood disorder and existential or religious well-being. Step 3 of all models added a neighborhood disorder by spiritual well-being (existential or religious) interaction term to test moderation hypotheses. Interactions that explained additional variance to the model ($p < .05$) were probed for conditional effects, the effect of a predictor variable on a dependent variable at a given level of a second predictor (i.e., moderator) variable, using standard procedures and SPSS macros (Hayes & Matthes, 2009). The conditional effect of neighborhood disorder on a parenting stress dependent variable was probed at 1 standard deviation (SD) above and below the mean, and at the mean, corresponding to high, low, and medium levels, respectively, of existential and religious well-being. Conditional effects were tested for significance ($p < .05$).

Results

Descriptives

Variables were examined for normality prior to the regression analysis. Neighborhood disorder was moderately platykurtic, and religious well-being was moderately platykurtic and negatively skewed; both were within acceptable limits and did not require transformations. Existential well-being and all parenting stress dependent variables were within limits of a normal distribution. Women reported a wide range of neighborhood disorder (Table 1), corresponding to the lowest score possible (1; very low neighborhood disorder) to almost the highest (3.90; very high neighborhood disorder). The average scaled score was slightly higher than means reported in a sample of low-income African American adolescents ($M = 1.79$) (Dulin-Keita, Thind, Affuso, & Baskin, 2013) and in older adult women ($M = 1.36$) (Scheiman & Meersman, 2004) using the same or modified scale. Most women indicated a high degree of religious well-being (Table 1). Reported existential well-being had a wider range and a lower mean scaled score than religious well-being. Participants had levels of each parenting stress variable ranging from very low (lowest possible scaled score) to moderate-to-high.

Bivariate correlations are shown in Table 1 between independent, moderator, and dependent variables of interest. Not shown are correlations between these variables and covariates ($p < .05$). Neighborhood disorder was unrelated to any covariate. Greater existential well-being was related to income, being employed, not being homeless, and not receiving treatment for psychiatric reasons. Only religious well-being was positively related to having a medical

problem. Both spirituality indicators were associated with a decreased likelihood of having had experienced recent IPV. Being unemployed and having a relatively low monthly income was associated with parental distress only. Psychiatric treatment was positively related to parental distress and difficult child, and having received substance abuse treatment was positively associated with parental distress only. Being on disability and having experienced recent IPV were positively associated with all parenting stress indicators. Child age and gender, and parent age, education, and relationship status, were not related to any variables of interest.

Direct Effects on Parenting Stress Dependent Variables

Step 1 of the hierarchical regressions involved entering all the covariates (not tabled). Covariates explained significant variance in all parenting stress dependent variables (*ps* < .01; 19-24% variance). IPV exposure was a predictor of all dependent variables (*ps* < .05). Substance abuse treatment was a predictor of parental distress (*B* = .36, 95% *CI* = [.02, 70]). Disability status (*B* = .46, 95% *CI* = [.18, 75]) and educational attainment (*B* = -.05, 95% *CI* = [-.11, 00]) were positive and negative, respectively, predictors of parent-child dysfunctional interaction.

Table 2 presents step 2 of the hierarchical regressions. These models demonstrated the effects of independent and moderator variables on parenting stress dependent variables above and beyond each other and the covariates. Of these models, neighborhood disorder remained significantly associated with all parenting stress dependent variables; greater neighborhood disorder predicted higher parenting stress. Also in each of these models, the spiritual well-being variables, either existential well-being or religious well-being, were negatively related to parenting stress dependent variables with the exception of difficult child regressed on existential well-being. Variance explained (R^2) in each step 2 model was significant (*ps* < .01), as was ΔR^2 due to the addition of predictor variables (*ps* < .01; between 6 to 15% additional variance explained). Thus, support was found for the hypotheses that neighborhood disorder confers risk for parenting stress, and in general, existential and religious well-being are protective against parenting stress. Several covariates were significant in step 2 (*ps* ≤ .05). In models with either existential or religious well-being, being on disability was associated with higher parent-child dysfunctional interaction, and IPV exposure was associated with higher ratings of difficult child. When controlling for religious but not existential well-being, IPV exposure was linked to greater parental distress; educational attainment was negatively related to parent-child dysfunctional interaction; and income was positively related to difficult child.

Moderation Analysis

For Step 3, the addition of a neighborhood disorder × spiritual (existential or religious) well-being interaction term, are presented in Table 2. In all models, the interaction between neighborhood disorder and existential well-being was significant (*p* < .05), but the interaction between neighborhood disorder and religious well-being was not. Interaction terms explained a significant amount of additional variance in each model (*ps* < .05; ΔR^2 due to interaction = 2 to 4%). Significant interactions were probed for conditional effects to address our moderation hypothesis. Figure 1 presents the conditional effects of

neighborhood disorder predicting parental distress at different levels of existential well-being. Lines represent the predicted values of parental distress based on the unstandardized regression coefficients of neighborhood disorder predicting parenting stress at low (1 SD below the mean), medium (the mean), and high (1 SD above the mean) levels of existential well-being. Representations made with parent-child dysfunctional interaction and difficult child as dependent variables would appear similar.

Probing of the neighborhood disorder × existential well-being interaction term revealed no significant effect of neighborhood disorder on parental distress at low levels of existential well-being ($p > .05$); mothers with low levels of existential well-being had high levels of parental distress regardless of their degree of neighborhood disorder. In contrast, participants with medium or high levels of existential well-being had a positive relation between neighborhood disorder and parental distress such that at low levels of neighborhood disorder parental distress was low, but at higher levels of neighborhood disorder, respondents reported higher levels parental distress. The conditional effects for medium ($B = .15$, 95% $CI = [.02, 28]$) and high ($B = .37$, 95% $CI = [.18, 57]$) levels of existential well-being were significant ($ps < .05$). Similar results were found when probing neighborhood disorder × existential well-being interaction terms on parent-child dysfunction and difficult dependent variables; at medium and high, but not low, levels of existential well-being the effect of neighborhood disorder on each dependent variable was significant and positive ($ps < .05$). This pattern also means that when neighborhood disorder is lower, parenting stress is also lower for participants with high and medium degrees of existential well-being. This is not the case, however, for those with low existential well-being— parenting stress is high regardless of neighborhood disorder.

Discussion

The findings uniquely contribute by highlighting the role of existential well-being, a culturally relevant protective factor, in enhancing our understanding of the association between neighborhood disorder, a culturally pertinent risk factor, and parenting stress. As predicted, neighborhood disorder was related to higher levels of parenting stress and both existential well-being and religious well-being were related to lower levels of parenting stress. Our moderating hypothesis was supported for existential, but not religious, well-being. A focused examination of this finding revealed that low-income African American mothers with low levels of existential well-being endorsed high levels of parenting stress, regardless of their level of neighborhood disorder. However, positive associations were found between neighborhood disorder and parenting stress for mothers with high or medium levels of existential well-being. This moderating effect was not precisely as hypothesized but nevertheless fits with perspective risk and protective factor model because it delineates one way in which parenting difficulties are related to both parent characteristics and neighborhood contextual factors. The findings suggest that disordered neighborhoods are stressful no matter what and, if they reach a high level of disorder, may overwhelm individuals' capacity to overcome parenting stress. Furthermore, individual-level resources interact with a community-level factor like neighborhood in such a way that high existential well-being and low neighborhood disorder creates a condition suitable to protect against parenting stress.

Our finding that neighborhood disorder is associated with parenting stress was consistent with prior research (Christie-Mizell & Erickson, 2007; Franco et al., 2010). These associations make conceptual sense given that parenting is more challenging in riskier, less supportive contexts. Dangerous neighborhoods provide opportunities for children to become involved in delinquency and crime, as perpetrators or victims (Chung & Steinberg, 2006; Ingoldsby et al., 2006), likely contributing to mothers' stress. Neighborhoods with more disorder offer fewer resources for mothers to draw on in terms of instrumental and emotional social support that could mitigate parenting stress (Gutman, McLoyd, & Tokoyawa, 2005).

Our results that existential and religious well-being were negatively associated with parenting stress are also in line with previous research (Cain, 2007; Weyand, O'Lauglin, & Bennett, 2013). Spirituality is a critical resource that can serve a protective function against a range of negative outcomes (Paranjape & Kaslow, 2010; Yonker, Schnabelrauch, & DeHaan, 2012). Especially for the low-income African American women in the study, spirituality represents a non-financial resource with important implications for parenting (Cain, 2007). Given the cross-sectional design, we cannot draw causal conclusions. In particular, more parenting stress could lead to less spiritual well-being, the opposite of the focus of this study. Interestingly, only existential well-being moderated the neighborhood disorder-parenting stress link. Compared to religious well-being, existential well-being captures a broader and more internally focused sense of life satisfaction, purpose, and meaning (Gow et al., 2011; Hill & Pargament, 2008). In line with prior research on health outcomes (Tsuang, Simpson, Koenen, Kremen, & Lyons, 2007; Zhang et al., 2013), existential well-being was found to be more strongly associated with parenting stress than religious well-being in African American women.

The study's contributions should be considered in light of its limitations: inclusion of data from one informant via self-report, attention to existential and religious well-being as separate constructs rather than as a combined latent construct; use of a cross-sectional design; combining of youth across an age spectrum (8-12 years of age); and incorporation of a relatively demographically homogeneous sample that includes primarily high-risk mothers. Future research should include data from multiple informants and use multiple methods including neighborhood mapping techniques (O'Campo, Burke, Peak, McDonnell, & Gielen, 2005); include multiple measures of family and individual outcome variables, as well as culturally relevant risk and protective factors; create a latent construct of spiritual well-being; examine the study question with longitudinal data, which will allow for a focus on both the causal question and developmental considerations given age differences between 8-12 year olds; incorporate a more diverse sample and one that has greater variability with regard to maternal level of risk. Because we found high levels of parenting stress in mothers in the most disordered neighborhoods regardless of their existential well-being, a critical direction for future research will be to look for additional protective factors that might mitigate parenting stress. Potential protective factors might include both interpersonal factors, such as social support, and intrapersonal factors, such as a strong capacity for self-regulation. If additional protective factors can be identified, such factors could be targeted for inclusion in parenting interventions.

The study also has several implications for practice. There is increasing recognition of the need for family interventions to target spiritual well-being (Mahoney, LeRoy, Kusner, Padgett, & Grimes, 2013). Doing so requires the family psychologist to convey respect for spirituality as a resilience factor that supports positive coping, regardless of his/her own religious persuasion and level of spirituality (Constantine, Lewis, Conner, & Sanchez, 2000). They must explore family members' beliefs with regard to spirituality, religious practices, religion, and the value of the "church family" (Boyd-Franklin, 2010). Stress reduction may occur through enhancement of spiritual well-being for several reasons (Rowold, 2011). Supporting connections to spirituality within the therapeutic context can empower individual members and the family as whole. Spiritual reframing is a technique that highlights the strength of the individual and family system, as well as the power of one's belief system (Boyd-Franklin & Lockwood, 2009). Therapeutic interventions with African American families for whom spirituality is central should convey that spirituality is associated with understanding that life has a deeper meaning beyond the trials of daily life, with forgiveness, and with coping resources such as prayer and meditation (Gillum & Griffith, 2010; Gockel, 2009). Without these resources, problems in any neighborhood conditions can seem insurmountable. Even without drawing on formal religious systems, interventions can target spiritual well-being by coaching parents in coping resources and the desirability of seeking deeper meaning in life.

The low-income African American sample is at high risk of parenting problems (Dotterer, Iruka, & Pungello, 2012; Pungello, Iruka, Dotterer, Mills-Koonce, & Reznick, 2009), and thus is an important and underserved population in terms of parenting interventions. By understanding associations of risk factors (neighborhood disorder) and protective factors (existential and religious well-being) with parenting stress in this population, interventions can be tailored to serve the needs of these mothers. Interventions that are culturally relevant and adapted to fit the needs of subgroups of female caregivers, rather than adopting a one-size-fits-all approach, have been shown to be more successful in changing parenting behaviors and child outcomes (Coard, Foy-Watson, Zimmer, & Wallace, 2007). Particularly because African American families are more likely to turn to clergy and other religious resources for help than to family psychologists and other mental health care professionals (Allen, Davey, & Davey, 2010), spiritual well-being represents a vital resource to be drawn in to interventions with these families. Although the link between neighborhood disorder and parenting stress depended on level of existential well-being, neighborhood disorder was related to less parenting stress regardless religious well-being level.

Our findings have implications for informing the development of culturally-sensitive interventions for African American mothers of 8-12 year olds living in stressful neighborhoods. These include encouraging parents to prioritize parent-child communication, support their child's education, be mindful of their children's physical and emotional well-being, and participate in enriching activities with their children (Ceballo, Kennedy, Bregman, & Epstein-Ngo, 2012). It is optimal if these interventions are strength-based in their orientation (Sheely-Moore & Bratton, 2010). These culturally sensitive parent training programs and other parent-focused interventions that target parenting among low income African American women residing in disordered neighborhoods should reduce parenting stress and improve overall quality of life.

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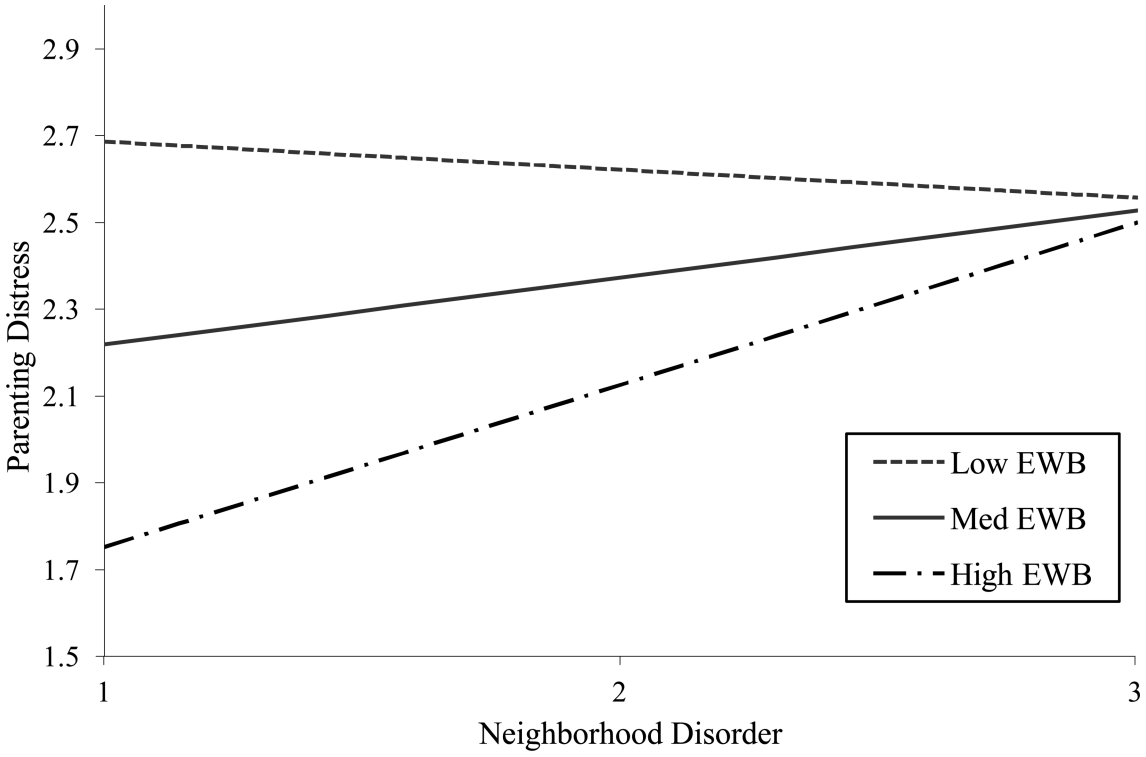

Figure 1.

Association between neighborhood disorder and parental distress by levels of existential well-being (EWB).

Note: Medium (mean) and high (+1 standard deviation [*SD*] above the mean) EWB slopes are significant ($p < .05$). The low (−1 *SD* below the mean) EWB slope is not.

Table 1

Descriptives and Bivariate Correlations Between Main Variables (N = 144)

Variable	1	2	3	4	5	6
1. Neighborhood disorder						
2. Existential well-being	−.24*					
3. Religious well-being	−.16	.68**				
4. Parental distress	27**	−.51**	−.33**			
5. Dysfunctional interaction	.32**	−.29**	−.25**	.56**		
6. Difficult child	.23**	−.29**	−.28**	.56**	.69**	
Range	1.00-3.90	2.20-6.00	3.50-6.00	1.00-4.09	1.00-3.58	1.00-4.42
Mean (*SD*)	2.09 (.72)	4.68 (.82)	5.29 (.69)	2.35 (.65)	1.93 (.59)	2.49 (.72)

Note: SD = standard deviation.

* $p < .05$

** $p < .01$

Table 2

Summary of Hierarchical Regression Analysis (N = 144)

	Parental Distress				Dysfunctional Interaction				Difficult Child			
	B	***SE***	***B***	***SE***	***B***	***SE***	***B***	***SE***	***B***	***SE***	***B***	***SE***
Neighborhood disorder	.15*	.07	−1.10**	.41	23**	.07	−.58	.41	.19*	.08	−1.15*	.51
Existential well-being (EWB)	−.29**	.06	−.84**	.19	−.13*	.06	−.49*	.19	−.14	.08	−.72*	.23
Neighborhood disorder*EWB			.27**	.09			.17*	.09			.29**	.11
Constant	3.54**	.60	6.28**	1.07	1.77**	.59	3.56**	1.07	2.37**	.73	5.36**	1.32
R^2	.39**		.43**		.30**		.32**		.25**		.29**	
ΔR^2 due to interaction			.04**				.02*				.04**	
Neighborhood disorder	.19*	.07	.30	.46	.24**	.07	.40	.43	.19*	.08	.29	.53
Religious well-being (RWB)	−.19*	.08	−.15	.18	−.16*	.07	−.10	.16	−.22*	.09	−.19	.20
Neighborhood disorder*RWB			−.02	.06			−.02	.06			−.01	.07
Constant	3.19**	.68	2.93*	1.22	2.00*	.63	1.64	1.13	2.90**	.78	2.68	1.40
R^2	.32**		.32**		.31**		.31**		.27**		.27**	
ΔR^2 due to interaction			.00				.00				.00	

Note: Coefficients are unstandardized. *SE* = Standard errors. All models include covariates.

*$p < .05$

**$p < .01$