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# The Role of Faith in Health Outcomes for Victims of Physical Intimate Partner Violence

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INTIMATE PARTNER VIOLENCE, FAITH, AND HEALTH

The Role of Faith in Health Outcomes for Victims of Physical Intimate Partner Violence

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## Introduction

Intimate partner violence (IPV), considered psychological aggression, stalking, sexual violence, and physical violence by a current or former partner, is a significant problem in the United States. Data from the 2011 National Intimate Partner and Sexual Violence Survey (NISVS), an ongoing, nationally representative survey of non-institutionalized (i.e., non-incarcerated, non-hospitalized) adults in the United States, indicate that over 12 million adults report IPV victimization each year (Breiding et al., 2014). IPV has been consistently linked to myriad negative outcomes for both males and females, including social isolation, financial insecurity, substance abuse, anxiety disorders, post-traumatic stress disorder, depressive disorders, physical injuries, chronic physical difficulties, homicide, and suicide (e.g., Ellison & Anderson, 2001; Wong & Mellor, 2014). Given IPV's prevalence and association with negative outcomes, it is important to explore factors that can improve the health and wellbeing of IPV victims.

One factor that may play a role in the functioning of IPV victims is faith<sup>1</sup>. Faith has repeatedly been identified as a beneficial factor in psychological and physical health generally (e.g., Balbuena, Baetz, & Bowen, 2013; Bonelli & Koenig, 2013; Brown, Carney, Parrish, & Klem, 2013; Campbell, Yoon, & Johnstone, 2010; Ellison, Fang, Flannelly, & Steckler, 2013; Steffen, 2012), and there is now also preliminary evidence of a beneficial relationship between faith and health amongst IPV victims (e.g., Gillum, Sullivan, & Bybee, 2006; Watlington & Murphy, 2006). However, this evidence has relied mostly on small samples of specific

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<sup>1</sup> The IPV literature, like the broader health literature, contains myriad terms for faith, the most prominent of which are “religiosity” and “spirituality,” which have varying definitions as equivalent, overlapping, and distinct constructs. For the purposes of this study, “faith” will be used to encompass religious and spiritual beliefs and practices. As the literature on faith and IPV expands, it can contribute to the important and ongoing conversation regarding the similarities and distinctions between religiosity and spirituality.

sociodemographic groups, such as Black and low-income females. It is necessary to test this relationship in additional samples that represent the diversity of IPV victims in order to examine how it may differ according to sociodemographic and victimization characteristics. The current study contributes to this necessity by examining the predictive abilities of faithfulness and sociodemographics for health in a large coed sample of physical IPV victims, who are relatively racially, ethnically, and socioeconomically diverse compared to most samples in the literature.

### **Intimate Partner Violence and Faith**

Substantial research has been conducted on the utility of faith as a coping mechanism in response to negative and traumatic events (e.g., McIntosh, Poulin, Silver, & Holman, 2011; Peres, Moreira-Almeida, Nasello, & Koenig, 2007). However, less research has been conducted on the utility of faith for IPV victims particularly. The research that has been conducted suggests that faith is an important factor in understanding the impact of IPV on victims' health. The burgeoning research on IPV, faith, and health can be summarized via the following themes: faith as a source of support, faith and meaning-making, faith and positive psychological and behavioral health, and health-diminishing contributions of faith.

**Faith as a source of support.** The literature indicates that many IPV victims derive various kinds of support from their faith. For example, Gillum et al. (2006) interviewed victims of recent IPV, and found that 97% of participants identified faith or God as a source of strength and comfort against victimization. Similarly, Potter (2007) conducted interviews with participants with IPV histories, and found that the majority of participants endorsed relying on faith to get through and out of abusive relationships. Stenius and Veysey (2005) asked victims of physical or sexual IPV, currently in treatment for psychological or substance use disorders, about

their self-care and supports. Seventy-two percent of participants reported that faith helped them maintain emotional balance and sobriety. Participants also reported that faith provided them with hope, peace, a sense of re-established order and fairness in life, and a belief that they were good people who did not have to feel ashamed of their victimization. De Castella and Simmonds (2013) asked their participants, who had experienced various traumatic events including IPV, about the role of faith in their recovery. Participants reported that faith helped them to feel fortified and protected, to identify and focus on their strengths and virtues, and to view themselves and others more positively and with more forgiveness. Participants also reported that faith increased their willingness to process rather than avoid their traumas, due to maxims in their faith that posit that recovery and redemption follow painful experiences. In summary, there is significant evidence that IPV victims derive emotional, social, and practical support from their faith and faith communities, which bolster their abilities to cope with, heal from, and leave violent relationships (Gillum, 2009; Pyles, 2007).

**Faith and meaning-making.** The literature also indicates that for many IPV victims, faith can help them find a positive meaning and higher purpose in their victimization. Meaning-making has been associated with greater understanding of oneself and the world, restored perceived control, post-traumatic growth, resilience, and recovery (Krok, 2015; Lawford & Ramey, 2015; O'Connor, 2003; Park, 2016). De Castella and Simmonds (2013) found that many of their participants reported viewing their suffering as a process through which they grew closer to Jesus Christ, who also suffered and was victimized, but ultimately revitalized. Additionally, a metasynthesis by Yick (2008) on qualitative research on faith amongst IPV victims found that IPV victims may view their suffering as part of divine plans for their lives, designed to teach them or lead them to an ultimately positive outcome. Yick (2008) also provided evidence that

some IPV victims are able to find meaning in their IPV by sharing their experiences in order to counsel and support other members of their faith communities also in abusive relationships.

Overall, research suggests that faith can provide a path for finding meaning in IPV victimization, which may help victims cope with and manage the psychological and interpersonal consequences of IPV.

**Faith and psychological wellbeing.** In addition to evidence that IPV victims derive support from faith and use it to find meaning in their suffering, the literature also provides evidence that faithful IPV victims experience psychological wellbeing. For example, Gillum et al. (2006) found that amongst their IPV-victimized participants, faith-service attendance predicted reduced depression and improved quality of life. Similarly, Watlington and Murphy (2006), who administered questionnaires regarding IPV, faith, and depressive and PTSD symptoms to victims of physical IPV, found that more faithful participants reported fewer depressive and PTSD symptoms. Moreover, Meadows, Kaslow, Thompson, and Jurkovic (2005), who conducted interviews with victims of past-year IPV, found that more faithful participants were less likely to have attempted suicide. Here again, research suggests that faithfulness can help victims of IPV psychologically.

**Health-diminishing contributions of faith.** The majority of the research on IPV, faith, and health shows a beneficial relationship between faithfulness and health for IPV victims. However, it has also been posited that faithfulness can be harmful for victims if their faith communities and maxims compromise safety and contribute to the perpetration of IPV. For example, faith communities may justify, minimize, ignore, or deny the occurrence of IPV. They may also prohibit reporting and divorcing, and shame or shun victims who choose to divulge or leave an abusive relationship. Faithful messages may include glorification of suffering and

endurance, obligation to rehabilitate perpetrators, and prioritization of forgiveness and reconciliation over personal safety. They may also encourage female subjugation and male mastery, or lead victims to believe that their victimization was somehow warranted and visited upon them as punishment from God (Chavis & Hill, 2009; Florida Coalition Against Domestic Violence, & FaithTrust Institute, n.d.; Fortune & Hertz, 1991; Horton & Williamson, 1988; Pyles, 2007).

It has also been posited that faithfulness can be harmful to individuals if, to address trauma, they utilize negative faithful coping strategies, as opposed to positive faithful coping strategies. Negative and positive faithful coping strategies have been respectively associated with negative and positive health outcomes (Pargament, Koenig, & Perez, 2000). Negative faithful coping strategies include beliefs that a Devil figure is responsible for one's suffering and that a higher power cannot, or will not, help to evade suffering; they have been associated with increased depression and decreased life satisfaction. Positive faithful coping strategies include forgiveness and perceived collaborative healing with a higher power; they have been associated with decreased depression and increased life satisfaction (Bjorck & Thurman, 2007; Pargament et al., 2000).

Overall, there is evidence to suggest that faithfulness can foster victim-blaming, hinder support-seeking for and departure from violent relationships, and worsen health outcomes. While this evidence should certainly not be overlooked, the majority of the research on IPV, faith, and health reveals salutary relationships.

### **Sociodemographic Factors, Faithfulness, and Health Benefits**

As shown above, there is preliminary evidence of a beneficial relationship between IPV victims' faith and health, but again, the research identifying this relationship has predominantly focused narrowly on Black, low-income females. There has yet to be explicit exploration into how this relationship may vary for IPV victims who differ on sociodemographic characteristics, specifically gender, race and ethnicity, and socio-economic status (SES). The broader faith literature shows differences in the endorsement of faithfulness, and in its impact on health outcomes, across these sociodemographic groups. Similarly, risk and prevalence of IPV have been shown to vary by these same groups. Thus, it is essential to consider these sociodemographic characteristics in the relationship between faith and health amongst IPV victims, as they may impact the applicability and value of faith-based interventions on IPV risk and recovery.

**Gender.** Gender differences have been found in the endorsement of faithfulness, with females reporting more faithfulness than males (Greenfield, Vaillant, & Marks, 2009; Steffen, 2012). For example, contrasted with males, females report attending faith services more frequently, and are more likely to report praying and considering faith as important in their lives (Steffen, 2012). Moreover, it has been suggested that faith is particularly important for females' health contrasted with that of males. For example, Greenfield et al. (2009) utilized cross-sectional, national survey data from US adults, and found that increasing faithfulness results in a greater increase in positive affect, purpose in life, and self-acceptance amongst females than amongst males. Additionally, in his review on the relationship between faith and health, Steffen (2012) reported that more faithful females have been found to show less responsiveness to stress than less faithful females, whereas this effect was not found for males.

**Race and ethnicity.** Individuals from racial and ethnic minority groups in the US have been found to endorse more faithfulness than White individuals (Brown, Taylor, & Chatters, 2015; Franzini, Ribble, & Wingfield, 2004; Steffen, 2012). For example, contrasted with White individuals, Black individuals report attending faith services and praying more frequently, having more commitment to their faith, deriving greater meaning from their faith, and feeling closer to God (Steffen, 2012). Evidence also suggests that Latinx/Hispanic individuals are generally more faithful than White individuals (Ellison, Trinitapoli, Anderson, & Johnson, 2007; Franzini et al., 2004; Merrill, Steffen, & Hunter, 2012). Most studies do not show significant differences between the faithfulness of Black and Latinx/Hispanic individuals, though (e.g., Sternthal, Williams, Musick, & Buck, 2012). As with females contrasted with males, it has been suggested that individuals from racial and ethnic minority groups may derive greater benefits from faith than White individuals. For example, Ellison et al. (2007) noted that compared to White individuals, Black individuals report receiving more assistance from their faithful congregations.

**Socio-economic status (SES).** SES differences have also been found in the endorsement of faithfulness, with individuals of relatively lower SES reporting more faithfulness than individuals of relatively higher SES (Steffen, 2012). As with individuals of different gender, race, and ethnicity, it has been suggested that individuals of relatively lower SES may derive greater benefits from faith than individuals of relatively higher SES (Koch, 2008; Steffen, 2012). For example, using data from a national survey of non-institutionalized adults, Koch (2008) found that amongst individuals with annual income levels below the national median, faith predicts more attendance at work. This prediction was not found amongst individuals with annual income levels above the national median (Koch, 2008).

In summary, the research cited above indicates that female, racial and ethnic minority, and poorer individuals are more likely than male, White, and wealthier individuals to endorse faithfulness. The research also indicates that female, racial and ethnic minority, and poorer individuals are more likely than male, White, and wealthier individuals to benefit from faith on health outcomes. However, these patterns have yet to be examined amongst IPV victims.

### **Current Study**

The current study expands the burgeoning literature on the beneficial relationship between faith and health amongst IPV victims by taking into account important sociodemographic variables (associated with varying endorsement of, and health benefits from, faithfulness) and victimization variables. These variables either have yet to be considered at all in the relationship between faith and health amongst IPV victims (victimization), or have yet to be considered as potential moderators (sociodemographic). Amongst individuals reporting IPV victimization, we hypothesize the following:

1. Participants who are female, minority (Black and Latinx/Hispanic), and of relatively lower SES will report more faithfulness than participants who are male, non-minority (non-Latinx/Hispanic White), and of relatively higher SES.
2. Increased faithfulness will be predictive of psychological and physical health across the sample.
3. Demographic factors will moderate the relationship between faith and health. Specifically, the positive relationship between faith and health will be stronger amongst participants who are female, minority, and of relatively lower SES than amongst participants who are male, non-minority, and of relatively higher SES.

4. Exploratory analyses will be conducted to examine whether the relationships between faith, health, and sociodemographics differ according to IPV victimization level. That is, the degree to which faith mitigates the negative impacts of IPV victimization upon health may be a consequence of the severity of the victimization. These analyses are exploratory, because it is possible that faithfulness becomes a more important protective factor as individuals experience worse IPV victimization. However, it is also possible that as IPV victimization worsens, faithfulness becomes a less important protective factor as other factors become more important (e.g., safety, relationship dissolution, other victimization, etc.).

## **Method**

### **Participants**

The current study is part of a larger research project funded by the National Institutes of Health (NIH). The goal of the larger project was to examine the effects of different concealable stigmatized identities (mental illness, substance abuse, childhood abuse, IPV, and sexual assault) on psychological and physical health outcomes, and included individuals with and without the targeted concealable stigmatized identities. Between 2009 and 2011, cross-sectional survey data were collected from a sample of 735 adults. All participants were recruited from three urban community sites in the northeast US: an agency providing psychological and behavioral health services; an agency providing a range of social services to predominantly Black and Latinx/Hispanic communities; and a community college, which serves a diverse student population.

All 735 participants in the larger project were asked about physical IPV victimization. The sample for the current study consists of the 273 participants who reported having been the victims of physical violence by a romantic partner(s) within the past year and who completed all relevant study measures. Participants in the current study ranged in age from 18 to 63, with a mean age of approximately 29. They were primarily English-speaking (93%), male (58%), and members of a racial or ethnic minority group (76%). Forty-one percent of participants earned \$5,000 or less per year. The majority of participants (54%) had experienced severe IPV victimization within the past year. Participants largely identified as Christian (49%) and considered themselves to be slightly or moderately faithful (60%), but only 37% of participants reported attending faith services more than rarely. Concurrent national data from the Pew Forum indicate that approximately 78% of the population identified as Christian, and 54% attended faith services at least Once or Twice a Month, while 45% attended no more than A Few Times a Year or Less (Pew Forum on Religion and Public Life, 2008). Thus, compared to national averages, the current sample was less affiliated with Christianity and attended faith services less frequently. Table 1 provides additional information about the current study's sample.

## **Procedures**

Project recruitment occurred on site by trained research assistants (RAs). Some participants were referred to the research project by site staff or by individuals who had already participated. However, generally the RAs approached prospective participants who were awaiting appointments or classes, and briefly informed them about the research project using a prepared script. Individuals who agreed to participate were then escorted by the RAs to designated quiet rooms where they received mini laptops programmed with the project

questionnaire, and were formally consented. Participants were given the option to complete English or Spanish questionnaires, and at least one bilingual RA was available on site at all times. Upon completion of the questionnaire, participants were given a debriefing form with information about the purpose of the research project, as well as contact information for mental health, substance abuse, and shelter services. Participants were compensated with \$15-\$20, depending upon how much of the questionnaire they completed.

## Measures

**Intimate partner violence.** Physical IPV victimization was assessed with The Physical Assault Scale of the Revised Conflict Tactics Scales (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996). This 12-item scale asks respondents about the frequency with which their partner(s) enacted violence against them. Sample items include “My partner pushed or shoved me” and “My partner choked me.” Each item is scored on an eight-point scale, where 0 = This Has Never Happened, 1 = Once in the Past Year, 2 = Twice in the Past Year, 3 = 3-5 Times in the Past Year, 4 = 6-10 Times in the Past Year, 5 = 11-20 Times in the Past Year, 6 = More than 20 Times in the Past Year, and 7 = Not in the Past Year but It Did Happen Before. Five of the items are categorized as minor IPV (e.g., “My partner threw something at me that could hurt”), and seven items are categorized as severe IPV (e.g., “My partner used a knife or gun on me”). All of the items Straus et al. (1996) designated as constituting minor or severe IPV victimization can be found in Appendix 2. In the current study, the CTS2 was used to determine inclusion in the sample (i.e., any IPV victimization within the past year). It was also used to determine whether victims had faced minor or severe IPV; they were categorized as minor IPV-victimized if they endorsed none of the severe IPV items, and as severe IPV-victimized if they endorsed any

of the severe IPV items. Evidence supports the CTS2's construct and discriminant validity, and Straus et al. (1996) reported a Cronbach's alpha coefficient of .86 for the scale used in the current study.

**Sociodemographic factors.** Participants were asked about a range of sociodemographic characteristics, including age, preferred language, gender, race and ethnicity, and annual household income. Age was assessed with an open-ended question, preferred language was assessed dichotomously (English or Spanish), and gender was assessed dichotomously (male or female). Participants had the option to endorse multiple categories for race. Ethnicity was assessed dichotomously (non-Latinx/Hispanic or Latinx/Hispanic). Yearly income was assessed with a scale ranging from 1 = Less than \$5,000 to 12 = Over \$100,000. The sociodemographic variables of primary interest in the current study were gender, race and ethnicity, and SES. Each of these variables was treated dichotomously, such that 0 = male and 1 = female, 0 = non-minority and 1 = minority, and 0 = yearly income  $\geq$ \$5,000 and 1 = yearly income  $<$ \$5,000.

**Faith.** Faith was assessed with The Religious and Spiritual Beliefs and Practices subscale of the Systems of Belief Inventory (SBI-15R; Holland et al., 1998). This 10-item subscale asks respondents about their convictions and rituals regarding faith and a supreme being. Sample items include "I believe God will not give me a burden I cannot carry" and "I have experienced peace of mind through my prayers and meditation." Each item is scored on a four-point scale, where 0 = Strongly Disagree, 1 = Somewhat Disagree, 2 = Somewhat Agree, and 3 = Strongly Agree. Thus, total SBI-15R subscale scores range from zero to 30, with higher scores indicating greater levels of faith. The SBI-15R has been found to have convergent and divergent validity with both healthy and physically ill individuals, and Holland et al. (1998) reported a Cronbach's

alpha coefficient of .92 for the subscale used in the current study. The Cronbach's alpha in the current study is .96.

**Health.** Health was assessed separately with the following two constructs: psychological distress and physical distress.

*Psychological distress.* Because depression and anxiety are highly correlated constructs, a composite scale of psychological distress was created by standardizing and aggregating all items on a measure of depression and a measure of anxiety.

*Depression.* Depressive symptomatology was assessed with The Center for Epidemiological Studies-Depression Scale (CES-D; Radloff, 1977). This 20-item measure asks respondents about frequency of depressive feelings and behaviors during the previous week. Sample items include "During the past week, I felt that people dislike me" and "During the past week, I had crying spells." Each item is scored on a four-point scale, where 0 = Rarely or None of the Time (Less than 1 Day), 1 = Some or a Little of the Time (1-2 Days), 2 = Occasionally or a Moderate Amount of Time (3-4 Days), and 3 = Most or All of the Time (5-7 Days). Thus, total CES-D scores range from zero to 60, with higher scores indicating increased severity of depressive symptoms. In the current study, mean scores rather than summed scores were reported, due to a programming error that resulted in the first 74 participants only being administered 19 of the 20 items. The CES-D is well validated with adult samples, and Radloff (1977) reported Cronbach's alpha coefficients ranging from .85 to .95 across studies.

*Anxiety.* Anxious symptomatology was assessed with The Spielberger Trait Anxiety Scale (STAI-T; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983). This 20-item measure asks respondents about general frequency of anxious feelings. Sample items include "I feel nervous and restless" and "I feel tension or turmoil in my life." Each item is scored on a four-

point scale, where 1 = Almost Never, 2 = Occasionally, 3 = Often, and 4 = All the Time. Thus, total STAI-T scores range from 20 to 80, with higher scores indicating increased severity of trait anxiety. The STAI is well validated with adult samples, and each STAI scale is high in internal validity. Its Cronbach's alpha coefficients have been found to range from .65 to .86.

***Physical distress.*** The tendency to report physical symptoms was assessed with The Pennebaker Inventory of Limbic Languidness (PILL; Pennebaker, 1982). The PILL presents respondents with 54 items and asks them to report on the frequency of each. Sample items include "Bleeding nose" and "Numbness or tingling in any part of body." Each item is scored on a five-point scale, where 0 = Have Never or Almost Never Experienced the Symptom, 1 = Less Than 3 to 4 Times Per Year, 2 = Every Month or So, 3 = Every Week or So, and 4 = More Than Once Every Week. The PILL can be scored by summing a participant's scores on each item, termed the summed method. Total summed scores range from zero to 216, with higher scores indicating greater symptom reporting. Specifically, scores between zero and 21 are considered Below Normal Range, between 22 and 66 Well Within Normal Range, between 67 and 84 Slightly Above Average – Within Normal Range, and at or above 85 the Top 25%. Pennebaker (1982) reported a Cronbach's alpha coefficient of .91 for the summed method. The Cronbach's alpha in the current study is .97.

### **Data Analytic Procedure**

Prior to running primary analyses, tolerance, variance inflation factor levels, and the distribution of variables were assessed in order to ensure that cases with high leverage, distance, or variability from the mean would not skew the data. Additional descriptive statistics were calculated. Bivariate correlations were computed to determine associations amongst covariate,

predictor, and outcome variables. Hierarchical regression analyses were conducted to determine the predictive capacity of covariate and predictor variables for faith, psychological distress, and physical distress. To test whether the relationship between faith and health is moderated by sociodemographic characteristics and by IPV victimization characteristics, interaction terms of the sociodemographic variables, faith, and IPV victimization level were added to the hierarchical regressions (Baron & Kenny, 1986).

## Results

### Faith and Health of Participants

Descriptive statistics for all study variables are shown in Table 1. On the faith measure (SBI-15R), participants scored on average 20.22 ( $SD = 8.98$ , *Possible Range* = 0 – 30), indicating that they endorse faithful beliefs and practices relatively highly. In terms of health outcome variables, the mean score of participants on psychological distress was .11 ( $SD = .53$ , *Range* = -0.95 – 1.48), indicating a relatively low level of distress. The mean score of participants on the physical distress measure (PILL) was 58.79 ( $SD = 40.23$ , *Possible Range* = 0 – 216), which is considered Well Within the Normal Range (Pennebaker, 1982).

### Associations Between Sociodemographics, Victimization Characteristics, Faith, and Health

All correlational statistics are shown in Table 2. The older a participant was, the more likely to speak Spanish ( $r = .220$ ,  $p = .000$ ), to identify as minority ( $r = .309$ ,  $p = .000$ ), to be of relatively lower SES ( $r = .309$ ,  $p = .000$ ), to endorse faithful beliefs and practices ( $r = .268$ ,  $p = .000$ ), and to report psychological distress ( $r = .255$ ,  $p = .000$ ). Spanish-speaking participants were more likely than English-speaking participants to identify as minority ( $r = .159$ ,  $p = .009$ ),

to be of relatively lower SES ( $r = .168, p = .005$ ), and to report psychological distress ( $r = .150, p = .013$ ). Females were more likely than males to report physical distress ( $r = .146, p = .015$ ). Minority participants were more likely than non-minority participants to be of relatively lower SES ( $r = .189, p = .002$ ) and to report faithful beliefs and practices ( $r = .396, p = .000$ ). Participants of relatively lower SES were more likely than their wealthier counterparts to report psychological distress ( $r = .227, p = .000$ ) and physical distress ( $r = .171, p = .005$ ). Participants who reported severe IPV victimization were more likely than those who reported only minor IPV victimization to report psychological distress ( $r = .163, p = .007$ ) and physical distress ( $r = .218, p = .000$ ). Participants who reported more psychological distress also reported more physical distress ( $r = .430, p = .000$ ).

Minority participants reported significantly more faithfulness than non-minority participants, but females and participants of relatively lower SES did not report significantly more faithfulness than males and participants of relatively higher SES (Hypothesis 1 partially supported). Increased faithfulness was not significantly correlated with psychological or physical health (Hypothesis 2 not supported).

### **Faith Predicted by Sociodemographics**

A hierarchical regression was run to assess the prediction of faith by gender, race and ethnicity, and SES (Table 3). Age and language were entered as covariates in Step 1, then gender, race and ethnicity, and SES as primary predictors in Step 2. In Step 2 of the model, age ( $\beta = .186, p = .003$ ) and race and ethnicity ( $\beta = .357, p = .000$ ) significantly predicted faith. Being a minority significantly predicted greater faithfulness, but being female and of relatively lower SES did not (Hypothesis 1 partially supported).

### **Psychological and Physical Distress Predicted by Faith**

Two hierarchical regressions were run to assess the prediction of psychological distress (Table 4) and physical distress (Table 5) by faithfulness. In both regressions, the covariates were entered in Step 1, then faith as a primary predictor in Step 2. In Step 2 of the model predicting psychological distress, only age ( $\beta = .262, p = .000$ ) significantly predicted the health outcome. Faith did not significantly predict either psychological distress or physical distress (Hypothesis 2 not supported).

### **Psychological and Physical Distress Predicted by the Interactions of Sociodemographics and Faith**

Two hierarchical regressions were run to assess the prediction of psychological distress (Table 6) and physical distress (Table 7) by the interactions of gender, race and ethnicity, and SES with faith. In both regressions, the covariates were entered in Step 1, then the sociodemographic variables and faith as primary predictors in Step 2, and the interaction terms in Step 3.

In the respective Step 3s of the model predicting psychological distress, age consistently significantly predicted the health outcome ( $\beta = .277, p = .000; \beta = .258, p = .000; \beta = .214, p = .001$ ). Gender ( $\beta = .133, p = .023$ ) and SES ( $\beta = .153, p = .013$ ) also had significant main effects upon psychological distress, but race and ethnicity did not. There were no significant moderating effects of the interactions of the sociodemographic variables and faithfulness upon psychological distress.

In the respective Step 3s of the model predicting physical distress, age significantly predicted the health outcome when assessed with gender ( $\beta = .136, p = .035$ ) and race and ethnicity ( $\beta = .135, p = .041$ ). As with psychological distress, gender ( $\beta = .161, p = .008$ ) and SES ( $\beta = .154, p = .016$ ) also had significant main effects upon physical distress, but race and ethnicity did not, and there were no significant moderating effects of the interactions of the sociodemographic variables and faithfulness upon physical distress. Gender, race and ethnicity, and SES did not significantly influence the relationships between faith and the health outcomes (Hypothesis 3 not supported).

### **Psychological and Physical Distress Predicted by the Interactions of Sociodemographics, Faith, and IPV Victimization Level**

Two hierarchical regressions were run to assess the prediction of psychological distress (Table 8) and physical distress (Table 9) by the interactions of gender, race and ethnicity, and SES with faith and IPV victimization level. In both regressions, the covariates were entered in Step 1, then the sociodemographic variables, faith, and IPV victimization level as primary predictors in Step 2, the two-way interaction terms in Step 3, and the three-way interaction term in Step 4.

In the respective Step 4s of the model predicting psychological distress, age consistently significantly predicted the health outcome ( $\beta = .274, p = .000; \beta = .266, p = .000; \beta = .210, p = .001$ ). Gender ( $\beta = .145, p = .013$ ) and SES ( $\beta = .155, p = .011$ ) had significant main effects upon psychological distress, but race and ethnicity did not. IPV victimization level also consistently had significant main effects upon psychological distress ( $\beta = .177, p = .002; \beta = .132, p = .037; \beta = .163, p = .005$ ). There were no significant moderating effects upon psychological distress.

In the model predicting physical distress, age only significantly predicted the health outcome when assessed with race and ethnicity ( $\beta = .143, p = .027$ ). As with psychological distress, gender ( $\beta = .176, p = .003$ ), SES ( $\beta = .159, p = .011$ ), and consistently IPV victimization level ( $\beta = .230, p = .000; \beta = .214, p = .001; \beta = .223, p = .000$ ) had significant main effects upon physical distress. There was a significant moderating effect of gender, faith, and IPV victimization level upon physical distress ( $\beta = -.119, p = .045$ ; see Figure 1).

Neither the relationships between faith, psychological distress, and sociodemographics, nor the relationships between faith, physical distress, and race and ethnicity and SES, differed by victimization level. However, the relationship between faith, physical distress, and gender significantly differed by victimization level. Specifically, at minor levels of IPV victimization, the physical distress of females increased as they reported more faithfulness, while the physical distress of males decreased as they reported more faithfulness. Conversely, at severe levels of IPV victimization, the physical distress of females decreased as they reported more faithfulness, while the physical distress of males increased as they reported more faithfulness (Hypothesis 4 partially supported). Using the PROCESS program, a more detailed analysis of the interaction effect was examined. At the highest levels of faithfulness (90<sup>th</sup> percentile), the effect of IPV victimization on physical distress was not significant for females ( $t = .31, p = .76$ ). However, at low levels of faithfulness (10<sup>th</sup> and 25<sup>th</sup> percentiles), the effect of IPV victimization on physical distress was significant for females ( $t = 2.20, p = .03; t = 2.33, p = .02$ ). For males, as levels of faithfulness reach the 25<sup>th</sup> percentile, the effect of IPV victimization on physical distress becomes and remains significant ( $t = 2.30, p = .02$ ).

## Discussion

The goal of this study was to add to the understanding of the relationship between faith and health amongst IPV victims by examining the role of sociodemographic and victimization variables. This line of inquiry can provide insight into the generalizability of the existing literature on the role of faith in this population. Overall, hypotheses from this study were partially supported, with specific findings that were both consistent and inconsistent with previous studies.

The first research question examined how sociodemographic factors relate to faithfulness. Consistent with the literature (Brown et al., 2015; Ellison et al., 2007; Franzini et al., 2004; Merrill et al., 2012; Steffen, 2012; Sternthal et al., 2012), minority participants reported significantly more faithfulness than non-minority participants. Inconsistent with the literature (Greenfield et al., 2009; Koch, 2008; Steffen, 2012), female and relatively lower SES participants did not report significantly more faithfulness than male and relatively higher SES participants. Gender and SES may not have significantly predicted faithfulness in the current study due to an age effect. Participants were relatively young, approximately 29 years old on average. Research suggests that younger generations have become less faithful (Brown et al., 2015), so in the current study, age may be trumping sociodemographic variables traditionally associated with faithfulness, namely gender and SES. Indeed, in the current study, increased age consistently significantly predicted increased faithfulness (Table 3).

The second research question examined how faithfulness relates to psychological and physical health. Increased faithfulness was not significantly predictive of psychological and physical health in the current sample, as hypothesized based on the literature (de Castella & Simmonds, 2013; Gillum, 2009; Gillum et al., 2006; Meadows et al., 2005; Potter, 2007; Pyles, 2007; Stenius & Veysey, 2005; Watlington & Murphy, 2006; Yick, 2008). This finding may be

explained by the current sample's health status. Participants reported relatively low levels of psychological and physical distress, which despite experiencing IPV victimization, is not unreasonable for a sample that was not exclusively clinical. It is possible that in a more distressed sample, or in a sample with more variability on health functioning, faithfulness would have more significant stress-buffering effects. Another possible explanation for this finding is that faithful coping strategies may have both positive and negative effects on health. As mentioned earlier, positive (e.g., forgiveness) and negative (e.g., punishing God appraisal) faithful coping strategies have been associated respectively with improved and worsened health outcomes after stress (Bjorck & Thurman, 2007; Pargament et al., 2000). Although only positive faithful coping strategies were assessed in the current study, given that positive and negative faithful coping strategies are not zero-sum, it is possible that participants would also have endorsed negative faithful coping strategies, if asked. The presence of both positive and negative relationships with faith may have canceled each other out in this study, resulting in a null relationship between faith and health in this sample. A third possible explanation for this finding is that the experience of IPV nullifies the relationship between faithfulness and health. That is, the health benefits of faithfulness may be more salient in other contexts (e.g., general life stress) than in an IPV context. It is not possible to know from the current study, which did not include a sociodemographically comparable comparison sample without a history of IPV victimization.

In addition to looking at bivariate relationships between sociodemographic factors, faithfulness, and health, a third goal of this study was to examine if sociodemographic factors moderate the relationship between faithfulness and health. In previous studies, these sociodemographic factors were found to distinguish participants on faithfulness and health, but were not assessed as moderators (Brown et al., 2015; Ellison et al., 2007; Franzini et al., 2004;

Greenfield et al., 2009; Koch, 2008; Merrill et al., 2012; Steffen, 2012; Sternthal et al., 2012). In the current study, gender, race and ethnicity, and SES did not significantly moderate the relationship between faithfulness and health. The absence of these significant moderating effects may be due to the lack of significant bivariate relationships between faithfulness and health outcomes across the sample.

The final goal of this study was to explore whether relationships between sociodemographic factors, faithfulness, and health vary based on IPV victimization severity. It was hypothesized that the potential protective role of faithfulness might vary depending on IPV victimization levels. Results were consistent with this possibility: the relationship between faithfulness and physical health varied by gender and victimization severity, with increased faithfulness playing a protective role for minor-victimized males and severe-victimized females, and a non-protective role for minor-victimized females and severe-victimized males. Specifically, for females at minor levels of IPV victimization, more faithfulness was associated with more physical distress. However, when faithfulness was at its highest, physical distress was comparable at minor and severe IPV victimization. For males, faithfulness was most impactful once it reached the 25<sup>th</sup> percentile. At that level, greater faithfulness was associated with decreased physical distress for minor IPV victimization but increased physical distress for severe IPV victimization.

The significant moderating effect upon physical distress of gender, faith, and IPV victimization level is a valuable and novel finding of the current study. Discrepancies between participants' experiences of IPV victimization and faithful dictates about gender roles may help to explain it. Messages females receive from their faith may include that they are responsible for provoking IPV victimization, and that they should tolerate the violence. Messages males receive

from their faith may include that they should be in control of their partners, and that it is atypical for them to experience IPV victimization, particularly at severe levels (Levitt & Ware, 2006a; Levitt & Ware, 2006b). Therefore, victimization and one's own negative responses to it may contradict faith-based expectations, thereby increasing one's distress (Marcussen, 2006; Reidy, Brookmeyer, Gentile, Berke, & Zeichner, 2016; Reidy, Smith-Darden, Cortina, Kernsmith, & Kernsmith, 2015). More faithful individuals would likely feel these discrepancies more strongly than their less faithful peers. Additionally, individuals experiencing minor levels of IPV victimization may be exposed to these faithful dictates more than those experiencing severe levels of IPV victimization, since victim-blaming may be more likely at minor levels. Thus, victims of minor IPV may be more vulnerable to discrepancy-based distress.

Another interesting point about the moderating effect upon physical distress of gender, faith, and IPV victimization level is that the same effect was not found upon psychological distress. The discrepancy-based distress theory hypothesized above makes it logical to expect effects upon psychological distress, but none were found in the current study. However, it is possible that the PILL (Pennebaker, 1982), whose items can be considered physical manifestations of psychological distress, is serving as a proxy for psychological distress. Participants' endorsement of physical symptoms on the PILL may have been a less threatening and stigmatizing way to express psychological distress than endorsement of the explicit depressive and anxious symptoms on the CES-D (Radloff, 1977) and STAI-T (Spielberger et al., 1983), especially for male and minority participants.

### **Clinical Implications**

This study did not find that faithfulness predicted psychological and physical health amongst IPV victims, as hypothesized. Nonetheless, it is still important for mental health

professionals working with victims of IPV to take faith into consideration, given its reported salience for many individuals in this population, especially those of minority status. Faith can both positively and negatively influence how victims see themselves, understand their victimization experiences, make decisions regarding their wellbeing, and generally cope with and heal from their victimization. Thus, professionals should be open to exploring how faith fits into a victim's experience, and to honoring it as a component of comprehensive treatment. They should also take victims' gender and victimization level into account when considering introducing faith into treatment, given the disparate associations found in this study between these variables and health.

Many IPV victims, especially females of color, seek support from their faithful beliefs and communities before or instead of from mental health, social service, or medical care providers (Pyles, 2007). This trend is unlikely to change soon if ever, but more integration and collaboration between mental health professionals and faith leaders is possible and could benefit IPV victims. Specifically, care providers should become familiar with faith-based resources in their communities that are safe, non-judgmental, and empowering. Faith leaders should seek out training on IPV such that they are best prepared to support victims in their congregations (Florida Coalition Against Domestic Violence, & FaithTrust Institute, n.d.; Fortune & Hertz, 1991).

### **Strengths**

This study has several strengths. Other studies that have assessed the role of faith in health amongst IPV victims have primarily utilized small sample sizes; female participants; participants with minimal variation on race, ethnicity, and SES, or no mention of these important sociodemographic factors; qualitative data; and general assessments of psychological health. The

current study used quantitative data to examine the relationships between faith and specific indicators of psychological and physical health amongst a large, diverse sample of male and female physical IPV victims. This study's inclusion of Latinx/Hispanic individuals is of particular note, since this population is often omitted from the IPV and faith literature, despite relatively high reporting of faithfulness and of IPV. Additionally, this is the first study to assess the potential moderating effects of important sociodemographic and victimization factors upon faith and health. Finally, the majority of research on the health impact of faith utilizes only a few items to assess faithfulness, typically overall self-rated faithfulness and service attendance. This study used a multi-item measure of beliefs and rituals, with good established reliability and validity, to assess faithfulness.

### **Limitations**

This study does have some limitations that must be noted when discussing its findings. Firstly, it is cross-sectional, which precluded implications about directionality and causation between variables. Additionally, comprehensive questions about participants' IPV victimization experiences were not asked. Including clarifying questions, such as "Are you currently experiencing this violence?" and "With how many partners have you experienced this violence?" would have strengthened this study. Because such questions were not included, although the participants in the current study all experienced IPV victimization within the past year, their victimization experiences could still have been variable enough to muddy the results. For example, individuals who are currently being victimized versus individuals who were victimized almost one year previously may have different levels of faithfulness and distress. Also, only physical IPV victimization was assessed in this study. Not including perpetration questions and

assessments of other IPV subtypes (i.e., emotional, verbal, sexual, financial) again may have muddied the results by grouping together participants who should actually have been considered distinct subsamples.

### **Future Research**

In the current study, faith did not predict psychological and physical health, as hypothesized, indicating that faith does not have a healthful impact for all IPV victims. However, additional work is necessary to further elucidate this finding, especially since the study of faith, health, and IPV is still nascent. Specifically, future research should examine the role of other factors that may impact the relationships between faith and health amongst IPV victims, such as imminent risk and relationship status. Future research would ideally utilize longitudinal and prospective designs to establish directionality and causation between faith, health, and IPV variables. Future research should strive to recruit a true clinical sample of participants, perhaps from IPV shelters. The current study's sample was not exclusively clinical; relationships between faithfulness and distress may be more potent in a purely clinical sample. Future research should include assessments of both positive and negative faithful coping, in order to see how they may differentially affect the health of IPV victims. It should also include assessments of different subtypes of IPV beyond just physical, and more detailed questions about victimization experiences, in order to ensure sufficient similarities amongst participants and to reveal patterns that may have been masked by a heterogeneous sample in this study. IPV perpetration should also be considered, since mutual violence is common (Marcus, 2012; Weston, Temple, & Marshall, 2005), and since relationships between faith and health outcomes may logically differ when an individual is both perpetrating and being victimized. Finally, while this study was more

sociodemographically representative than most of the existing literature on faith, health, and IPV, future work should represent more genders, faiths, races, and ethnicities, and assess any differing relationships between faithfulness and health amongst them.

APPENDIX 1: TABLES

Table 1: Descriptive Statistics for Participant Characteristics

Variable	Mean(SD)	Values – Quantity(%)	Cronbach's $\alpha$	Range	
				Minimum	Maximum
Sexual Orientation <ul style="list-style-type: none"> <li>• Heterosexual</li> <li>• Bisexual</li> <li>• Homosexual</li> </ul>	--	237(87) 21(8) 15(6)	--	--	--
Age	29.42(11.64)	--	--	18	63
Language <ul style="list-style-type: none"> <li>• English</li> <li>• Spanish</li> </ul>	1.07(.26)	253(93) 20(7)	--	1	2
Gender <ul style="list-style-type: none"> <li>• Male</li> <li>• Female</li> </ul>	.42(.49)	159(58) 114(42)	--	0	1
Race and Ethnicity <ul style="list-style-type: none"> <li>• Non-Minority</li> <li>• Minority</li> </ul>	.76(.43)	66(24) 207(76)	--	0	1
Socio-economic Status <ul style="list-style-type: none"> <li>• Yearly Income of <math>\geq</math>\$5,000</li> <li>• Yearly Income of <math>&lt;</math>\$5,000</li> </ul>	.41(.49)	162(59) 111(41)	--	0	1
IPV Victimization Level <ul style="list-style-type: none"> <li>• Minor</li> <li>• Severe</li> </ul>	1.54(.50)	126(46) 147(54)	--	1	2
Faith Affiliation <ul style="list-style-type: none"> <li>• Catholic</li> <li>• Hindu</li> <li>• Jewish</li> <li>• Muslim</li> <li>• Protestant</li> <li>• Other</li> <li>• Unaffiliated</li> </ul>	--	85(31) 3(1) 2(1) 10(4) 49(18) 64(23) 60(22)	--	--	--

Variable	Mean(SD)	Values – Quantity(%)	Cronbach’s <i>α</i>	Range	
				Minimum	Maximum
Self-Reported Faithfulness <ul style="list-style-type: none"> <li>• Not Faithful</li> <li>• Slightly Faithful</li> <li>• Moderately Faithful</li> <li>• Very Faithful</li> </ul>	1.45(1.03)	62(23) 74(27) 89(33) 48(18)	--	0	3
Service Attendance <ul style="list-style-type: none"> <li>• Never</li> <li>• Rarely</li> <li>• Regularly</li> <li>• Frequently</li> </ul>	1.17(.99)	85(31) 86(32) 73(27) 29(11)	--	0	3
Faith *	20.22(8.98)	--	.96	0	30
Psychological Distress *	.11(.53)	--	--	-0.95	1.48
Physical Distress *	58.79(40.23)	--	.97	0	216

\* Higher scores indicate greater endorsement

Table 2: Bivariate Pearson Correlations of Primary Study Variables

	Language	Gender	Race and Ethnicity	Socio-economic Status	Faith	IPV Victimization Level	Psychological Distress	Physical Distress
Age	.220***	-.094	.309***	.309***	.268***	.006	.255***	.103
Language		.018	.159**	.168**	.082	.007	.150*	.036
Gender			-.077	-.020	.034	-.050	.104	.146*
Race and Ethnicity				.189**	.396***	.112	.069	-.062
Socio-economic Status					.060	-.012	.227***	.171**
Faith						.033	-.028	-.027
IPV Victimization Level							.163**	.218***
Psychological Distress								.430***

\* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$

Language: 1 = English, 2 = Spanish

Gender: 0 = male, 1 = female

Race: 0 = non-minority, 1 = minority

SES: 0 = yearly income of  $\geq \$5,000+$ , 1 = yearly income of  $< \$5,000$

IPV Victimization Level: 1 = minor, 2 = severe

Table 3: Predicting Faith by Sociodemographics

<b>Predictor</b>	<b>Step 1</b>	<b>Step 2</b>
	<i><math>\beta</math></i>	<i><math>\beta</math></i>
Age	.263***	.186**
Language	.025	-.006
Gender		.078
Race and Ethnicity		.357***
Socio-economic Status		-.062
<b>Change in R<sup>2</sup></b>	<b>.073***</b>	<b>.117***</b>
<b>Adjusted R<sup>2</sup></b>	<b>.066***</b>	<b>.175***</b>

\* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$

Table 4: Predicting Psychological Distress by Faith

<b>Predictor</b>	<b>Step 1</b>	<b>Step 2</b>
	<i><math>\beta</math></i>	<i><math>\beta</math></i>
Age	.234***	.262***
Language	.099	.102
Faith		-.107
<b>Change in R<sup>2</sup></b>	<b>.075***</b>	<b>.011</b>
<b>Adjusted R<sup>2</sup></b>	<b>.068***</b>	<b>.075***</b>

\* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$

Table 5: Predicting Physical Distress by Faith

<b>Predictor</b>	<b>Step 1</b>	<b>Step 2</b>
	<i><math>\beta</math></i>	<i><math>\beta</math></i>
Age	.100	.115
Language	.014	.016
Faith		-.060
<b>Change in R<sup>2</sup></b>	<b>.011</b>	<b>.003</b>
<b>Adjusted R<sup>2</sup></b>	<b>.003</b>	<b>.003</b>

*\*p<.05, \*\*p<.01, \*\*\*p<.001*

Table 6: Predicting Psychological Distress by the Interactions of Sociodemographics and Faith

<b>Predictor</b>	<b>Step 1</b>	<b>Step 2</b>	<b>Step 3</b>
	<i>β</i>	<i>β</i>	<i>β</i>
Age	.234***	.278***	.277***
Language	.099	.096	.096
Gender		.133*	.133*
Faith		-.115	-.112
Gender x Faith			-.035
<b>Change in R<sup>2</sup></b>	<b>.075***</b>	<b>.028*</b>	<b>.001</b>
<b>Adjusted R<sup>2</sup></b>	<b>.068***</b>	<b>.089***</b>	<b>.087***</b>
Age	.234***	.258***	.258***
Language	.099	.100	.099
Race and Ethnicity		.018	.036
Faith		-.113	-.109
Race and Ethnicity x Faith			.043
<b>Change in R<sup>2</sup></b>	<b>.075***</b>	<b>.011</b>	<b>.001</b>
<b>Adjusted R<sup>2</sup></b>	<b>.068***</b>	<b>.072***</b>	<b>.070***</b>
Age	.234***	.217**	.214**
Language	.099	.085	.080
Socio-economic Status		.152*	.153*
Faith		-.103	-.104
Socio-economic Status x Faith			.051
<b>Change in R<sup>2</sup></b>	<b>.075***</b>	<b>.031*</b>	<b>.003</b>
<b>Adjusted R<sup>2</sup></b>	<b>.068***</b>	<b>.092***</b>	<b>.092***</b>

\**p*<.05, \*\**p*<.01, \*\*\**p*<.001

Table 7: Predicting Physical Distress by the Interactions of Sociodemographics and Faith

<b>Predictor</b>	<b>Step 1</b>	<b>Step 2</b>	<b>Step 3</b>
	$\beta$	$\beta$	$\beta$
Age	.100	.135*	.136*
Language	.014	.009	.010
Gender		.161**	.161**
Faith		-.070	-.073
Gender x Faith			.037
<b>Change in R<sup>2</sup></b>	<b>.011</b>	<b>.029*</b>	<b>.001</b>
<b>Adjusted R<sup>2</sup></b>	<b>.003</b>	<b>.025*</b>	<b>.023*</b>
Age	.100	.135*	.135*
Language	.014	.024	.024
Race and Ethnicity		-.096	-.106
Faith		-.027	-.030
Race and Ethnicity x Faith			-.023
<b>Change in R<sup>2</sup></b>	<b>.011</b>	<b>.011</b>	<b>.000</b>
<b>Adjusted R<sup>2</sup></b>	<b>.003</b>	<b>.007</b>	<b>.004</b>
Age	.100	.071	.065
Language	.014	.000	-.009
Socio-economic Status		.153*	.154*
Faith		-.056	-.058
Socio-economic Status x Faith			.078
<b>Change in R<sup>2</sup></b>	<b>.011</b>	<b>.024*</b>	<b>.006</b>
<b>Adjusted R<sup>2</sup></b>	<b>.003</b>	<b>.021*</b>	<b>.023*</b>

\* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$

Table 8: Predicting Psychological Distress by the Interactions of Sociodemographics, Faith, and IPV Victimization Level

Predictor	Step 1	Step 2	Step 3	Step 4
	$\beta$	$\beta$	$\beta$	$\beta$
Age	.234***	.279***	.283***	.274***
Language	.099	.095	.092	.093
Gender		.142*	.142*	.145*
Faith		-.121*	-.120*	-.115
IPV Victimization Level		.172**	.175**	.177**
Gender x Faith			-.050	-.053
Gender x IPV Victimization Level			.042	.041
Faith x IPV Victimization Level			.027	.032
Gender x Faith x IPV Victimization Level				-.072
<b>Change in R<sup>2</sup></b>	<b>.075***</b>	<b>.057**</b>	<b>.005</b>	<b>.005</b>
<b>Adjusted R<sup>2</sup></b>	<b>.068***</b>	<b>.116***</b>	<b>.110***</b>	<b>.112***</b>
Age	.234***	.263***	.264***	.266***
Language	.099	.101	.101	.103
Race and Ethnicity		-.002	.023	.025
Faith		-.112	-.105	-.113
IPV Victimization Level		.164**	.166**	.132*
Race and Ethnicity x Faith			.048	.055
Race and Ethnicity x IPV Victimization Level			.039	.077
Faith x IPV Victimization Level			.016	.026
Race and Ethnicity x Faith x IPV Victimization Level				.102
<b>Change in R<sup>2</sup></b>	<b>.075***</b>	<b>.038*</b>	<b>.004</b>	<b>.007</b>
<b>Adjusted R<sup>2</sup></b>	<b>.068***</b>	<b>.095***</b>	<b>.090***</b>	<b>.094***</b>
Age	.234***	.217**	.212**	.210**
Language	.099	.084	.080	.078
Socio-economic Status		.154*	.156*	.155*
Faith		-.108	-.110	-.107
IPV Victimization Level		.166**	.166**	.163**
Socio-economic Status x Faith			.045	.048
Socio-economic Status x IPV Victimization Level			.069	.068
Faith x IPV Victimization Level			.025	.023
Socio-economic Status x Faith x IPV Victimization Level				.037
<b>Change in R<sup>2</sup></b>	<b>.075***</b>	<b>.059**</b>	<b>.008</b>	<b>.001</b>
<b>Adjusted R<sup>2</sup></b>	<b>.068***</b>	<b>.117***</b>	<b>.115***</b>	<b>.113***</b>

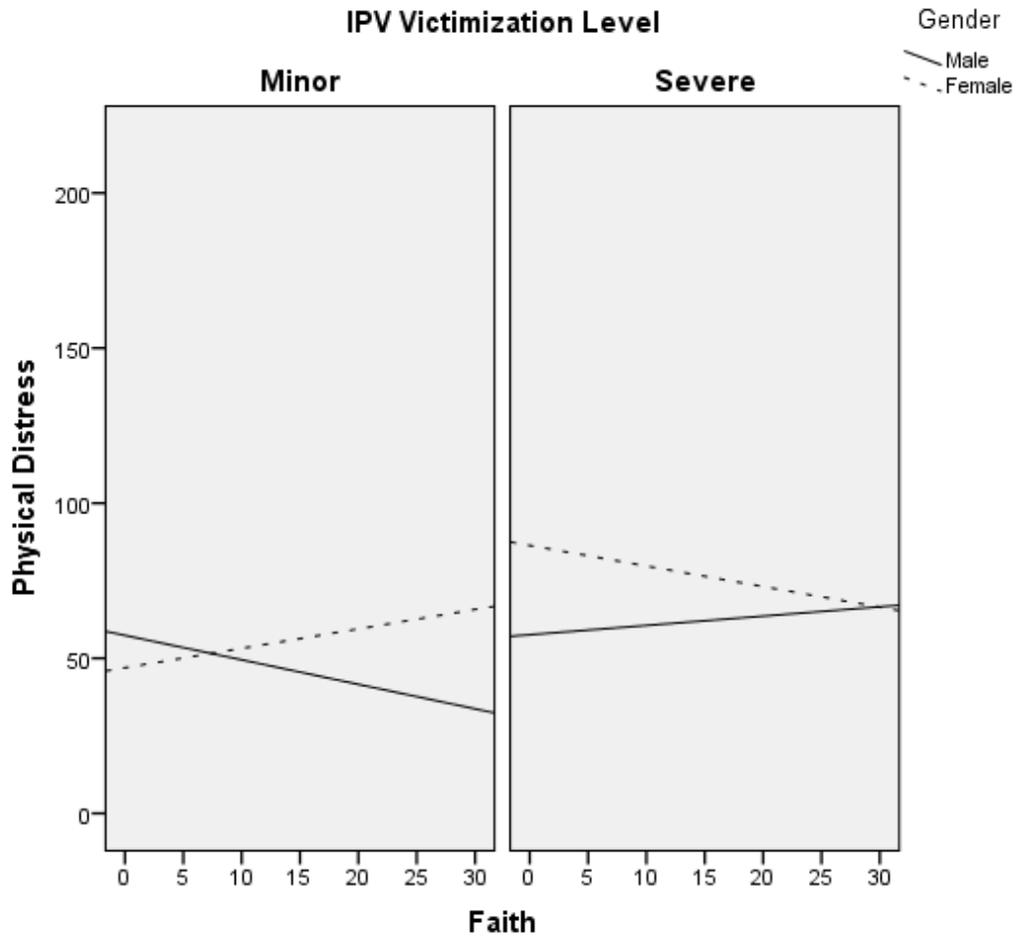
\* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$

Table 9: Predicting Physical Distress by the Interactions of Sociodemographics, Faith, and IPV Victimization Level

Predictor	Step 1	Step 2	Step 3	Step 4
	$\beta$	$\beta$	$\beta$	$\beta$
Age	.100	.137*	.134*	.119
Language	.014	.008	.013	.015
Gender		.173**	.171**	.176**
Faith		-.078	-.076	-.067
IPV Victimization Level		.228***	.227***	.230***
Gender x Faith			.024	.018
Gender x IPV Victimization Level			-.047	-.048
Faith x IPV Victimization Level			.008	.016
Gender x Faith x IPV Victimization Level				-.119*
<b>Change in R<sup>2</sup></b>	<b>.011</b>	<b>.081***</b>	<b>.003</b>	<b>.014*</b>
<b>Adjusted R<sup>2</sup></b>	<b>.003</b>	<b>.075***</b>	<b>.067**</b>	<b>.078***</b>
Age	.100	.141*	.142*	.143*
Language	.014	.026	.025	.026
Race and Ethnicity		-.126	-.122	-.121
Faith		-.025	-.023	-.027
IPV Victimization Level		.232***	.232***	.214**
Race and Ethnicity x Faith			-.014	-.010
Race and Ethnicity x IPV Victimization Level			.089	.109
Faith x IPV Victimization Level			-.023	-.017
Race and Ethnicity x Faith x IPV Victimization Level				.055
<b>Change in R<sup>2</sup></b>	<b>.011</b>	<b>.064***</b>	<b>.007</b>	<b>.002</b>
<b>Adjusted R<sup>2</sup></b>	<b>.003</b>	<b>.057**</b>	<b>.054**</b>	<b>.052**</b>
Age	.100	.071	.065	.069
Language	.014	-.002	-.010	-.007
Socio-economic Status		.156*	.157*	.159*
Faith		-.063	-.065	-.070
IPV Victimization Level		.221***	.220***	.223***
Socio-economic Status x Faith			.071	.066
Socio-economic Status x IPV Victimization Level			.021	.022
Faith x IPV Victimization Level			.013	.016
Socio-economic Status x Faith x IPV Victimization Level				-.065
<b>Change in R<sup>2</sup></b>	<b>.011</b>	<b>.073***</b>	<b>.006</b>	<b>.004</b>
<b>Adjusted R<sup>2</sup></b>	<b>.003</b>	<b>.067***</b>	<b>.062**</b>	<b>.063**</b>

\* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$

Figure 1: Moderating Effect of Gender, Faith, and IPV Victimization Level Upon Physical Distress



APPENDIX 2: MEASURES

## CTS2

**No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired, or for some other reason. Couples also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences. Please select how many times your partner did each of these things in the past year. If your partner did not do one of these things in the past year, but it happened before that, select "7."**

**How often did this happen?**

- 0 = This Has Never Happened
- 1 = Once in the Past Year
- 2 = Twice in the Past Year
- 3 = 3-5 Times in the Past Year
- 4 = 6-10 Times in the Past Year
- 5 = 11-20 Times in the Past Year
- 6 = More Than 20 Times in the Past Year
- 7 = Not in the Past Year But It Did Happen Before

- |   |          |
|---|----------|
| 1. My partner threw something at me that could hurt.            | [MINOR]  |
| 2. My partner twisted my arm or hair.                           | [MINOR]  |
| 3. My partner pushed or shoved me.                              | [MINOR]  |
| 4. My partner grabbed me.                                       | [MINOR]  |
| 5. My partner slapped me.                                       | [MINOR]  |
| 6. My partner used a knife or gun on me.                        | [SEVERE] |
| 7. My partner punched or hit me with something that could hurt. | [SEVERE] |
| 8. My partner choked me.  | [SEVERE] |
| 9. My partner slammed me against a wall.                        | [SEVERE] |
| 10. My partner beat me up.                                      | [SEVERE] |
| 11. My partner burned or scalded me on purpose.                 | [SEVERE] |
| 12. My partner kicked me.                                       | [SEVERE] |

## SBI-15R

**Please respond to each of the following items using the scale given below:**

- 0 = Strongly Disagree
- 1 = Somewhat Disagree
- 2 = Somewhat Agree
- 3 = Strongly Agree

- \* 0 = None of the time
- 1 = A Little Bit of the time
- 2 = A Good Bit of the time
- 3 = All of the Time

1. Religion is important to my day-to-day life.
2. Prayer or meditation has helped me cope during times of serious illness.\*
3. I feel certain that God in some form exists.
4. I believe God will not give me a burden I cannot carry.
5. During times of illness, my religious or spiritual beliefs have been strengthened.
6. I have experienced a sense of hope as a result of my religious or spiritual beliefs.
7. I have experienced peace of mind through my prayers and meditation.
8. One's life and death follows a plan from God.
9. I believe God protects me from harm.
10. I pray for help during bad times.\*

## CES-D

**Below is a list of the ways you might have felt or behaved. Please indicate how often you have felt this way during the past week. Use the scale below and write the corresponding number for how often you felt each way next to the item.**

0 = Rarely or None of the Time (Less than 1 Day)

1 = Some or a Little of the Time (1-2 Days)

2 = Occasionally or a Moderate Amount of Time (3-4 Days)

3 = Most or All of the Time (5-7 Days)

During the past week:

1. \_\_\_\_ I was bothered by things that usually don't bother me.
2. \_\_\_\_ I did not feel like eating; my appetite was poor.
3. \_\_\_\_ I felt that I could not shake off the blues even with help from my family or friends.
4. \_\_\_\_ I felt that I was just as good as other people.
5. \_\_\_\_ I had trouble keeping my mind on what I was doing.
6. \_\_\_\_ I felt depressed.
7. \_\_\_\_ I felt that everything I did was an effort.
8. \_\_\_\_ I felt hopeful about the future.
9. \_\_\_\_ I thought my life had been a failure.
10. \_\_\_\_ I felt fearful.
11. \_\_\_\_ My sleep was restless.
12. \_\_\_\_ I was happy.
13. \_\_\_\_ I talked less than usual.
14. \_\_\_\_ I felt lonely.
15. \_\_\_\_ People were unfriendly.
16. \_\_\_\_ I enjoyed life.
17. \_\_\_\_ I had crying spells.
18. \_\_\_\_ I felt sad.
19. \_\_\_\_ I felt that people dislike me.
20. \_\_\_\_ I could not get "going."

## STAI-T

**Please complete the following mood rating scale according to how you generally feel. For each of the items below, please indicate the frequency of your feelings by selecting the number that best reflects the way you generally feel.**

- |  |              |              |       |              |
|--|--------------|--------------|-------|--------------|
| 1. I feel pleasant.                        | 1            | 2            | 3     | 4            |
|  | Almost Never | Occasionally | Often | All the Time |
| 2. I feel nervous and restless.            | 1            | 2            | 3     | 4            |
|  | Almost Never | Occasionally | Often | All the Time |
| 3. I feel satisfied.                       | 1            | 2            | 3     | 4            |
|  | Almost Never | Occasionally | Often | All the Time |
| 4. I wish I felt as happy as others.       | 1            | 2            | 3     | 4            |
|  | Almost Never | Occasionally | Often | All the Time |
| 5. I feel like a failure.                  | 1            | 2            | 3     | 4            |
|  | Almost Never | Occasionally | Often | All the Time |
| 6. I feel rested.                          | 1            | 2            | 3     | 4            |
|  | Almost Never | Occasionally | Often | All the Time |
| 7. I feel calm, cool, and collected.       | 1            | 2            | 3     | 4            |
|  | Almost Never | Occasionally | Often | All the Time |
| 8. I feel that difficulties are piling up. | 1            | 2            | 3     | 4            |
|  | Almost Never | Occasionally | Often | All the Time |
| 9. I worry too much.                       | 1            | 2            | 3     | 4            |
|  | Almost Never | Occasionally | Often | All the Time |
| 10. I am happy.                            | 1            | 2            | 3     | 4            |
|  | Almost Never | Occasionally | Often | All the Time |

11. I have disturbing thoughts.

1	2	3	4
Almost Never	Occasionally	Often	All the Time

12. I lack self-confidence.

1	2	3	4
Almost Never	Occasionally	Often	All the Time

13. I feel secure.

1	2	3	4
Almost Never	Occasionally	Often	All the Time

14. I make decisions easily.

1	2	3	4
Almost Never	Occasionally	Often	All the Time

15. I feel inadequate.

1	2	3	4
Almost Never	Occasionally	Often	All the Time

16. I am content.

1	2	3	4
Almost Never	Occasionally	Often	All the Time

17. Some unimportant thought runs through my mind and bothers me.

1	2	3	4
Almost Never	Occasionally	Often	All the Time

18. I take disappointments keenly.

1	2	3	4
Almost Never	Occasionally	Often	All the Time

19. I am a steady person.

1	2	3	4
Almost Never	Occasionally	Often	All the Time

20. I feel tension or turmoil in my life.

1	2	3	4
Almost Never	Occasionally	Often	All the Time

## PILL

**Several common symptoms or bodily sensations are listed below. Most people have experienced most of them at one time or another. We are currently interested in finding out how prevalent each symptom is among various groups of people. On the page below, select how frequently you experience each symptom. For all items, use the following scale:**

0 = Have Never or Almost Never Experienced the Symptom

1 = Less than 3 or 4 Times Per Year

2 = Every Month or So

3 = Every Week or So

4 = More Than Once Every Week

1. Eyes water
2. Itching or painful eyes
3. Ringing in ears
4. Temporary deafness or hard of hearing
5. Lump in throat
6. Choking sensations
7. Sneezing spells
8. Running nose
9. Congested nose
10. Bleeding nose
11. Asthma or wheezing
12. Coughing
13. Out of breath
14. Swollen ankles
15. Chest pains
16. Racing heart
17. Cold hands or feet even in hot weather
18. Leg cramps
19. Insomnia
20. Toothaches
21. Upset stomach
22. Indigestion
23. Heartburn
24. Severe pains or cramps in stomach
25. Diarrhea
26. Constipation
27. Hemorrhoids
28. Swollen joints
29. Stiff muscles
30. Back pains
31. Sensitive or tender skin
32. Face flushes
33. Severe itching

34. Skin breaks out in rash
35. Acne or pimples on face
36. Acne or pimples other than face
37. Boils
38. Sweat even in cold weather
39. Strong reactions to insect bites
40. Headaches
41. Sensation of pressure in head
42. Hot flashes
43. Chills
44. Dizziness
45. Feel faint
46. Numbness or tingling in any part of body
47. Twitching of eyelid
48. Twitching other than eyelid
49. Hands tremble or shake
50. Stiff joints
51. Sore muscles
52. Sore throat
53. Sunburn
54. Nausea

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