EFFICACY OF A CHRISTIAN INTERVENTION TO PROMOTE POSTTRAUMATIC GROWTH IN WOMEN RECOVERING FROM INTIMATE PARTNER VIOLENCE

By

Jerra L. Dooley

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

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ABSTRACT

This quantitative pretest-posttest design evaluated a biblically based personal development program (PDP) for promoting PTG in Christian women who have experienced intimate partner violence (IPV). A convenience sample ($N = 7$) of volunteers included women within a large county in the Southeastern United States. Participants were recruited through numerous large and small Southern Baptist churches. Qualifications included being female, at least 19 years old, and having experienced IPV but not within the last 12 months, to reduce the possibility of reinjury by rumination. Participants completed pretest assessments, attended the 3-hour personal development program, and completed a posttest assessment. Data was collected using a research website. The study sought to know if the PDP improved PTG in Christian women who have suffered IPV. A paired samples *t* test revealed a statistically significant increase in four of the five subscales of PTG. The study also aimed to determine if there was a predictive linear relationship between the time since the last occurrence of IPV, the severity of IPV, and the change in the total and subscale scores of the PTG. However, the multivariate regression analysis was inconclusive due to the sample size. Recommendations were made to evaluate other spiritual/religious interventions, study PTG among women of multicultural backgrounds, incorporate mixed methods to include participants' experiences and future intentions for PTG, conduct PDP using web-related venues for live video events or upload prerecorded sessions to be viewed when convenient, and to conduct the PDP over four or more weeks to allow more time for cognitive processing before completing the posttest PTGI.

Keywords: women, intimate partner violence, shattered assumptions theory, posttraumatic growth, biblical, spiritual/religious, posttraumatic growth inventory, intimate partner violence inventory

Dedication

This paper is dedicated to my wonderful husband, Randy Dooley, without whom there would be no certificates, bachelor's, master's, or doctoral degrees. He has been consistent and constant in supplying loving support and timely encouragement to sustain forward progress on the degree completion plans. My daughter, Dacia, has also been a steadfast supporter. She has read countless papers, helped with late-night edits, and offered pep talks as needed. A special mention goes to my delightful grandson, Hunter, who helped me maintain my sanity by providing countless interruptions that involved joy, laughter, and cuddles during the long days and nights of researching and writing and to my 95-year-old mother who has patiently waited for me to finish studying. Now, as I bypass retirement and enter a new phase of life, I plan to become a grand reciprocator of the love that God and others have lavished on me.

Acknowledgments

All glory belongs to my Lord, Savior, and Redeemer, Jesus Christ, for first loving me, then inviting me to be reconciled to him. I am forever grateful for his transforming grace and power to produce purpose from pain, meaning from misery, and beauty from brokenness. He allows me to flourish in him and with others, making me as complete as possible on this side of heaven. To God be all the glory!

While divine health comes from above, earthly encouragement and guidance came from my dissertation chair, Dr. Pamela Moore, who availed her time and knowledge to answer even the most elementary questions. She had a remarkable knack for placing a stop sign on my road to overthinking, and she provided the pathway to progress when I was experiencing dissertation brain fog. I will forever cherish Dr. Moore's smiling face and joyful disposition during our video chats.

Many other people were instrumental to the success of this doctoral journey and deserve to be acknowledged for their faithful support through friendship, prayer, and ministry support, including fellow doctoral candidate Karen Hubbard, worship pastor Brett Fuller, and senior pastor Dr. Daven Watkin, and PDP facilitator Amanda Clarity, who are forever colleagues and friends.

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List of Abbreviations

ACBC – Association of Certified Biblical Counselors

APA - American Psychiatric Association

DSM - *Diagnostic and Statistical Manual of Mental Disorders*

IPV - Intimate partner violence

IPVC - Intimate partner violence checklist

IPVW - IPV against women

IRB - Liberty University Institutional Review Board

LO-IPV - Time since last occurrence of IPV

PDP - Personal development program

PTG - Posttraumatic growth

PTGI - Posttraumatic growth inventory

PTSD - Posttraumatic stress disorder

S-IPV - Severity of IPV

T-IPV - Time since last occurrence of IPV

CHAPTER ONE: INTRODUCTION

Overview

Chapter One of this proposal provides background information surrounding the issues of intimate partner violence (IPV) of women (IPVW), trauma, and the incumbent need for spiritually integrated posttraumatic growth (PTG) intervention for Christian women, including the historical, social, and conceptual/theoretical contexts. In addition, broader insight encompassing the study's problem, purpose, and significance is stated along with the research questions, which provide a compass for the study design. Key definitions and a summary conclude the chapter.

Background

IPV is “one of the most life-threatening and traumatic family and public health problems in all societies” (Simonic, 2020, p.41). The Centers for Disease Control and Prevention (CDC, 2022) reports that IPV is a serious, preventable public health issue that affects more than 61 million women over a lifetime. IPV, also known as partner, spousal, or domestic abuse or violence, includes but is not limited to acts of emotional aggression, physical violence, and/or stalking of an individual or their personal property (CDC, 2022; Danis & Bhandari, 2010; Garcia-Moreno et al., 2013; Jayasundara et al., 2017). In a national survey of intimate partner and sexual violence, lifetime prevalence rates for psychological aggression toward women are 50% (one in two), with 33% experiencing stalking, physical violence, and/or contact sexual violence (Smith et al., 2018). IPV can also range in severity of impact and frequency of occurrence, resulting in significant emotional, physical, and sexual damage and more (CDC, 2022).

IPV is no respecter of persons; victims are comprised of all races, religious beliefs, and socioeconomic backgrounds (Black et al., 2011; WHO, 2021), including Christian women (Simonic, 2021; Westenberg, 2017). The trauma of IPV prompts Christian women to turn to their faith and spiritual leaders for support and healing (Bloom, 2021; Houston-Kolnik & Todd, 2016; Jankowski et al., 2018; Pandya, 2017; Simonic, 2020). Unfortunately, many Christian pastors and leaders are inadequately prepared to respond to IPV against women (DeRose et al., 2021; Fisher-Townsend et al., 2009; McMullin et al., 2015; Zust et al., 2017). Moreover, secular IPV response centers tend to follow "second-wave feminist ideologies" incompatible with a Christian woman's religious beliefs concerning marriage and family (Bloom, 2021, p. 627; Kolb, 2014). This conundrum often creates a "holy hush" among Christian women who feel they must suffer in silence due to the inability to voice their concerns with neither pastoral nor professional counselors (Houston-Kolnik et al., 2019, p. 135).

The trauma of IPV leaves emotional scars that can cause fractured assumptive beliefs (Houston-Kolnik et al., 2019; Lilly et al., 2011; Valdez & Lilly, 2015) and spiritual distress that results in moral injury for Christian women (Harris et al., 2021; Jinkerson, 2016). Likewise, the "state of terror" victims experience from exposure to IPV often results in a "sense of loss of control or agency within one's life" (Fair & Ochberg, 2012, p. 185), a diminished sense of self (Bakaityte et al., 2022; Bryngeirsdottir et al., 2022; D'Amore et al., 2021; Moulding et al., 2021; O'Doherty et al., 2016), and an existential crisis that involves the loss of meaning and purpose in life (Noviyanti et al., 2019). For many women, IPV leads to a lengthy process of endurance and recovery from the trauma of abuse (Dillon et al., 2013). However, studies on PTG reveal that many evangelical Christian women have experienced significant personal growth during,

immediately after, and beyond their experience with IPV by applying an "anthropological understanding of evangelical Christianity" (Bloom, 2021, p. 628).

Historical Context

Women have been the focus of IPV interventions due to the historical data that reveals a higher incidence rate for domestic violence in women versus men, mainly because women experience "more frequent, longer lasting violence, as well as more threats and fear of bodily harm" (Fair & Ochberg, 2012, p. 178). The U.S. Department of Justice reports that women are victims of domestic violence 76% of the time, with those ages 20 to 24 at the most significant risk (Truman & Morgan, 2014). It is estimated that 24% of adolescent girls (15-19 years old), who have ever had intimate partners, have already experienced physical and/or sexual abuse at least once, and females aged 15-24 have experienced IPV within the past 12 months (WHO, 2021).

Social Context

IPV is a global pandemic with no boundaries of ethnicity, gender, socioeconomic status, or religious affiliation (Breiding et al., 2015). IPV severely affects the health and well-being of women around the world (Garcia-Moreno et al., 2013). It involves the Christian community within the U.S. with similar precedent rates to the general public (Bloom, 2021; Simonic, 2021; Zust et al., 2017). Christian women, however, tend to stay with abusive partners to honor their belief in God and the biblical view of marriage (Drumm et al., 2014).

A victim's decision to stay in a violent relationship usually involves a combination of "social, cultural, psychological, religious-theological and situational constructs" (Simonic, 2021, p. 4280). Unfortunately, a woman's religious affiliation does not protect her from becoming a victim or perpetrator of IPV (Annis & Rice, 2002). Social factors are often based on a patriarchal

view of marriage that gives the dominant role of headship to the husband and the submissive role to the wife (Simonic, 2021; Stephens & Walker, 2015). This gives power to the husband to lead, decide, and manage things for everyone in the household, including his wife (Tracy, 2007). When his patriarchal power is threatened, the husband believes he has the right to impose his authority by force (Simonic, 2021). Social factors can also play a role in causing a woman to stay in an abusive relationship, including cultural norms that cause a woman to consider violence as a normal part of marriage or a trial to be endured (Oyedokun, 2008). Psychological factors may also contribute to a woman's choices, such as poor development of emotional regulation due to childhood family violence (Lee et al., 2020; Simonic, 2021). Still, other factors can include low education, low income, unemployment, and more (Simonic, 2021).

The effects of religious beliefs, spiritual practices, and cultural customs are interwoven in the complexities of IPV (Stephens & Walker, 2015). They range from having the power to "influence individuals to deny, minimize, or even condone [IPV]" to those that supply the strength to confront perpetrators, hold them accountable for the harm they have done, and provide healing support to survivors and their children (Johnson, 2015, p. vii). Positive forms of religious coping begin with a deep personal relationship with God and extend to a strong sense of connection with the Christian community, which undergirds the optimistic belief that meaning, purpose, and hope may be found within this system of thought (Pargament, 2002). On the other hand, negative religious coping encompasses a tenuous connection with God and an anxious interaction with the world that results in a complicated search for meaning and purpose (Pargament, 2002).

According to Fowler and Rountree (2010), "Spirituality is increasingly recognized in practice and research as an important factor in the lives of trauma survivors" (p. 10). A fair

amount of research points to the success of positive spiritual/religious coping leading to constructive transformations in a trauma victim's thinking and behaviors (Bloom, 2021; Fowler & Rountree, 2010; Simonic, 2021). This study hopes to add to the literature by validating the efficacy of a biblically based solution for promoting PTG in Christian women victimized by IPV.

Conceptual / Theoretical Context

Assumptive Worlds Theory

In 1989, Janoff-Bulman applied the schema construct when addressing the stress of traumatic events that create fractures in the victim's assumptive worlds, also known as shattered assumptions. She identified the content of people's assumptive worlds as those beliefs about self, others, and their world that function in daily life. These assumptions typically go unchallenged and unquestioned until adversity strikes (Janoff-Bulman, 1989, 1992). Numerous studies of IPV survivors report religiosity playing an essential role in women's recovery from abuse (Lilly et al., 2015). Because religion involves a structured belief system that includes organized principles, behaviors, and theology (Giesbrecht & Sevcik, 2000), it provides an excellent coping strategy for survivors of IPV (El-Khoury et al., 2004; Fallot & Heckman, 2005; Gillum et al., 2006) to rebuild their assumptive worlds. Other studies confirm the use of religion/spirituality in affirming the victim's faith and strengthening their resolve to overcome adversity with positive gains (Ai & Park, 2005; Anderson et al., 2012; Fowler & Rountree, 2010; Leo et al., 2021; Simonic, 2020).

Posttraumatic Growth Theory

In 1996, Tedeschi and Calhoun found success in treating victims of very difficult or traumatic life circumstances and gave birth to *posttraumatic growth* (PTG). PTG portrays the instinctive power of humans to process adversity in a way that produces personal development

during and following traumatic events in life (Calhoun & Tedeschi, 2013; Tedeschi et al., 2018). Known as the *process* and *outcome* of PTG, it is the actual "struggle with traumatic events" that results in "constructive and informative changes" (Tedeschi & Moore, 2021, p. 180). PTG theory views trauma, not as the DSM-5 identifies it but as "a circumstance that can produce transformative change because of challenges to core beliefs" or the reconstruction of fractured core beliefs (Tedeschi & Moore, 2021, p. 180), also referenced as "assumptive worlds" or "basic schemas" (Janoff-Bulman, 1989, p. 113). Tedeschi and colleagues evaluate five areas of change measuring PTG: (1) personal strength, (2) new possibilities, (3) improved relationships, (4) spiritual growth, and (5) appreciation for life (Calhoun & Tedeschi, 2004; Tedeschi, 2020; Tedeschi & Calhoun, 1996).

There are possible mediating effects on PTG, including time since the last occurrence of IPV. Researchers have found that positive changes in PTG are more significant within the first two years of the traumatic events (Anderson et al., 2012; Bakaityte et al., 2022). Bakaityte et al. (2022) noted that the decrease in growth is likely caused by the stabilization of "deep inner processes of the reevaluation of life values and ability to optimistically see self and others" (p. NP1070). Bloom (2021) provides evidence that Christian women can experience significant personal growth during, immediately after, and beyond their experience with IPV. By engaging in a more intimate relationship with God women were enabled with greater confidence, pride, and strength to move forward with their lives (Bloom, 2021).

Problem Statement

IPV survivors report finding the strength to cope with IPV through religious and spiritual teachings and practices (Bloom, 2021; Liebert, 2019; Simonic, 2021). Research records the tendency of Christian women to consult with religious leaders for spiritual solutions that can

address the trauma caused by IPV (Houston-Kolnik et al., 2019; Pandya, 2017; Simonic, 2020, 2021), while religious leaders express feelings of inadequacy in addressing such issues (Houston-Kolnik et al., 2019; Zust et al., 2017). Mental health professionals tend to follow secular approaches to counseling victims of IPV but have expressed interest in finding ways to integrate spirituality with their clinical efforts (Bloom, 2021). However, scant research has been conducted on developing Christian interventions that promote PTG in victims of IPV (Bloom, 2021; Houston-Kolnik et al., 2019; Simonic, 2020). This leaves devout Christian women suffering in silence without the pastoral or clinical support they need to help them recover from IPV (Drumm et al., 2014; Houston-Kolnik et al., 2019; Zust et al., 2017). The literature affirms how positive aspects of Christianity can prevent IPV or provide a pathway to recovery (Simonic, 2020). The problem is the lack of empirically validated interventions that offer spiritual solutions to promote PTG in Christian women who seek recovery from IPV (Bloom, 2021; Leo et al., 2021; Pandya, 2017; Simonic, 2020).

Purpose Statement

This study aims to evaluate the efficacy of a biblically based personal development program (PDP) for promoting PTG in Christian women who have experienced IPV. The study also seeks to know if there is a predictive linear relationship between the time since the last occurrence of IPV (T-IPV), the severity of IPV (S-IPV), and the change in the total and subscale scores of the Posttraumatic Growth Inventory (PTGI;Tedeschi & Calhoun, 1996). The criterion variable is PTG, the predictor variable is S-IPV, and T-IPV is the moderating variable. The five subscales of the PTGI include: (1) personal strength, (2) new possibilities, (3) improved relationships, (4) spiritual growth, and (5) appreciation for life (Tedeschi & Calhoun, 1996).

Significance of the Study

The study of a biblically based PDP and its effectiveness in promoting PTG in Christian women who have experienced IPV will add value to the literature in several ways. First, it will add to the growing literature on posttraumatic growth (Bryngeirsdottir & Halldorsdottir, 2021; Samios et al., 2020; Tedeschi & Moore, 2021; Valdez & Lilly, 2015; Zukauskiene et al., 2021b) by introducing a much-needed program for promoting PTG by addressing the spiritual needs of Christian women whom partners have abused. Second, this study will increase the scant literature on shattered assumptions and religious beliefs (Janoff-Bulman, 2010; Leo et al., 2021) by providing an empirically tested PDP that establishes a better organized assumptive worldview founded on biblical teachings that can promote PTG in women who have experienced IPV. Third, this study will provide much-needed information regarding the moderating effects of the severity of abuse and the time since the last abuse occurred (Bakaityte et al., 2022). Fourth, this study will increase the nascent scholarly literature on providing spiritually integrated care for women with PTSD, spiritual distress, or moral injury (Harris et al., 2021). Fifth, and perhaps most significant, is the empirically validated benefit this study offers to pastors, biblical counselors, and mental health professionals who currently feel unequipped to counsel women who have experienced IPV (McMullin et al., 2015; Zust et al., 2017) by offering a theologically sound, empirically proven program for addressing the foundational need for reestablishing a core belief system that rebuilds meaning and purpose in life.

Research Questions

RQ1: Does the PDP improve any of the subscales of PTG in Christian women who have suffered IPV?

RQ2: Does T-IPV moderate the relationship between S-IPV and PTG?

Definitions

1. *Assumptive worldview* - The firmly held beliefs about the self and the world formed over time and are used to process and respond to events (Parkes, 1971, 1975). When life seems normal, assumptive beliefs go unquestioned and unchallenged (Janoff-Bulman, 1989). Stressful life events can create fractures in assumptive premises, with the most significant effect on perceived benevolence of the world, the self, and meaningfulness (Janoff-Bulman, 1989).
2. *Domestic abuse* – According to the United Nations (n.d.), the term “domestic abuse” is used interchangeably with “domestic violence,” and "intimate partner violence.” It describes “a pattern of behavior in any relationship that is used to gain or maintain power and control over an intimate partner,” but it can also involve the abuse of others in the household including children, the elderly, and pets (United Nations, n.d.).
3. *Intimate partner* – “A person with whom one has a close personal relationship that may be characterized by the partners’ emotional connectedness, regular contact, ongoing physical contact and sexual behavior, identity as a couple, and familiarity and knowledge about each other’s lives. The relationship need not involve all of these dimensions” (Breiding et al., 2015, p. 11).
4. *Intimate partner violence (IPV)* - Acts of aggression and/or violence perpetrated by an intimate partner that includes emotional distress, physical and/or sexual violence, and/or stalking that causes psychological, physical, sexual, or spiritual damage to an individual or their personal property (CDC, 2022; Garcia-Moreno et al., 2013; Jayasundara et al., 2017).

5. *Moral injury* - A type of PTSD that violates the victim's moral code, creating feelings of helplessness or betrayal (Jinkerson, 2016; Litz et al., 2009). Moral injury can occur as the result of witnessing or perpetrating an act that goes against an individual's core belief system and can be caused by oneself (Litz et al., 2009) or a trusted authority figure (Shay, 2014). It can be intensified when the victim's social system fails to provide support (Koenig et al., 2017).
6. *Moral injury syndrome* - "A specific type of spiritual distress often co-morbid with trauma exposure or PTSD . . . experienced that challenge deeply held moral, spiritual, or values-related beliefs" (Harris et al., 2021, p. 197; Jinkerson, 2016; Litz et al., 2009).
7. *Posttraumatic growth (PTG)* - The positive personal transformation of thinking that results from struggling to cope with trauma (Tedeschi & Calhoun, 1996); is "connotated by changes in one's sense of self, experiences within relationships, and an altered philosophy of life" (Lenz et al., 2021, p. 106).
8. *Posttraumatic stress disorder (PTSD*. - The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM–5; American Psychiatric Association, 2013) provides diagnostic criteria for PTSD that includes exposure to the act or threat of death, serious injury, or sexual violence; witnessing such events against another person; experiencing long-term exposure to such traumatic events; intrusive memories and more (p. 271).
9. *Religious beliefs* – Relatively stable convictions that reflect personal assumptions regarding spiritual and existential concerns (Spilka et al., 1985).

10. *Spiritual distress* - Response to the struggle with God, values, or a spiritual community with others that produces anxiety, guilt, shame, confusion over meaning or purpose in life, or religious/spiritual doubts (Harris et al., 2021).
11. *Trauma* - A functional description of trauma is "an experience that overwhelms normal patterns of life, coping strategies, and meaning-making" (Moon, 2012, p. 72). Tedeschi and Moore (2021) define trauma simply as "a circumstance that can produce transformative change because of challenges to core beliefs" (p. 180).

Summary

IPV has been identified as a severe biopsychosocial and spiritual issue for roughly one-third of all women of all ages, races, and religions (CDC, 2022; Drumm et al., 2014; Simonic, 2020). Christian women tend to seek IPV counseling solutions from their religious leaders (Houston-Kolnik & Todd, 2016; Jankowski et al., 2018; Simonic, 2020). However, few empirically proven resources include theological or spiritual elements for promoting PTG for pastors' use (Bloom, 2021; Drumm et al., 2014; Leo et al., 2021; Pandya, 2017; Simonic, 2020). This study offers a response to the gap in the literature by proposing to evaluate the efficacy of a biblically based PDP for promoting PTG in Christian women seeking to recover from the trauma of IPV.

Research reveals how the trauma of IPV leaves emotional scars in women that result in shattering their assumptive beliefs (Janoff-Bulman, 1989, 1992; Lilly et al., 2011; Valdez & Lilly, 2015), which leads to a diminished sense of self (Bakaityte et al., 2022; Bryngeirsdottir & Halldorsdottir, 2022; D'Amore et al., 2021; Moulding et al., 2021; O'Doherty et al., 2016), moral injury (Koenig et al., 2017; Litz et al., 2009; Shay, 2014), and loss of meaning and purpose in life (Exline et al., 2014; Harris et al., 2018). Christian women have affirmed that the

most significant component in their healing process was their loving, personal relationship with God which produced a transformation of their minds and recovery of value, meaning, and purpose in their lives (Anderson et al., 2012; Fowler & Rountree, 2010; Leo et al., 2021; Simonic, 2020). The proposed study hopes to empirically validate a biblically based PDP for promoting PTG in Christian women seeking to recover from the trauma of IPV.

CHAPTER TWO: LITERATURE REVIEW

Overview

IPV is a serious public health issue that affects roughly 30% of the adult female population worldwide (Black et al., 2011; Garcia-Moreno et al., 2013). In addition to physical injuries ranging from short-term headaches to long-term traumatic brain injury, IPV can also lead to sustained intrapersonal trauma that results in a shattered sense of self (Bakaityte et al., 2022; Moulding et al., 2021; Simonic, 2021), disrupted core beliefs (Leo et al., 2021), spiritual distress (Harris et al., 2021; Pandya, 2017) and loss of meaning in life (Harris et al., 2018; Pandya, 2017). Christian women victimized by IPV seek spiritual/biblical solutions to promote growth following such experiences (Bloom, 2021; D'Amore et al., 2021; Simonic, 2020). Unfortunately, there is a dearth of empirically validated, spiritually integrated interventions to promote PTG in women suffering from IPV (Harris et al., 2021; Pandya, 2017; Samios et al., 2020).

Chapter two briefly describes the conceptual and theoretical framework, related literature, and gaps identified within the research. This chapter expands upon the theories of Christian constructivism, assumptive worldviews, and PTG. It also provides an overview of previous research relating to IPV of women, shattered assumptions, special concerns for Christian women, PTG after IPV, and the need to address these issues from a spiritual perspective compatible with victims' religious belief systems. Gaps within the literature have been identified and expanded throughout the chapter.

Conceptual or Theoretical Framework

Three conceptual and theoretical frameworks are foundational to this study's quantitative design for evaluating a biblically based intervention that promotes PTG in Christian women victimized by IPV. First, Janoff-Bulman's (1989) assumptive worldview theory offers a

conceptual understanding of the woundedness that stems from IPV trauma in women (Leo et al., 2021). Next, the posttraumatic growth theory (Tedeschi & Calhoun, 1996) explicates the healing process and outcome of PTG during and after exposure to trauma such as IPV. Finally, the Christian integrationist approach provides a biblical foundation for a spiritually integrated intervention that promotes PTG in Christian women who have experienced trauma related to IPV.

Assumptive Worlds Theory

Janoff-Bulman (1989) equated the assumptive world to Bowlby's (1969) "world models," Marris's (1975) "structures of meaning," and Epstein's (1973, 1979, 1980) "theory of reality." She applied the schema construct when addressing the stress of traumatic events that create fractures in the victim's assumptive worlds, also known as shattered assumptions (Janoff-Bulman, 1989). Assumptive worlds were identified as beliefs about self, others, and their world that function in daily life and typically go unchallenged and unquestioned until adversity strikes (Janoff-Bulman, 1989, 1992; Parkes, 1971, 1975). The theory of shattered assumptions (Janoff-Bulman, 1989) may also explain adverse outcomes to mental health following trauma, which "disintegrates individuals' core assumptions" that the world is safe, life is meaningful, and the self is worthy (Lilly et al., 2015, p. 87). These assumptions explain people's universal belief that because people are generally good, there is hope for the future (universal benevolence); that humans have greater control than they do, which allows the false assumption that humans can control future outcomes (meaningfulness of world); and that people are generally good, capable, and moral beings (self is worthy; Lilly et al., 2015).

Lilly et al. (2015) explain how Janoff-Bulman's (1989, 1992) theory of shattered assumptions "integrates social, cognitive, and dynamically oriented research and theory to

describe how trauma adversely impacts mental health, especially about PTSD" (p. 88). Assumptive beliefs can quickly be challenged by a traumatic event, such as IPV, that is "extraordinary and highly contradictory to these principles" (Lilly et al., 2015, p. 88). Traumatic events such as IPV can shatter a woman's assumptions by revealing the unreliability of those beliefs (Lilly et al., 2015). Interpersonal trauma, such as IPV, interrupts the victim's assumptive schemata, shaking or even shattering their belief system and leaving them with the sense that life in this world is meaningless, wicked, and uncontrollable (Lilly et al., 2015; Valdez & Lilly, 2015). Interpersonal victimization, such as IPV, threatens the survivor's assumptive belief system, creating an imbalance or cognitive dissonance between their core beliefs and reality (Valdez & Lilly, 2015).

Recovery begins with the ensuing schema reconstruction process as the survivor assimilates the traumatic experience that brings elements of her existing belief system into question (Janoff-Bulman & Sheikh, 2006). The victim's "recognition of the meaninglessness of existence triggers and feeds the creation of PTG" as a new appreciation for life develops (Valdez & Lilly, 2015, p. 225). Growth has been found during and after traumatic experiences, as people have reevaluated and rebuilt their core belief system in self, others, and the world (Calhoun & Tedeschi, 2013, 2014; Janoff-Bulman, 1989, 1992; Leo et al., 2021; Pargament, 2002; Tedeschi et al., 2018; Valdez & Lilly, 2015). From a Christian perspective, this restorative process occurs when one understands their relationship with God, the Creator who gives meaning to life (Johnson, 2011).

Posttraumatic Growth Theory

PTG is a construct within the counseling profession that portrays the instinctive power of humans to process adversity in a way that produces personal development of the meaning and

purpose of life (Calhoun & Tedeschi, 2013; Tedeschi & Calhoun, 1996; Tedeschi et al., 2018). PTG is explained as the process and outcome of the "struggle with traumatic events" that results in "constructive and informative changes" (Tedeschi & Moore, 2021, p. 180). PTG theory thinks of trauma as "a circumstance that can produce transformative change because of challenges to core beliefs" or the reconstruction of fractured core beliefs (Tedeschi & Moore, 2021, p. 180), also referenced as "assumptive worlds" or "basic schemas" (Janoff-Bulman, 1989, p. 113). PTG is measured by "one's sense of self, experiences within relationships, and an altered philosophy of life" (Lenz et al., 2021, p. 106).

Tedeschi et al. (2015) attest, "Facing mortality can produce important changes in the religious, spiritual, and existential components of philosophies of life" (p. 505). For centuries people have reported experiencing positive personal transformations in the wake of trauma by being forced to grapple with the existential questions on what it means to be human, e.g., *Who am I? What am I here for?* (Calhoun & Tedeschi, 2013, 2014; Tedeschi et al., 2018). The understanding that distress and suffering can be the catalysts for positive change in human beings is "thousands of years old" (Tedeschi & Calhoun, 2004, p. 2). Ancient writings of the Hebrews, Greeks, and early Christians, along with some teachings of Hinduism, Buddhism, and Islam, speak of the transformative effects of suffering (Tedeschi & Calhoun, 1995).

The modern history of PTG began about sixty years ago when Caplan (1964) affirmed the potential for growth through adverse life events as a fundamental assumption of crisis theory. Thirty years later, stress-related development had become recognized as a significant part of various models of stress and coping processes (Park et al., 1996). Taylor et al. (1983) provides a model of selective evaluation that indicates that victims of aversive states "selectively evaluat[e] themselves and their situation in ways that are self-enhancing" (p. 19). Janoff-Bulman (1992)

introduced the assumptive worldview (expounded in the preceding section) that explains how tragedy shatters assumptions, which are rebuilt and modified over time. In the 1980s and '90s, Tedeschi and colleagues began studying how stressful events could produce positive outcomes (Tedeschi et al., 2018). After empirical studies documented the success in treating victims of very difficult or traumatic life circumstances, Tedeschi and Calhoun (1996) published their research and gave birth to *posttraumatic growth* (Tedeschi et al., 2018).

Personal growth from life crises has also been found in the arts, biology, economics, history, literature, philosophy, psychology, and sociology (Tedeschi et al., 2018). Finding meaning from human suffering has been the focus of dramatists, novelists, and poets (Tedeschi & Calhoun, 1995, 2004). PTG is recognized as "a powerful aspect of human nature" and has gained interdisciplinary interest "in the phenomenon of trauma response, including psychology, gender and sexuality studies, cultural studies, medicine, military studies, nursing, and social work" (Tedeschi et al., 2018, p. 8). Several subdisciplines of psychology have included PTG in theoretical perspectives, including cognitive, developmental, existential, and humanistic psychology, and more (Tedeschi et al., 2018). Historically, the fields of psychology and medicine focused primarily on the harmful effects of trauma (Plews-Ogan et al., 2019) or the field of "victimology" (Seligman & Csikszentmihalyi, 2000, p. 6). As psychology broadened its outlook from studying "pathology, weakness, and damage," it began considering the roles of "strength and virtue" by "not just fixing what is broken" but "nurturing what is best" (Seligman & Csikszentmihalyi, 2000, p. 6).

PTG has a great deal in common with positive psychology as they were both developed with the assumption that "past researchers and clinicians focused too much on deprivation and the mental ill-health of human beings (e.g., how we could repair the damage, rather than how we

could support each other to grow as human beings or to live meaningfully)" (Tedeschi et al., 2018, p. 13). PTG theory follows the lead of philosophers Kierkegaard, Nietzsche, and Sartre, who sought to understand the existence of humans from the "broad perspective of meaning in life and the inevitable reality of death" (Tedeschi et al., 2018, p. 10). The logotherapy work of Victor Frankl (1992) and Irving Yalom (1980) has also been influential in the development of PTG. The concept of positive transformation after pain and suffering can also be found throughout religious and philosophical literature (Plews-Ogan et al., 2019, p. 371), including in the Bible (Eccl 3:1; Jer 29:11; Ps 147:3; Matt 5:4; 8:17; Rom 8:28; 8:37-38; 2 Cor 1:3; Heb 9:8; Rev 21:4). Romans 8:28 references God's ability to produce good from life's difficult circumstances. This is not to say that the trauma itself is good, but to acknowledge that "despite these distressing experiences, people often report positive transformation" because the "traumatic events set in motion attempts to cope and that the struggle in the aftermath of the crisis, not the event itself, produces the posttraumatic growth" (Tedeschi et al., 2015, p. 506).

The *struggle* referenced in PTG references the difficulty in reconstructing one's core beliefs following trauma (Tedeschi & Moore, 2021). It is essential to differentiate PTG from resilience; Tedeschi and Calhoun (2004) explain resilience as resistance against emotional harm before, during, and after trauma, while PTG refers to the process and outcome of positive psychological well-being that develops from grappling with the traumatic event (Tedeschi & Calhoun, 2004). Walsh (2002) describes resilience as a rebounding effect for returning a person to their pre-trauma state of normalcy (Walsh, 2002). This term does not represent the growth experienced by women following trauma (Brosi et al., 2020). Instead, the term *posttraumatic* indicates something that occurs in the aftermath of trauma, and the term *growth* underscores development "beyond her previous level of adaptation, psychological functioning, or life

awareness" (Zoellner & Maercker, 2006, p. 628). Tedeschi and Calhoun (2004) posit that trauma victims experience growth that improves their pre-trauma state by re-establishing or strengthening their core beliefs. Meanwhile, the meanings and differences between PTG and resilience are still being debated (Crann & Barata, 2016; Infurna & Jayawickreme, 2019) as victims describe PTG as "a journey, rather than a destination" (Bryngeirsdottir & Halldorsdottir, 2021, p. 1).

Recent research reveals success in promoting PTG in women victimized by IPV through identity exploration (Bakaityte et al., 2022), positive reframing of meaning-making (Samios et al., 2020), by establishing a healthy set of beliefs for life (Brosi et al., 2020), and by affirming religious beliefs regarding meaning and hope for the future (Bloom, 2021). However, little research has shed light on the effect of evangelical Christianity on PTG and IPV (Bloom, 2021). Further research is needed to develop a better understanding of how victims of IPV acquire PTG (Bakaityte et al., 2022; Brosi et al., 2020; Bryngeirsdottir & Halldorsdottir, 2021) and mainly what role Christian beliefs play in this process (Bloom, 2021)

Related Literature

Intimate Partner Violence (IPV)

The CDC (2022) defines IPV as a serious but preventable public health issue that involves "physical violence, sexual violence, stalking, or psychological harm by a current or former partner or spouse." Zukauskiene et al. (2021) notes that IPV is "often characterized by physical violence, but it also includes psychological and emotional, sexual, financial, social, and spiritual abuse" (p. . The *Intimate Partner Violence Surveillance Uniform Definitions and Recommended Data Elements* (Breiding et al., 2015) provides examples of what constitutes the most prevalent forms of IPV, which have been paraphrased by the CDC (2022):

- Physical violence is when a person hurts or tries to hurt a partner by hitting, kicking, or using another type of physical force.
- Sexual violence is forcing or attempting to force a partner to participate in a sex act, sexual touching, or a non-physical sexual event (e.g., sexting) when the partner does not or cannot consent.
- Stalking is a pattern of repeated, unwanted attention and contact by a partner that causes fear or concern for one's own safety or the safety of someone close to the victim.
- Psychological aggression is the use of verbal and non-verbal communication with the intent to harm a partner mentally or emotionally and/or to exert control over a partner.

Economic abuse is another form of nonphysical abuse that has been mentioned in the literature. Miller (1995) described the economic dependency one intimate partner forces upon the other that also results in further emotional harm. Economic abuse is particularly degrading and debilitating since the perpetrator has likely isolated the victim from the supportive network of family and friends, and he is either the sole provider or sole manager of the couple's finances (Stylianou, 2018). Financial abuse occurs in 99% of domestic violence cases, yet less than 20% of Americans recognize financial abuse as a form of domestic violence (Adams, 2011). Consequently, economic abuse is the least studied form of nonphysical abuse (Stylianou, 2018).

IPV Against Women (IPVW)

IPVW is a type of gender-based violence widely reported to affect more women than men in sizable numbers worldwide (Renzetti et al., 2017). IPV is reported as being a standard and preventable health issue that affects millions of people in the U. S. annually (Leemis et al., 2022) and causes "serious health issues and economic consequences" (CDC, 2022). Broken down by gender, 41% of women (26% of men) report experiencing physical and/or sexual violence,

and/or stalking by an intimate partner, and 61 million women (53 million men) report experiencing psychological aggression by an intimate partner (Leemis et al., 2022). What may be more startling is that most IPV cases go unnoticed or are never reported to authorities (Gracia, 2004; WHO, 2013). At least one study has challenged these widely accepted findings on gender-based violence with a compelling argument that IPV against men appears lower than reality due to inaccurate reporting of IPW data (Hoff, 2012). Regardless, there is overwhelming evidence that millions of women suffer from issues related to IPV in the U.S. (CDC, 2022; WHO, 2021), including Christian women (Bloom, 2021).

According to the National Intimate Partner and Sexual Violence Survey conducted by the National Center for Injury Prevention and Control (Breiding et al., 2015), the "12-month prevalence of rape, physical violence, or stalking was highest among 18- to 24-year-olds," with decreasing prevalence for each subsequent age group (p. 66). Also reported 60% of women experienced the first occurrence of IPV before age 18 (Breiding et al., 2015, p. 66). This indicates that a large population of young adult females has experienced IPV at least once, leading to higher trauma-related issues rates (Breiding et al., 2015). Department of Justice reports that women are victims of domestic violence 76% of the time, compared to 24% of males (Truman & Morgan, 2014).

Data recorded over recent decades (CDC, 2022; WHO, 2021) reveals that IPV knows no boundaries relative to social class, skin tone, nationality, or religious preferences. Based on past research, IPV exists in Christian families as its prevalence in Western families of faith is like that of the general population (Todhunter & Deaton, 2010; Westenberg, 2017). Brinkerhoff et al. (1992) state that religion is not related to IPV directly, but religiosity in combination with other interpersonal elements may contribute to a victim's vulnerability or the empowerment of an

abuser (Nason-Clark, 2004). The complexities and causes of IPV and a victim's persistence to remain in an abusive relationship are numerous (Simonic, 2021). Ellison and Anderson (2001) point to IPV as a product of demographics, socioeconomics, relationship status, "power differentials among partners," and "traditionalist or patriarchal gender role orientations. This points to the need to address specific religious issues when working with abused Christian women who hold traditional religious views.

Special Concerns for Christian Women

IPV affects people universally; it knows no boundaries to social class, skin tone, or religious orientation (Black et al., 2011). Christian families in Western cultures experience IPV at similar rates to the general population (Simonic, 2021; Todhunter & Deaton, 2010; Westenberg, 2017). This indicates that places of worship unwittingly provide momentary shelter for abused women each time they gather for religious services (McMullin et al., 2015). These women and nonreligious women report how IPV has deteriorated their mental well-being, self-esteem, and self-identity (Adler et al., 2016; Lillevoll, et al., 2013; Matheson et al., 2015; Zukauskiene et al., 2021a, b).

Women who have experienced abuse often share experiences of emotional, physical, and spiritual traumas, yet most of them turn to family and friends for support before seeking help from professional or religious systems (Barrett & Pierre, 2011; Fanslow & Robinson, 2010; Liao, 2019). Consequently, Christian pastors admit to feeling ill-equipped to provide IPV to women (Bloom, 2021; DeRose et al., 2021; Houston-Kolnik & Todd, 2016; Jankowski et al., 2018; Pandya, 2017; Simonic, 2020; Zust et al., 2017). Of the 75% of abused women who have shared their personal stories of abuse with someone else, less than 40% felt they had received any support afterward (Fanslow & Robinson, 2010). This leaves many women, inside and outside of

churches, suffering in silence as they attempt to tend to their wounds from domestic violence (Houston-Kolnik et al., 2019). Kreidler (1995) reports a women can suffer deep spiritual distress when she is wounded by an intimate partner who was used his power and influence to harm her instead of loving, cherishing, and protecting her.

Moreover, the secular IPV response tends to follow feminist ideologies that blame patriarchal headship as the primary contributor to IPV (Bloom, 2021, p. 627; DeKeseredy, 2011; Kolb, 2014). Christian women sometimes follow misinformed biblical teachings about patriarchal headship, believing they are to blindly submit to a coercive or controlling husband (Clifton, 2018; Langberg, 2003, 2020; Nason-Clark, 2004; Westenberg, 2017; Zust et al., 2017), allowing the wife's identity of self to be overridden by a dominating husband's demands. Pierre and Wilson (2021) affirm the biblical teaching that abuse is a sin that negatively affects God's design for personhood, interrupting the flow of worship from God to the abuser (Matt. 22:37-40). God empowers man with authority to serve others (Mark 10:42-45). When a man uses his power to force others to serve him, it results in "desecrating the personhood of the one being abused" (Pierre & Wilson, 2021, p. 40). However, Christian woman have shown they can "refocus their energy and actions from the false beliefs and assumptions around a lack of control toward beliefs that ultimately led to healing and abuse-free living" (Pandya, 2017, p. 826).

The *DSM-5* (American Psychiatric Association [APA], 2013) points to "prolonged and intense coercive persuasion," such as can be experienced with emotional or physical abuse, as the catalyst for "prolonged changes in, or conscious questioning of, their identity" (p. 306). According to Stark (2012), the distinguishing characteristic of IPV is the coercive control of men against women, which includes male dominance behaviors through "intimidation, sexual degradation, isolation, and control" (Stark, 2012, p. 7). Coercive control, psychological abuse,

and sexual abuse have produced the most damaging trauma for women (Scheffer Lindgren & Renck, 2008).

Sadly, Christian women who have survived domestic abuse often find themselves more vulnerable because their faith creates a sense of duty and submission for staying with the abusive partner (Nason-Clark, 2004). Regardless of the trigger for IPV, Christian women use religious and spiritual coping mechanisms to work through the trauma left in its wake (Bloom, 2021; Pandya, 2017; Simonic, 2020).

Factors influencing IPV behavior and the victim's determination to remain in the abusive relationship are plentiful and complex (Simonic, 2021). Research affirms that personal religious affiliation and beliefs do not prevent the victimization or perpetration of IPV (Annis & Rice, 2002). IPVW usually involves a combination of constructs, including social, cultural, psychological, religious-theological, and situational (Ellison & Anderson, 2001). Religious leaders can play a positive role in preventing domestic abuse of women and children through strategic messaging that promotes peace, love, respect, and goodwill with others (Ellison & Anderson, 2001; Ellison et al., 1996) and by empowering IPV survivors to replace feelings of helplessness with the empowerment that comes from discovering meaning and purpose that is reflected through life events and even suffering (Fowler & Rountree, 2010).

Common Effects of IPVW

Studies of IPV reveal that female survivors are at increased risk for physical injuries, traumatic brain injuries, emotional challenges, financial barriers, social isolation, and more (Fair & Ochberg, 2012). Common effects of IPV include fear and concern for safety, injury, PTSD, law enforcement, and loss of work (Leemis et al., 2022). The CDC (2022) fact sheet on IPV reports that 75% of females (48% of males) experience physical injury related to IPV. In a study

of U. S. emergency room (ER) visits coded for IPV, Davidov et al. (2014) report a total of 112,664 visits were made to ERs between 2006-2009 that involved battering by an intimate partner; 93% were female, 15% of which required medical care. The most common diagnoses included “superficial injuries and contusions, skull/face fractures, and complications of pregnancy” (Davidov et al., 2014, p. 1). There are many other adverse outcomes of IPV.

Partner violence has been reported as the leading cause of injury to women, more than car accidents, muggings, and rapes combined (Black et al., 2011). Studies of IPV reveal that female survivors are at increased risk for physical injuries, including traumatic brain injuries (Fair & Ochberg, 2012). Women are also more likely than men to report injuries that require medical and/or mental health care, time off from work, and costly legal assistance (Fair & Ochberg, 2012, p. 178).

Gendered violence among women ages 15-44 is the cause of more disabilities and deaths worldwide than cancer, malaria, traffic accidents, and war combined (De Alwis, 2012). IPV is also on record by Black et al. (2011) as being a greater health risk to women compared to other major diseases. They report that over a lifetime, 1 in 4 women will experience partner abuse; twice or more the rate of breast cancer (1 in 8), diabetes (1 in 10), and heart disease (1 in 10; Black et al., 2011). Because women experience more frequent, longer-lasting occurrences and threats of violence than men, they are also more likely to require medical attention and mental health care (Dillon et al., 2013; Fair & Ochberg, 2012).

Women who have been physically battered or sexually assaulted often suffer injuries in the head, face, neck, thorax, and abdomen, that lead to higher-than-average medical issues related to gastrointestinal, cardiac, and immune system distress and disorders (Campbell, 2002; Coker, 2021; Coker et al., 2002; Diez et al., 2009). These issues can lead to depression, post-

traumatic stress and other anxiety disorders, sleep difficulties, eating disorders, and suicide attempts (Garcia-Moreno et al., 2013). Women who have experienced IPV are almost twice as likely to experience depression and problem drinking and are at increased risk for substance abuse and eating disorders (Garcia-Moreno et al., 2013). Other health effects include sexual and reproductive issues (WHO, 2021).

More than 1 in 3 women will experience rape, physical violence, and/or stalking in their lifetime; 1 in 5 reports being raped in their lifetime (Black et al., 2011). Of these reports of rape, the most common involves forced penetration (12.3% o), attempted forced penetration (5.2%), and alcohol/drug-facilitated completed forced penetration (8.0%; Black et al., 2011). In addition to the emotional and physical harm, women who experienced physical or sexual IPV were 1.5 times more likely to develop a sexually transmitted disease, such as HIV, and twice as likely to have an abortion (WHO, 2021). Yet, “rape within marriage is not a crime in 127 countries” (Carter, 2014, p. 144).

Alhusen et al. (2015) report that 30% of first-time abuse occurs during pregnancy. Research recognizes the devasting consequences of IPV on the mother and unborn child (Martin-de-las-Heras et al., 2019). IPV during pregnancy increases the probability of a miscarriage, pre-term delivery, low birth weight, and stillbirth (Hill et al., 2016; WHO, 2021). It has also been found that urinary tract and vaginal infections are correlated with psychological abuse during pregnancy (Martin-de-las-Heras et al., 2019), likely due to physical or sexual IPV (Chambliss, 2008; McFarlane et al., 2005). Extreme physical violence can result in the death of a mother and unborn child (Eldridge & Kerry, 2012; Martin-de-las-Heras et al., 2019; Rachana et al., 2002). Unfortunately, the history of violence does not end here; it too often ends in death through the intentional and nonintentional homicide that occurs with IPV (Petrosky et al., 2017).

According to Truman and Morgan (2014), IPV accounts for 15% of all violent crimes. Petrosky et al. (2017) reported, "Homicide is one of the leading causes of death for women aged ≤44 years," and more than half the homicides with known causes were the result of IPV, with a higher incident rate among young, racial/ethnic minority women (p. 741). Reporting data from U.S. crime reports, the CDC (2022) concludes that an intimate partner kills about 1 in 5 homicide victims. Of all the circumstances reported in U.S. homicides, IPV of women was identified in 45.4%, compared to 8.4% of males (Jack et al., 2018). Between 2000 and 2006, the Federal Bureau of Investigation reported the deaths of 3,200 military troops in battle; during the same time, 20,600 domestic homicides occurred in the U.S; 85% were women (Carter, 2014). Greater than 50% of all female murders were committed by their intimate partners (Jack et al., 2018). Crandall et al. (2004) found that most murdered women had presented to the ER with IPV-related injuries within two years of their deaths. The health and well-being of future generations of female victims of IPV are in jeopardy (WHO, 2021).

IPV & Trauma

The statistics are staggering, and the body of literature is growing that illuminates the potential health impacts of IPV on women, which produces both acute and chronic physical and mental health symptoms, disorders, and related psychological issues (Dillon et al., 2013) as well as emotional, social, and spiritual matters (DeKeseredy, 2011). The trauma of IPV leaves emotional scars that can cause fractured assumptive beliefs (Houston-Kolnik et al., 2019; Lilly et al., 2011; Valdez & Lilly, 2015) and spiritual distress that can lead to moral injury (Harris et al., 2021; Jinkerson, 2016). Likewise, the "state of terror" victims experience from exposure to IPV often results in a "sense of loss of control or agency within one's life" (Fair & Ochberg, 2012, p. 185), a diminished sense of self (Bakaityte et al., 2022; Bryngeirsdottir & Halldorsdottir, 2022;

D'Amore et al., 2021; Moulding et al., 2021; O'Doherty et al., 2016), and an existential crisis that involves the loss of meaning and purpose in life (Noviyanti et al., 2019). While the impact of physical violence on women is more immediate than other forms of IPV, "psychological IPV is much more detrimental to women's health" (Matheson et al., 2015, p. 562).

Trauma can be experienced through severe injury, interpersonal violence, including emotional, physical, or sexual abuse, and exposure to actual or threatened death (CDC, 2022). Almost 50% of adult women will endure psychological aggression by intimate partners in their lifetime (Black et al., 2011; Garcia-Moreno et al., 2013). Research attests to psychological trauma from IPV resulting in "depression, anxiety, sleep disturbances, isolation, anger, hopelessness, despair, and post-traumatic stress disorder" (PTSD; Gerber et al., 2021, p. 2). This also sets a "cycle of violence" that can lead to cyclical patterns of trauma and abuse (Fair & Ochberg, 2012, p. 181).

Defining Trauma

Historically, experts have disagreed on the definition of trauma which has resulted in a definitional evolution by the APA (Weathers & Keane, 2007). Initially, the DSM-III describes *trauma* as an event "generally outside the range of usual human experience" that results in "significant symptoms of distress in most people (APA *Diagnostic and Statistical Manual of Mental Disorders*, 1980, p. 236). The DSM-IV (APA, 1994) extended this definition to include anyone who "experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others . . . [which] resulted in intense fear, helplessness or horror." (pp. 427-428). In its latest revision, the DSM-5 (APA, 2013) provides more detailed explanations of the criteria compared to the DSM-IV and removes the need for identifying the symptoms as acute or chronic. The

DSM-5 (APA, 2013) also adds a cluster of signs for "Negative alterations in cognitions and mood associated with the traumatic event(s)" (p. 271). These psychological alterations include the following symptoms: Dissociative amnesia; exaggerated negative beliefs about self, others, or the world; distorted cognitions that result in blaming self or others; persistent feelings such as fear, guilt, or shame; severe lack of interest in significant activities; and feelings of being ostracized by others (pp. 271-272). This group of criteria aligns with experiences associated with female victims of IPV (Matheson et al., 2015; Pagliaro et al., 2022).

Briere and Scott (2015) suggest the DSM-5 definition presents an issue for female victims of psychological abuse because it "underestimates the extent of actual trauma in the general population" and prohibits some individuals from receiving a proper diagnosis who have experienced severe emotional distress (p.10). They instead define trauma as an event that is "extremely upsetting, at least temporarily overwhelms the individual's internal resources, and produces lasting psychological systems" (Briere & Scott, 2015, p. 10).

PTSD

Existing research reveals startling trends that women are twice as likely as men to develop PTSD following a traumatic event (Blanco et al., 2018). Women report experiencing IPV more frequently and with greater constancy than men, resulting in repeated threats that create ongoing fear of bodily harm that can lead to PTSD (Fair & Ochberg, 2012). Some research identifies IPV as the most significant cause of PTSD, which is more common in women (Iverson et al., 2013; Kessler et al., 2017; Scott et al., 2017). Even with the more descriptive criteria for diagnosing PTSD, not everyone with symptoms that align with the DSM-5 (APA, 2013) criteria will be diagnosed with PTSD. In Kirkpatrick (2012), of the nearly 3,000 adults surveyed, 89.7% met Criterion A for PTSD in the DSM-5 (APA, 2013). However, the DSM-5

(APA, 2013) reports a lifetime prevalence rate for developing PTSD at only 8.3%, including victims of IPV and combat. Broken down by gender, the lifetime prevalence rate for PTSD in women (9.7%) is more than twice that of men (3.6%; National Center for PTSD, 2014). Unfortunately, there is a lack of research investigating IPV-caused PTSD in women (Crombie et al., 2021).

Spiritual Distress & Moral Injury

Harris et al. (2021) report PTSD as being co-morbid with co-existing challenges related to core beliefs and values, such as moral injury (Jinkerson, 2016; Litz et al., 2009) or spiritual distress (Exline et al., 2014; Fontana & Rosenheck, 2004; Harris et al., 2008; Kopacz et al., 2016; ter Kuile & Ehring, 2014). Harris et al. (2021) explains that the precipitating trauma that causes spiritual distress or moral injury includes "experiences such as violating one's moral code, seeing one's moral code violated by others, feeling helpless to address harm or being betrayed by authorities or peers" (p. 197; see also Litz et al., 2009). Exline et al., 2014, describe spiritual distress as anxiety, guilt, or other painful emotions that evoke conflict, struggle or abnormal fear relative to a God or a community of faith, or create feelings of fear, guilt or shame, religious or spiritual doubts, or loss of meaning or purpose.

Moral injury creates trauma by forcing violations in the victim's moral code, such as deeply held moral, spiritual, or values-related beliefs (Jinkerson, 2016; Pomerleau et al., 2020). Harris et al. (2021) reference moral injury as "a specific type of spiritual distress" that is often co-morbid with PTSD (p. 197). Liebert (2019) "moral injury describes a trauma to the moral sensibility grounding our personhood, a trauma in which one's moral moorings are so challenged that it is experienced as a wound to the very spirit" (p. 42). A moral injury can result from a violation of one's deeply held beliefs, such as "violating a core moral belief," such as taking an

action that goes against those deeply held principles or failing to do that which upholds such values (Liebert, 2019, p. 42). Moral injury can also result from blows sustained to one person's spirit by another and can involve living in a manner that causes one's moral compass to shatter (Graham, 2017).

Symptoms of moral injury may include loss of previously honored spiritual beliefs or sense of connection with God; lack of forgiveness for self, others, or a God; feelings of helplessness or betrayal; enduring guilt; loss of meaning or purpose in life; anger or shame; and suicide ideation or attempts (Jinkerson, 2016; Litz et al., 2009). Little research has investigated the relationship between IPV and moral injury (Jinkerson, 2016; Pagliaro et al., 2022).

Shattered Assumptions

The theory of shattered world assumptions (Janoff-Bulman, 1989) offers a plausible explanation for the adverse mental health outcomes following trauma, such as PTSD, spiritual distress, and moral injury (Lilly et al., 2015). Janoff-Bulman (1992) conveys, "Surely our basic assumptions may be more private and less elegant than theories that guide scientific observation and research, yet they are no less important as guides for our day-to-day thoughts and behaviors (p. 4). In 1980, Epstein shared a similar thought, "everyone unwittingly develops a personal theory of reality that includes a self-theory and a world-theory. A personal theory of reality does not exist in conscious awareness but is a preconscious conceptual system that automatically structures a person's experiences and directs their behavior" (p. 65). Researchers conclude that the shattering of core beliefs or cognitive schemas leads to trauma, yet the literature has been very quiet concerning the relationship between IPV victimization and assumptive beliefs (Lilly et al., 2011; Valdez & Lilly, 2015).

Kelley (1971) explains that schemas provide a framework through which individuals extrapolate the meaning of their world and make plans for their futures. As new events are encountered, they are assimilated into the preexisting schemas, reducing the cognitive processing required to make sense of life events (Leo et al., 2021). However, cognitive dissonance occurs when life events do not fit into an individual's core belief system (Festinger, 1962). When an individual's basic schemas fail to make sense, she is forced to re-evaluate her basic assumptions and rebuild or adopt new beliefs that provide a better understanding of the traumatic events (DePrince & Freyd, 2002; Martin & Kleiber, 2005). Sometimes this produces a negative cognitive schema as one way of reconciling the attack on a person's generally positive core belief system regarding self and the world (Lilly et al., 2011). This results in a view of the world that is less benevolent, less meaningful, and perceives less self-worth (Janoff-Bulman, 1989; Lilly et al., 2011).

Trauma types appear to have differing effects on world assumptions (Janoff-Bulman, 1992). For example, some traumas, such as those that do not involve a malicious perpetrator, can be reconciled as a common misfortunate event (Solomon et al., 1997). Noninterpersonal trauma also has limited effects on core beliefs (Bodvarsdottir & Elklit, 2004; Wagner et al., 2009), as compared to interpersonal trauma involving a malicious perpetrator (Magwaza, 1999; Ullman, 1998), which "can shatter the very foundation of one's assumptive schemata, leaving a survivor all too aware of a world that is malevolent and threatening" (Valdez & Lilly, 2015; p. 225).

Role of Religious Schemas

Studies of IPV survivors report religiosity playing an essential role in women's recovery from abuse (Leo et al., 2021; Lilly et al., 2015). Because religion involves a structured belief system that includes organized principles, behaviors, and theology (Giesbrecht & Sevcik, 2000),

it provides an excellent coping strategy for survivors of IPV (El-Khoury et al., 2004; Fallot & Heckman, 2005; Gillum et al., 2006). Religion/spirituality can affirm a victim's faith and strengthen their resolve to overcome adversity with positive gains (Ai & Park, 2005; Anderson et al., 2012; Fowler & Rountree, 2010; Simonic, 2020). McIntosh (1995) recognized "religion-as-schema" and explained that religion goes beyond being an organization of cognitive beliefs as it includes an individual's internal "rites, habits, and other behaviors" (p. 1). Religious beliefs are the primary framework for developing schemas about one's meaning in life and existence in the world (Allport & Ross, 1967; Spilka et al., 1985). Social and cultural groups can influence and reinforce religious schemas (Lim & Putnam, 2010).

Religious assumptions also have a dark side; *religious doubt* can undermine one's sense of well-being following suffering and trauma (Exline & Rose, 2005; Pomerleau et al., 2020; Upenieks, 2021). People who claim to be religious but have not established organized theology behind their beliefs are the most vulnerable to experiencing shattered assumptions when trauma strikes (Leo et al., 2021; Upenieks, 2021). On the other hand, those who have a well-established religious belief system are much more likely to achieve positive outcomes as they process and work through trauma (Leo et al., 2021; Lilly et al., 2015; Pomerleau et al., 2020). These patterns of religious change align well with Janoff-Bulman's (2010) shattered assumptions hypothesis (Leo et al., 2021).

Some researchers suggest that trauma counselors address religious concerns to address trauma caused by the cognitive dissonance of religious beliefs (Smith, 2004). "The greater the explanatory power of a person's beliefs regarding the perceived presence of suffering–their theodicies–the less likely it is that their trauma experiences will affect their beliefs" (Leo et al., 2021). Counselors and religious leaders can collaborate with trauma victims to resolve the

cognitive dissonance of religious beliefs by first helping them find meaning in the events that align with their assumptive religious beliefs (Leo et al., 2021). Second, they can extend the victim's challenged belief systems to allow them to accommodate the reality of trauma (Leo et al., 2021). Ankri et al. (2010) report that this schema accommodation may challenge many fundamentalist faith leaders due to the unchangeable nature of their theological systems. In such cases, the fundamentalist leaders are encouraged to work with the trauma victim in a manner that is consistent with their belief system to "preserve their self-worth, minimize feelings of guilt, and reduce stigmatization (Leo et al., 2021). Additionally, religious counselors can refer these clients to social support services that offer secure, reliable, and sympathetic support (Ben-Ezra et al., 2010).

Mediating Effects of Time on PTG

For many women, IPV leads to a lengthy process of endurance and recovery from the trauma of abuse (Dillon et al., 2013). However, Bloom (2021) found significant PTG in evangelical Christian women during and beyond their traumatic experiences with IPV because of applying evangelical Christian teachings concerning God's design and purposes for humans. Findings from Cobb et al. (2006) were similar to those of Tedeschi and Calhoun (1995), which projected that higher rates of PTG begin to occur soon after the abuse has been resolved. Others have found, however, that IPV is unlike other forms of single-occurrence trauma in that it usually occurs repeatedly over time (Cobb et al., 2006; Landenburger, 1993; Ulloa et al., 2015). In a study of post-IPVW schema reconstruction, Valdez and Lilly (2015) report that some level of PTG can be experienced anytime during or following abusive periods (Cobb et al., 2006; Renzetti et al., 2017). Other research indicates that positive changes in PTG are greater within the first two years of the cessation of the traumatic events (Anderson et al., 2012; Bakaityte et

al., 2022). Bakaityte et al. (2022) point to the mediating effects of time since the last occurrence of IPV (T-IPV) on PTG and recommend future research in this matter.

Time Sense Last Occurrence of IPV

Previous research exposes the problem of retraumatization of women by probing their history of IPV, which can engage their emotions at a time when they are still very vulnerable to this topic (Edwards, Kearns, et al., 2009; Edwards, Probst, et al., 2013). While self-discovery can provide a step toward healing and recovery from IPV (Flinck et al., 2005; Lynch & Graham-Bermann, 2004; Morales-Campos et al., 2009), the newfound awareness can also trigger unsettling emotions (Becker-Blease & Freyd, 2006; Burke-Draucker, 1999). Valpied and colleagues (2014) heard directly from women they surveyed, who expressed that the research process was less difficult to undergo at 12 and 24 months than only six months out from the last experience of IPV.

Spiritually Integrated Christian Solutions for PTG in IPVW

A wealth of data demonstrates the significant effects of IPV on women's physical, psychological, and spiritual health and that of their children, but there is only a tiny amount of research, primarily qualitative, that examines how women achieve PTG after IPV (D'Amore et al., 2021; Flasch et al., 2017; Harris et al., 2018). As proposed in the theory of logotherapy (Frankl, 2014), PTG can be promoted by discovering meaning and purpose in suffering and anguish (Bloom, 2021; Kristyanti, 2009). For years, trauma treatment has involved the psychotherapeutic approach of making new meaning relative to the traumatic event (van der Kolk et al., 1995), which teaches IPV victims to apply self-compassion with meaning-making theory (Samios et al., 2020). Frankl promotes, "even the tragic and negative aspects of life, such as unavoidable suffering, can be turned into a human achievement by the attitude a man adopts

toward his predicament" (2014: n.p.). Humans have shown that they can experience PTG by adjusting their understanding, perceptions, and response to suffering, which leads to finding meaning from adverse events (Bloom, 2021). Still, few methods address spirituality, which includes a person's core religious beliefs to guide the meaning-making processes (Harris et al., 2011).

Considering the relationship between spiritual and values-related distress that often leads to trauma, spiritually integrated care has become a higher priority among clients and mental health professionals (Bloom, 2021; Harris et al., 2021; Simonic, 2021). Regarding promoting PTG, Anderson et al. (2012) expressed the need to go beyond rumination of the harmful realities of IPV to focus on survivors' strengths. In her ethnographic research of Latina women who had immigrated to the U.S., Bloom (2021) found that survivors of IPV found PTG through a deeper relationship with God through the teachings of evangelical Christianity. Through "finding community support and spiritual meaning through evangelical conversion," suffering took on a new meaning that promoted PTG (Bloom, 2021, p. 627.)

IPV is a traumatic event or series of events that play a significant role in inducing the positive aspects of religiosity and spirituality that utilize the victims' core belief system to empower them to strengthen their relationship with God and reconnect to the meaning and purpose he offers (Bloom, 2021; Fowler & Rountree, 2010; Simonic, 2020; Tedeschi & Calhoun, 2004).

The literature identifies aspects of spirituality and faith that can either empower or impede recovery through both positive and negative forms of religious coping (Bloom, 2021; Simonic, 2021). Women who view God, their spirituality, and their religious community as accepting, supportive, and confirming tend to develop positive meanings from their traumatic experiences,

compared to women who have a negative association with the components of religious faith (Harris et al., 2011).

While trauma can undergird one's distorted religious beliefs, it can also be the catalyst for strengthening well-organized religious schemas (Tedeschi & Calhoun, 2004). The concept of personal growth through Christianity's redemptive and restorative teachings is not new (Pals & McAdams, 2004; Tedeschi & Calhoun, 2004). Ancient teachings from the Bible affirm, "I [The Lord] will give you a new heart and put a new spirit within you; I will remove your heart of stone and give you a heart of flesh" (Ez 36:26, NKJV); "See, I am doing a new thing! Now it springs up; do you not perceive it? I am making a way in the wilderness and streams in the wasteland" (Is 43:19, NIV); "This means that anyone who belongs to Christ has become a new person. The old life is gone; a new life has begun!" (2 Cor 5:17, NLT).

Spirituality and religion can significantly promote PTG in women of faith who have endured IPV (Bloom, 2021; Jayasundara et al., 2017; Simonic, 2020, 2021). Bryngeirsdottir et al. (2022) suggest that female IPV survivors achieve PTG as they address "personal, inner growth and the reconstruction of themselves" (p. 14). For Christians, this would involve discovering God's design for their lives, including establishing their identity in Christ (Gen 1:27; Jer 1:5; 29:11; Ps 139; 1 Cor 12:27; 1 Pet 2:9; Gal 3:27-29; 1 John 3:1-2; Col 3:1-3; Johnson, 2007; Lambert, 2016). Victims have recognized that the spiritual component that promotes healing from adversity is a deep, personal relationship with God, which brings transformation of their minds and recovery of value, meaning, and purpose in life (Anderson et al., 2012; Bloom, 2021; Fowler & Rountree, 2010; Simonic, 2020). Noviyanti et al. (2019) report the unfortunate lack of female victims of IPV who seek to discover meaning in life as a pathway to healing.

When Christian women experience IPV, they tend to rely on their core spiritual beliefs or seek guidance through their local ministry leadership to sustain them through periods of domestic violence (Band-Winterstein & Freund, 2018; Shaw et al., 2022). Simonic (2020) concluded that there are plenty of existing resources in the Christian tradition to make significant progress toward preventing and ending IPV (Simonic, 2020). However, there is an excellent need for scientifically validated resources that incorporate spirituality when addressing IPV to promote post-abuse growth (Bloom, 2021; D'Amore et al., 2021; Drumm et al., 2014; Leo et al., 2021; Pandya, 2017).

Summary

The proposed study aims to provide a biblically based intervention for IPV that promotes PTG in Christian women victimized by IPV. The PDP (intervention) seeks to rebuild women's shattered belief system by restoring a scripturally sound understanding of God, his design for human beings, the depravity of man, the love of the Savior, and the transformative work of the Spirit. A thorough review of the literature has been synthesized to support using the Assumptive Worldview theory (Janoff-Bulman, 1989) and Posttraumatic Growth Theory (Tedeschi & Calhoun, 1996) within a Christian worldview. Other literature has been extrapolated to reveal the severe nature of IPV, particularly in women, along with the special concerns of Christian women. The literature review offers a brief look at the causes of IPV-related trauma, including PTSD, moral injury, and shattered assumptions, along with the literature that supports the use of spirituality and particularly evangelical Christian principles in promoting PTG. Gaps have been revealed to encompass the need for more literature on promoting PTG in women victimized by

IPV, with a special need for spiritual components within the interventions evaluated for counseling practice.

CHAPTER THREE: METHODS

Overview

An examination of the literature reveals the severity of issues women can experience due to IPV (Black et al., 2011; Breiding et al., 2015; Leemis et al., 2022). The research affirms the PTG theory (Tedeschi & Calhoun, 1996) that a traumatic event can produce a transformative change in the victim's life by challenging their assumptive world in a manner that brings about the positive reconstruction of a new state of normalcy (Janoff-Bulman, 1989; Tedeschi & Moore, 2021) Additionally, the efficacy of evangelical Christian psychoeducation to promote PTG in Christian women victimized by IPV has been empirically proven (Bloom, 2021; Leo et al., 2021; Simonic, 2020, 2021). The problem is the lack of empirically validated interventions that offer spiritual solutions to promote posttraumatic growth (PTG) in women of faith who seek to recover from IPV (Bloom, 2021; D'Amore et al., 2021; Leo et al., 2021; Pandya, 2017; Simonic, 2020). Therefore, the study explored a biblically based PDP to promote PTG in Christian women IPV survivors.

Chapter three describes the methodology used for the study, beginning with a description of the study design, research questions, and hypotheses. This chapter further explains the involvement of participants and instrumentation. The final section illuminates the study procedures and data analysis with a closing summary.

Design

A pretest-posttest within-subjects design (Heppner et al., 2016) was used to evaluate the changes observed in this study following the implementation of the PDP intervention. The study used a convenience sample of women who self-selected participation in a 3-hour spiritually integrated PDP group study for survivors of IPVW who identify with an evangelical Christian

worldview. The study assessed the effect of one predictor variable and one moderating variable on one criterion variable with five subscales. The predictor variable (S-IPV) and moderator (T-IPV) were measured by pretest only. The criterion variable (PTG) was measured pretest and posttest.

Research Questions

RQ1: Does the PDP improve any of the subscales of PTG in Christian women who have suffered IPV?

RQ2: Does T-IPV moderate the relationship between S-IPV and PTG?

Hypotheses

Ho1: The PDP does not improve in any of the five subscales of PTG in Christian women who have suffered IPV.

Ha1: The PDP improves one or more of the five subscales of PTG in Christian women who have suffered IPV.

Ho2: There is no relationship between S-IPV and PTG for T-IPV to moderate.

Ha2: T-IPV moderates the relationship between S-IPV and PTG and reflects the greatest effect in T-IPV Stage 1, with diminishing effects in Stage 2 and beyond.

Participants and Setting

Liberty University Institutional Review Board (IRB) approval was granted before participant recruitment began (see Appendix I). The sample size for RQ1 was determined to be 45 using G*Power (Figure 1) with a .95 statistical power and alpha set at .05 to provide a medium effect size (Faul et al., 2007). However, a sample size of 50 was necessary to achieve a boot effect size of .59 and a power of .77 (Wiedmaier, 2017; Table 1). Therefore, the study

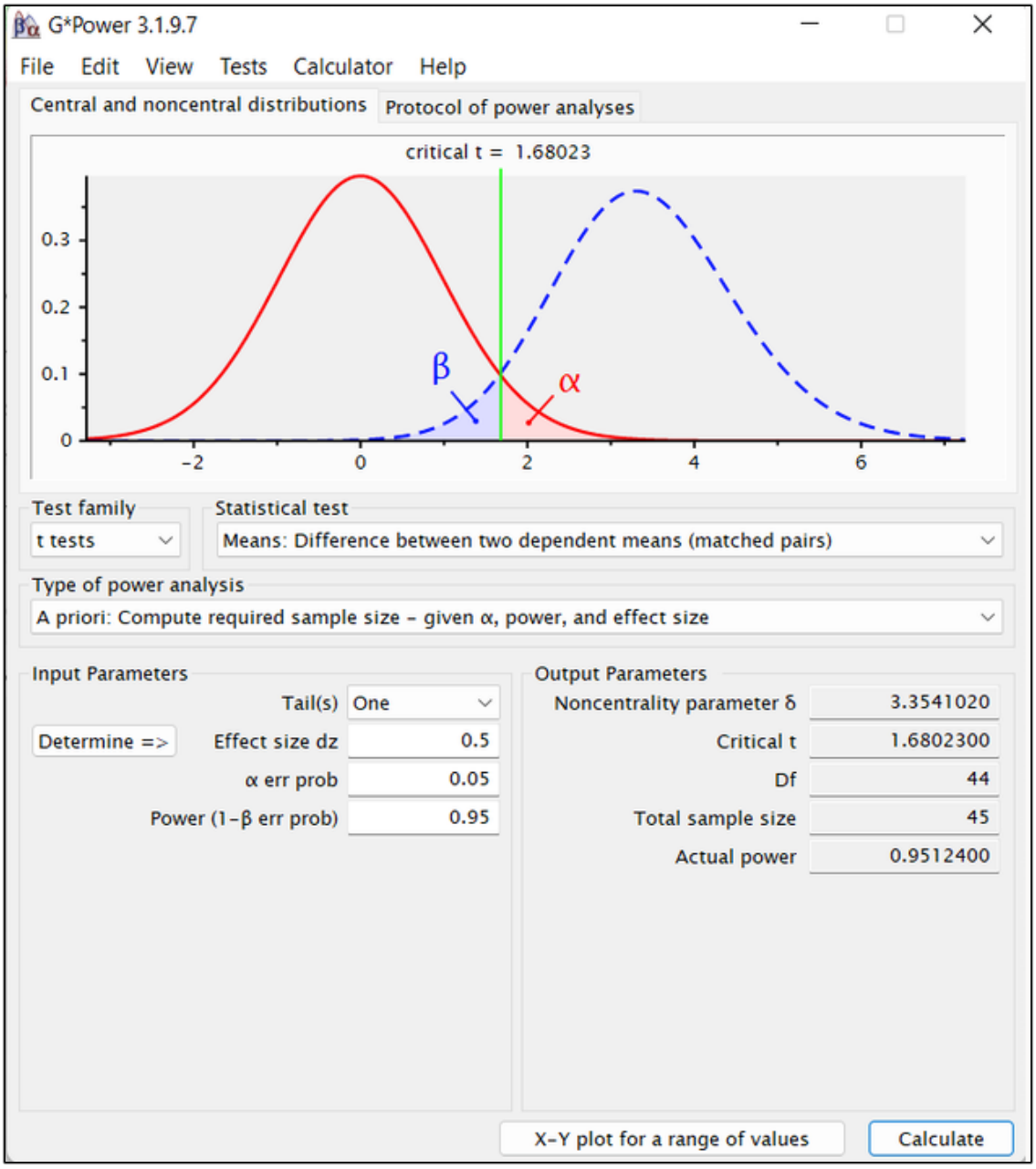
aimed to enlist 60 participants, 20% more participants than needed to allow for dropouts and data collection errors.

A convenience sample (Warner, 2013) was used to assemble the population for this study. The study included a total of nine adult women, ages 30 to 69 years, who identified as Christian and indicated a personal history of IPV with no occurrences in the last 12 months. Women who did not meet these qualifications were excluded from participation. Two participants dropped out before completing the study, leaving a total of seven participants ($N = 7$).

Participants were recruited through several Christian churches located within one county in the Southeastern U. S., which were asked to send invitations to women on their membership rolls to advertise the study. The membership of these churches represents a diversity of races, including White, Black, Hispanic, and others, as well as various Christian denominational affiliations. However, only white, non-Latino women participated in part or in whole. Participants were asked to sign up and complete all forms using the private web portal to assure anonymity and to attend a 3-hour lecture-style PDP facilitated by a researcher-trained adult female. There was no compensation for participation and no cost incurred by participants for study materials. In appreciation for participation in the study, snacks and gift bags were provided to attendees at the PDP.

Figure 1

*G*Power Sample Size for RQ 1*



This graph indicates a sample size of 45 was needed to address research question one with statistically significant power of 0.95.

Table 1

Wiedmaier (2017) Table for RQ2 Sample Size

TABLE 3
Type I Error Rates and Empirical Power for Model 1

Test	*Regression Coefficients*	*Sample Size* 50	100	200	500	1000
first	.00	.000	.000	.000	.000	.000
first	.14	.001	.005	.046	.316	.792
first	.39	.210	.613	.975	1.000	1.000
first	.59	.710	.978	1.000	1.000	1.000
second	.00	.000	.000	.000	.000	.000
second	.14	.001	.003	.040	.282	.769
second	.39	.187	.588	.972	1.000	1.000
second	.59	.689	.976	1.000	1.000	1.000
boot	.00	.000	.002	.001	.003	.000
boot	.14	.015	.031	.140	.514	.852
boot	.39	.322	.720	.977	1.000	1.000
boot	.59	.769	.983	1.000	1.000	1.000
bc	.00	.003	.007	.005	.007	.005
bc	.14	.030	.065	.223	.623	.891
bc	.39	.414	.786	.982	1.000	1.000
bc	.59	.818	.987	1.000	1.000	1.000
bca	.00	.003	.007	.005	.007	.005
bca	.14	.030	.065	.223	.623	.891
bca	.39	.414	.785	.982	1.000	1.000
bca	.59	.818	.987	1.000	1.000	1.000

Note. In this and subsequent tables, *first* refers to tests using first-order standard errors, *second* to second-order standard errors, *boot* to rejection rates using percentile-based bootstrapped confidence intervals, *bc* to bias-corrected limits, and *bca* to bias-corrected and accelerated limits.

This table indicates a sample size of 50 was needed to to achieve a boot effect size of .59 and a power of .77 to test research question two.

Instrumentation

The study involves one predictor variable (S-IPV), one moderating variable (T-IPV), and one criterion variable (PTG). The *Intimate Partner Violence Checklist* (Zukauskiene et al., 2021a) will be used to measure S-IPV, and the *Posttraumatic Growth Inventory* (Tedeschi & Calhoun, 1996) will measure PTG. One question from the demographic survey will provide the measure for T-IPV.

Intimate Partner Violence Checklist

The 21-item *Intimate Partner Violence Checklist* (IPVC; see Appendix A) was developed by Zukauskiene et al. (2021a) based on the Composite Abuse Scale (CAS; Ford-Gilboe et al., 2016) and the Scale of Economic Abuse (Adams et al., 2008). Variations of these scales have been validated for use beginning with the 74-item CAS (Hegarty et al., 1999), the 38-item CAS (Hegarty et al., 2005), the 15-item CAS (Revised) Short Form (CAS_R-SF; Ford-Gilboe et al., 2016), the 21-item IPVC (Zukauskiene et al., 2021a) and the 16-item IPVC (Zukauskiene et al., 2021b).

The Zukauskiene et al. (2021a) IPVC measures four categories of domestic violence, including psychological violence (8 items, e.g., “Screamed and yelled at you”), physical violence (5 items, e.g., “Pushed, grabbed or shoved you”), sexual violence (3 items, e.g., “Intimately touched you when you did not want to”), and economic abuse (5 items, e.g., “Demanded to know how your money was spent”). Dummy variables were created to establish total results for each category of the IPVC (sexual, physical, economic, psychological, and total combined score) and rated separately for levels of violence to be measured (Zukauskiene et al., 2021a). Cronbach’s alpha coefficients for the subscales ranged from .81 to .90 (Zukauskiene et al., 2021a), which reflects a high level of internal consistency (Tavakol & Dennick, 2011). Results were scored by

dividing the sum of all answers by the total possible points (147) to reflect a percentage of the total level of severity experienced (see email correspondence in Appendix A).

Posttraumatic Growth Inventory

The PTGI (see Appendix B) is a 21-item scale for "assessing positive outcomes reported by persons who have experienced traumatic events" (Tedeschi & Calhoun, 1996, p. 455). The PTGI includes five subscales measuring personal strength, new possibilities, improved relationships, spiritual growth, and appreciation for life (Tedeschi, 2020). Embedded within these five factors are specific obstacles for posttraumatic growth mentioned in existing literature, such as loss of meaning and purpose in life (Fowler & Rountree, 2010; Hill & Pargament, 2003; Peres et al., 2007), broken self-identity (Bryngeirsdottir & Halldorsdottir, 2022), and shattered assumptive worldview (Janoff-Bulman, 1989). Tedeschi and Calhoun (1996) found that women report more significant growth than men, and people who have experienced trauma tend to report more positive change than those who have not experienced such events (Tedeschi & Calhoun, 1996). The PTGI measures how well individuals can reconstruct or strengthen their posttraumatic "perceptions of self, others, and the meaning of events" (Tedeschi & Calhoun, 1996, p. 455).

The PTGI is an "open-source measure that features clear administration and scoring procedures" (Lenz et al., 2021, p. 116). The instructions for completing the PTGI can be modified to apply to the specific trauma or crisis being measured (Tedeschi et al., 2017), such as IPV. Statements are quantified using a Likert-type scale ranging from 0 = "I did not experience this change as a result of my crisis" to 5 = "I experienced this change to a great degree as a result of my crisis." Items include "I changed my priorities about what is important in my life," "I have a greater feeling of self-reliance," "I have a better understanding of spiritual matters," "I have a

stronger religious faith," "I feel more connected with all of existence." The scale was scored by averaging the total points from all responses, and subscales scores were achieved by totaling all responses for each factor, as indicated on the administrator's copy of the form (see Appendix B; Tedeschi et al., 2017).

The PTGI has been used since its inception in 1996, including, but not limited to, more recent researchers Taku et al. (2008), Jin et al. (2014), Tedeschi et al. (2017), and Lenz et al. (2021). In Lenz et al. (2021) evaluation of the reliability coefficients for the degree to which the PTGI could be generalized across participants and study data, meta-analysis resulted in "observed and predicted mean alpha coefficients ranging from acceptable to excellent" (Lenz et al., 2021, p. 106). While there was a release of the PTGI expanded version (PTGI-X; Tedeschi et al., 2017), the original version of the PTGI continues to be the "measure of choice" among clinicians and researchers wishing to evaluate the construct of PTG (Lenz et al., 2021, p. 107).

A review of 259 documents selected for inclusion yielded a total of 589 alpha coefficients (Lenz et al., 2021). The sample of 266 alpha coefficients (N = 76,327) yielded a value of .941 (95% CI = .939, .943), $\tau^2 < .001$, $p < .001$, indicating an internal consistency of scores within the excellent range and reflecting a range of alpha coefficients between .937 and .944 (Lenz et al., 2021). The mean alpha reliability coefficients and confidence intervals reflected a range in precision from excellent (PTGI Total) to good (Relating to Others, New Possibilities, Personal Strength, Spiritual Change) and acceptable (Appreciation for Life; Lenz et al., 2021).

The PTGI total score reflected a high level of precision for prediction intervals for reliability estimates of scale scores, but subscales indicated less consistency, ranging from 1%-6% of the scale range (Lenz et al., 2021). The values of reliability for PTGI subscales are suitable for basic research, based on Nunnally and Bernstein (1994), but only "the PTGI Total

Scale scores have internal consistency suitable for clinical decision making" (Lenz et al., 2021, p. 116).

Time Since Last Exposure to IPV

Participant answers to one question from the demographic survey were used to measure the mediating effects of time on PTG: *How long has it been since you last experienced partner abuse?* The question offered four stages for identifying the distance of time since last exposure to IPV: Stage 1 - 1 to 2 years; Stage 2 - 3 to 5 years; Stage 3 - 6 to 10 years; Stage 4 - 10 years or more. Previous research reports higher rates of PTG begin occurring when the abuse ends (Cobb et al., 2006; Tedeschi and Calhoun, 1995). Other research indicates higher rates of PTG within the first two years after abuse is resolved (Anderson et al., 2012; Bakaityte et al., 2022).

Procedures

Ethical research standards were maintained throughout the study, which was conducted according to the guidelines set by Liberty University's Institutional Review Board (IRB). The researcher obtained permission to use the proposed assessment scales: IPVC (see Appendix A) and PTGI (see Appendix B). A request was sent to a local pastor (see Appendix C) for permission to use his church as a meeting location for conducting the PDP. The PDP was administered by the researcher-trained PDP leader for the one-time 3-hour event (see Appendix H).

Recruitment of participants and data collection began after the IRB granted permission to conduct the study. Several local churches were asked to distribute participant recruitment flyers (see Appendix D) by email and Facebook at least two weeks prior to the PDP event date and again one week prior to the event. The flyers included information regarding the nature and purpose of the study, with a text link to the research study website.

The website provided the gateway for anonymous participation in the study and access to the consent form, a brief demographic data survey, pretest assessments, and the posttest assessment. Those interested in participating as research volunteers registered using the web portal, which provided the informed consent on the homepage (see Appendix G). They were asked to press a "click here if you agree. . ." button, which was followed by instructions on creating a unique identifier code for use on the remaining forms. This code would not contain any information that could be used to personally identify the participant. Using the unique identifier code allowed the webmaster to connect pretest data to posttest data submitted by each participant while protecting anonymity. This was also done to reduce the possibility of expectation bias from the study participants (Heppner et al., 2016). Upon agreeing to the consent, the participants were guided to answer the qualifying screening questions (see Appendix E). Qualified applicants were directed to create a unique identifier code that contained no personal information and was used on the demographic questions (see Appendix F) and subsequent assessments. Applicants who did not agree with the consent or who answered "no" to any of the qualifying questions were redirected to a "thank you for your interest..." page that thanked them for their interest in the research study and explained the reason for disqualification.

Next, qualified participants were directed to the pretest assessments that required about 20 minutes to complete. The website was made live a day before participant recruitment flyers were distributed. Pretests were allowed to be submitted through February 10, 2023, the night before the PDP event was conducted. At the conclusion of the PDP, the PDP leader made a general announcement to attendees to remind any research participants to return to the website to complete the posttest survey by Sunday, May 12, midnight. In addition, the link to the posttest section of the website was printed on the back of the participant workbooks, and a link was

placed on the homepage of the research website for easy access. The posttest assessment required about 10 minutes for completion.

The independent third-party webmaster downloaded and forwarded the data collected to the researcher via email. Data was assimilated into an Excel spreadsheet using each participant's unique identifier code, which was promptly replaced with a sequential numeric identifier. The anonymous data is now stored on the researcher's secure private computer, where it shall remain for three years, at which time it will be permanently deleted by the researcher. As soon as the researcher verified the readability of the data, the webmaster was instructed to delete all data submitted through the website; this request was completed within hours after the request.

Data Analysis

This study used a paired samples *t* test to analyze RQ1, *Does the PDP improve any of the subscales of PTG in Christian women who have suffered IPV?* This will test the null hypothesis (Ho1) that the PDP does not improve in any of the five subscales of PTG in Christian women who have suffered IPV. The null hypothesis is confirmed if there is no statistically significant difference found in the pretest to posttest between the sample means of all individual scores (Jackson, 2016).

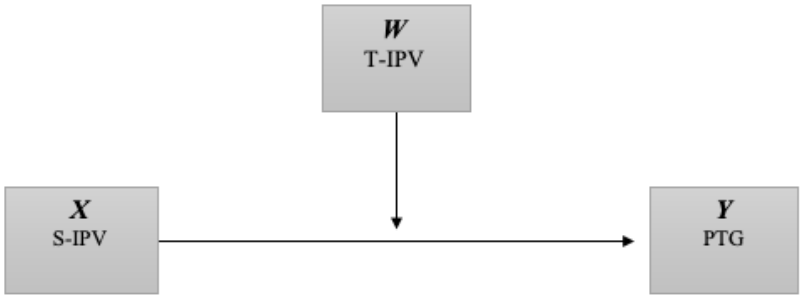
The paired samples *t* test was planned to identify each participant's difference between pretest and posttest scores and the mean of the difference in scores. The paired samples *t* test was an appropriate analysis for RQ1 because it provided the means across scores collected and how they differ under various treatment conditions to evaluate their differences at two points in time (Warner, 2013). Then, the effect size was computed using Cohen's *d* to indicate the role of the criterion (independent) variables on the predictor (dependent) variables (Jackson, 2016). This allowed the 95% confidence interval to be calculated for a one-tailed test (Jackson, 2016). The

researcher anticipated that the mean of the individual difference in scores would reflect a statistically significant increase pretest to posttest in at least one subscale of PTG, which would support Ha1 and reject Ho1.

Using SPSS (Version 4.2), a moderated multiple regression analysis was conducted using the PROCESS macro (Hayes, 2018) to analyze RQ2, *Does T-IPV moderate the relationship between S-IPV and PTG*? The PROCESS macro combines several functions of computational tools such as INDIRECT, SOBEL, MODPROBE, and MODMED, into one single command (Hayes, 2018). Hayes regression Model 1 (see Figure 2) offers a visual of how predictor *X* (S-IPV) and moderator *W* (T-IPV) interact with the criterion variable *Y* (PTG). Moderation tests for interaction between *X* and *W* in a regression analysis that begins with *X* and moves in a linear path toward *Y* that is intercepted by *W* at some point (Hayes, 2018; Warner, 2013). The PROCESS moderation analysis estimates the effects of *X* at each level of *W*. Then the researcher can probe the moderation of *W* using the "pick-a-point approach" to determine if the conditional effect of *X* on *Y* yields different values at zero and other targeted values of *W* (Hayes, 2018, p. 259). If *X*'s effect on *Y* is dependent on *W*, then *X*'s effect on *Y* will be greater than zero at one or more of the specified values of *W*. The significance of that difference will be determined by probing the interaction of two or more values of *W* along the line from *X* to *Y* (Hayes, 2018). A moderation effect of *W* on *X* to *Y* that is greater in Stage 1 and diminishes after Stage 1 will confirm Ha2, that T-IPV moderates the relationship between S-IPV and PTG, and this effect is greatest in Stage 1 and diminishes in Stage 2 and beyond. The null hypothesis (Ho2) is accepted if T-IPV has no moderating effect on the relationship between S-IPV and PTG.

Figure 2

Hayes Process Model 1



In this simple moderation model, W is reflected as a moderator of the X →Y relationship, or X and W interact in their influence on Y.

Summary

This pretest-posttest design tested for differences within groups to measure the effect of the PDP on PTG and evaluate the relationships between three variables: *X* (S-IPV), *W* (T-IPV), and *Y* (PTG). S-IPV was measured by the IPVC (Zukauskiene et al., 2021a), and PTG was measured using the 21-item PTGI with five subscales, including personal strength, new possibilities, improved relationships, spiritual growth, and appreciation for life (Tedeschi & Calhoun, 1996). T-IPV was measured by one item on the demographic data survey *(How long have you lived apart from your abuser?*). The population for the study was Christian women aged 19 and older who have experienced IPV in their lifetime but not within the preceding 12 months. Participants' data were collected anonymously by having the participants create their unique identifier code to be used in conjunction with completing demographic questions and pretest-posttest data on the website. Data were collected online and forwarded to the researcher in an Excel spreadsheet.

Following data screening and assumption testing, data analysis began by conducting a paired samples *t* test to measure the amount of change in total PTG and subscale scores from pretest to posttest. The PROCESS macro (Hayes, 2018) was used to conduct a multiple regression analysis comparing the moderating effect of T-IPV on the relationship between S-IPV and PTG. The goal was to accept both alternate hypotheses, including Ha1, that *the PDP will improve one or more of the subscales of I in Christian women who have suffered IPV*, and Ha2, that *T-IPV moderates the relationship between S-IPV and PTG, and reflects the greatest effect in T-IPV Stage 1, with diminishing effects in Stage 2 and beyond.*

CHAPTER FOUR: FINDINGS

Overview

This study explored the impact of a biblically based PDP toward promoting posttraumatic growth in women, age 19 and older, who identify as Christians and have experienced intimate partner violence but not within the past 12 months. To accomplish this, a pretest-posttest design with intervention was used, the results of which are presented in this chapter. Two research questions and their alternate hypotheses were addressed, beginning with RQ1, which seeks to know if the PDP reflected improvement to any of the subscales of PTG in Christian women who have suffered IPV. The data was also evaluated to discover any moderating effect that T-IPV had on the relationship between S-IPV and PTG. Data analysis included paired samples *t* tests and PROCESS Model 1 linear regression analysis. This chapter provides descriptive statistics, hypotheses, results, and a summary of the data analysis.

Descriptive Statistics

Nine volunteers qualified to participate in this study by self-reporting that they were women, age 19 or older, who identify as Christians and have experienced IPV but not within the past 12 months. All participants completed the informed consent, demographic data, and pretest assessments. Seven participants completed the posttest assessment; data for the two participants who failed to complete the posttest assessment was removed from further analysis. Therefore, the sample size consisted of seven participants. The research data were screened and analyzed using IBM SPSS Statistics (Version 28). Descriptive analyses revealed the race/ethnicity of all participants to be White, Non-Latino. Other options not selected included: Asian; Black, Non-Latino: Latino, any race; and Other. Participants ranged in age from 30 to 69 as follows: age 30 to 39 (28.6%); age 40 to 49 (28.6%), age 50 to 59 (28.6%); and age 60 to 69 (14.3%; see Table

2). Five participants (71.4%) indicated they were married or in a domestic partnership, while two were currently divorced (28.6%); none identified as single, never married (see Table 3). The length of time since last exposure to IPV was self-reported through a one-question survey. Participants selected one of four categories: 1 to 2 years ago (28.6%); 3 to 5 years ago (14.3%); 6 to 10 years ago (42.9%); and 10+ years ago (14.3%; see Table 4).

Table 2

Age of Participants

	Freq.	%
30 to 39	2	28.6%
40 to 49	2	28.6%
50 to 59	2	28.6%
60 to 69	1	14.3%

Table 3

Relationship Status of Participants

	Freq.	%
Married, or in domestic partnership	5	71.4%
Divorced	2	28.6%

Table 4

Participants' Report of Time Since Last Exposure to IPV

	Freq.	%
1 to 2 years	2	28.6%
3 to 5 years	1	14.3%
6 to 10 years	3	42.9%
10+ years	1	14.3%

Results

Data Screening

The data generated on the research website was forwarded to the researcher in an Excel spreadsheet, which was cut and pasted into the IBM SPSS (Version 28) data file. Preliminary data screening included proofreading the SPSS data file with the raw data file for the accurate transfer of numbers. Next, the SPSS data file was screened for errors, missing values, outliers, and inconsistencies (Warner, 2013). SPSS descriptive statistics were used to check for missing values, of which there were none (see Table 5).

Table 5

Descriptive Statistics Reveal No Missing Values

Statistics				
		S-IPV	T-IPV	PTG
N	Valid	7	7	7
	Missing	0	0	0
Mean		44.14	2.43	10.00
Median		56.00	3.00	11.00
Std. Deviation		22.071	1.134	4.320
Skewness		-.330	-.235	-.608
Std. Error of Skewness		.794	.794	.794
Kurtosis		-2.110	-1.227	-.638
Std. Error of Kurtosis		1.587	1.587	1.587
Minimum		14	1	3
Maximum		70	4	15

Considering the small sample size, the researcher also performed a visual inspection of the data for suspicious response patterns or problematic observations, as recommended by Van den Broeck et al., (2005). This was accomplished by reviewing the raw data for straight-lining (respondents choose only 5s), zigzagging (1,5,1,5), and other suspicious patterns. No such

patterns were noted. Outliers were checked using boxplot analyses for S-IPV, T-IPV, PTG; none were identified (see Figures 3, 4, and 5).

Figure 3

S-IPV Boxplot Analysis for Outliers

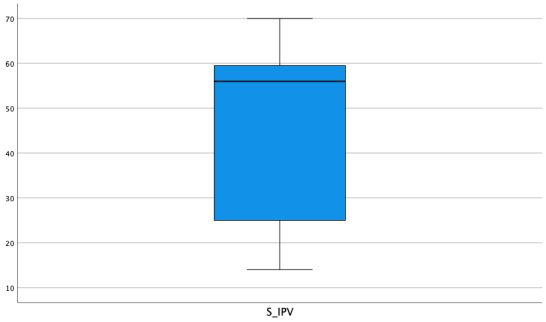


Figure 4

T-IPV Boxplot Analysis for Outliers

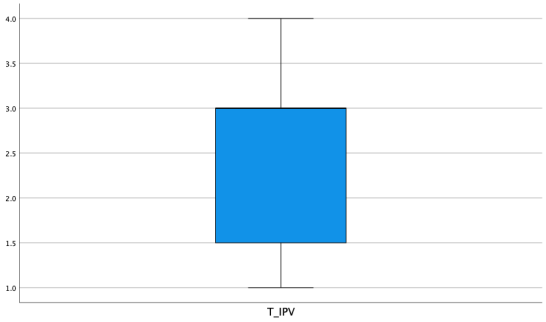
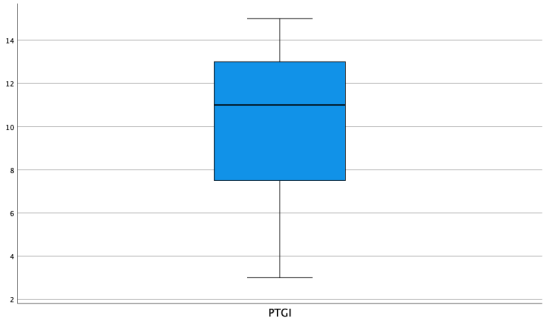


Figure 5

Boxplot Analysis for Outliers of PTG



Internal consistency of the instruments for S-IPV and PTG was evaluated using Cronbach's alpha. According to Warner (2013), Cronbach alpha scores are ranked from acceptable (α = 0.5), to good (α = 0.7), better (α = 0.8), or best (α = 0.9). Because T-IPV was only a one-question instrument, it was not tested for internal reliability. The 21-item IPVC (Zukauskiene et al., 2021b), was used to measure S-IPV only once, prior to attending the PDP. The questionnaire was organized by subcategories, including sexual violence, physical violence, economic violence, and psychological violence. Of the 21 items on the S-IPV assessment, three were removed because they had zero answers, leaving 18 items to confirm internal consistency (α = .86) between better and best rankings (see Table 6).

Table 6

Cronbach's Alpha for S-IPV

Reliability Statistics – S-IPV		
Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.862	.825	18

Cronbach's alpha was conducted on the 21-item PTGI used to measure PTG before and after the PDP. The assessment measured subcategories including relating to others, new possibilities, personal strength, spiritual change, and appreciation for life. Questions were organized in random order. Because the same questionnaire was used pretest and posttest, only one set of questions (pretest) were tested for internal consistency. All 21 items were included in the score (α = 0.63), indicating internal consistency that was between acceptable and good (see Table 7).

Table 7

Internal Reliability of PTG Pretest

Reliability Statistics – PTG Pretest		
Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.631	.634	21

Research Questions

A literature review provided insight for developing two research questions for this study concerning Christian women who desire to recover from the trauma of IPV by utilizing tools and teachings that support their Christian worldview. Because IPV attacks a woman's sense of identity by shattering her assumptive world (Janoff-Bulman, 1989), religion offers a structured belief system that provides a pathway toward PTG as evidenced by rebuilding her worldview (El-Khoury et al., 2004; Fallot & Heckman, 2005; Giesbrecht & Sevcik, 2000; Gillum et al., 2006; Lilly et al., 2015; Simonic, 2020). The problem is the lack of empirically validated interventions that offer spiritual solutions to promote PTG in Christian women who have survived IPV (Bloom, 2021; Leo et al., 2021; Pandya, 2017; Simonic, 2020). This knowledge has driven the researcher to evaluate the efficacy of a biblically based PDP for promoting PTG in Christian women who have experienced IPV. The study also seeks to know if T-IPV moderates the relationship between S-IPV and PTG. Data analysis begins with the hypothesis for research question one.

Hypothesis One

This section seeks to answer RQ1: *Does the PDP improve any of the subscales of PTG in Christian women who have suffered IPV?* and to test the null hypothesis.

Ho1: The PDP does not improve in any of the five subscales of PTG in Christian women who have suffered IPV.

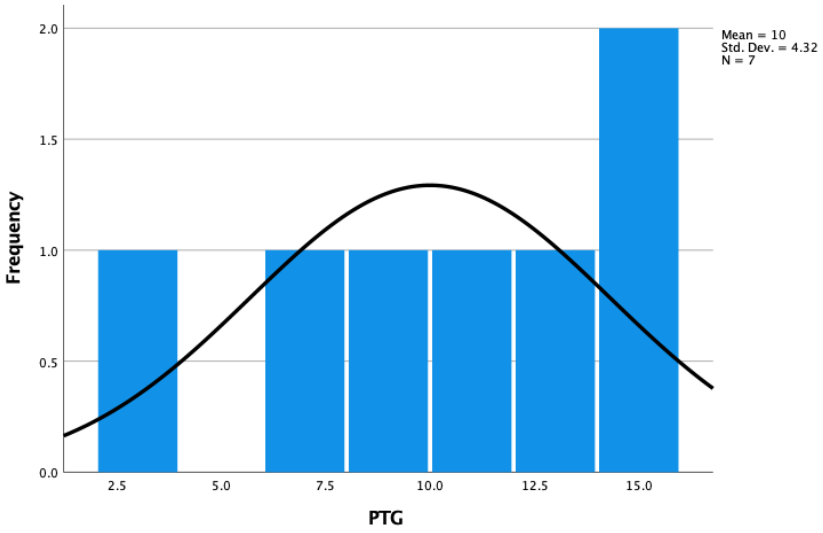
Ha1: The PDP improves one or more of the five subscales of PTG in Christian women who have suffered IPV.

Assumptions for t-Test

In a within-groups quantitative design, a paired samples *t* test is used to compare scores from the same participants at two or more points in time (Jackson, 2016). Assumptions for evaluating the statistical significance of the *t* ratio are based on the criterion (outcome) variable, PTG, being quantitative, interval/ratio, and approximately normally distributed (Warner, 2013). Since PTG is a quantitative, interval/ratio variable, description analysis was performed to gain visual and statistical confirmation of the normality of distribution. Histograms for PTG pretest and posttest scores provide a visual presentation of the data's bell shape, which appears mostly normally distributed (see Figure 6).

Figure 6

Histogram of PTG



To confirm the visual test for normalcy, descriptive statistics determined PTG to be somewhat positively skewed (-.608) and slightly platykurtic (-.638), though it is within the normal range (see Table 8). According to Hair et al. (2022), skewness and kurtosis are said to be in an excellent range when values fall between +1 and -1; generally acceptable between +2 and -2; and non-normal for anything beyond +2 and -2.

Table 8

Descriptive Statistics for PTG

	N	Min.	Max.	Mean	S.D.	Skewness		Kurtosis	
						Statistic	S.E.	Statistic	S.E.
PTG	7	3	15	10.00	4.320	-.608	.794	-.638	1.587
Valid N (listwise)	7								

Warner (2013) states skewness and kurtosis may be unreliable for a sample size of $N < 30$. When working with a small sample size, Krithikadatta (2014) recommends using the Kolmogorov-Smirnov test to check for normalcy. Results of the Kolmogorov-Smirnov test for PTG ($p = .200$) reject the null hypothesis for non-normal distribution and confirm previous testing that PTG is normally distributed (see Table 9). Additionally, the Shapiro-Wilk score affirms rejection of non-normal distribution ($p = .746$).

Table 9

PTG Difference Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
PTG	.163	7	.200*	.952	7	.746

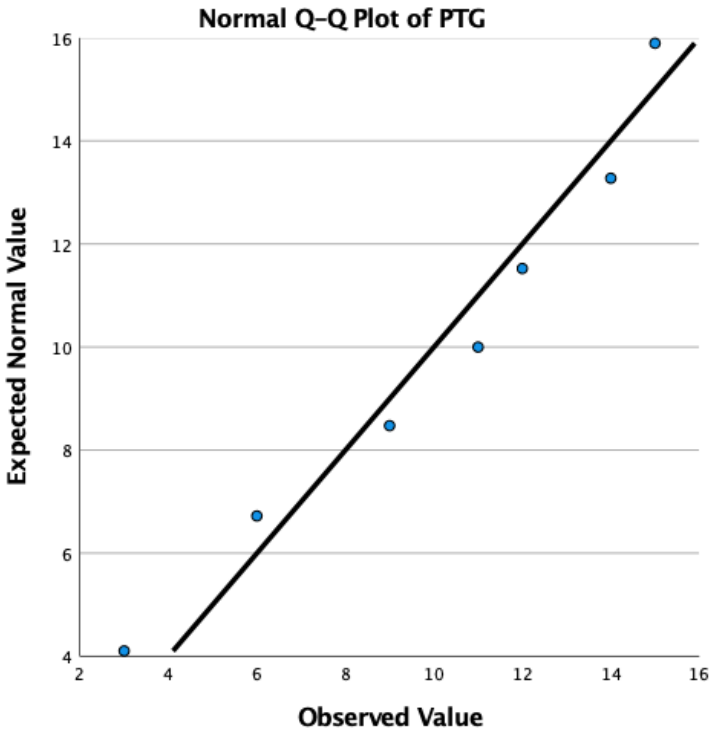
*. This is a lower bound of the true significance.

a. Lilliefors Significance Correction

Final confirmation for normal distribution can be seen in the Q-Q Plot, where the observed values reveal slightly negative skewing that will still be considered within the normal range (see Figure 7).

Figure 7

Normal Q-Q Plot of PTG



Data Analysis

The PTGI was completed twice, pretest and posttest. Measurements were analyzed for total PTG and totals of each of the five subscales, including (1) relating to others, (2) new possibilities, (3) personal strengths, (4) spiritual change, and (5) appreciation for life (Tedeschi & Calhoun, 1996). The score of the subscales ranges from 1 to 5, with the higher score corresponding to greater agreement with the subscale. To evaluate whether the PDP had a positive impact on promoting PTG in Christian women who have experienced IPV, a paired

samples *t* test was conducted to compare PTG scores reported before the PDP and after the PDP was administered. There was a significant difference in the scores for PTG pretest (M = 165.17, SD = 174.56) and posttest (M = 188.83, SD = 198.25) conditions; $t(5) = -2.41$, $p = .030$ (one-sided; See Tables 10 and 11). There was a positive change in PTG following attendance of the PDP: pretest score (M = 165) minus the posttest score (M = 189) equals the difference of -14.

Table 10

PTG Paired-Samples Statistics – Pretest/Posttest Totals

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Pretest	165.17	6	174.557	71.263
	Posttest	188.83	6	198.246	80.933

Table 11

PTG Paired-Samples Results for Pretest/Posttest Totals

		Paired Differences					*t*	*df*	Significance	
					95% Confidence Interval of the Difference				One-Sided *p*	Two-Sided *p*
		Mean	*SD*	*SE*	Lower	Upper				
Pair 1	Pretest - Posttest	-23.667	24.064	9.824	-48.920	1.587	-2.409	5	.030	.061

Additional testing reveals a statistically significant change in four of the five subscales on the 5% level of alpha (one-tailed): relating to others, $t(6) = -2.15$, $p = .038$; new possibilities, $t(6) = -3.72$, $p = .005$; personal strength, $t(6) = -3.38$, $p = .007$; and spiritual, $t(6) = -3.87$, $p = .004$ (see Table 12). Only one subscale failed to show significance in change: appreciation for life, $t(6) = -.826$, $p = .220$. These results reject the null hypothesis, that the PDP does not improve in any of the five subscales of PTG in Christian women who have suffered IPV, and the alternate hypothesis is accepted, that the PDP improves one or more of the five subscales of PTG in Christian women who have suffered IPV.

Table 12

Paired-Samples t-Test Output for PTG Subscales

		Paired Differences							Significance	
					95% *CI* of the Difference				One-Sided *p*	Two-Sided *p*
		Mean	*SD*	*SE*	Lower	Upper	*t*	*df*		
Pair 1	RelatingPre - Post	-3.000	3.697	1.397	-6.419	.419	-2.147	6	.038	.075
Pair 2	NewPossPre - Post	-3.429	2.440	.922	-5.685	-1.172	-3.718	6	.005	.010
Pair 3	StrengthPre - Post	-2.429	1.902	.719	-4.188	-.669	-3.378	6	.007	.015
Pair 4	SpiritualPre - Post	-.714	.488	.184	-1.166	-.263	-3.873	6	.004	.008
Pair 5	AppforLifePre - Post	-.714	2.289	.865	-2.831	1.402	-.826	6	.220	.441

Hypothesis Two

This section seeks to answer RQ2: *Does T-IPV moderate the relationship between S-IPV and PTG?* and to test the null hypothesis.

Ho2: There is no relationship between S-IPV and PTG for T-IPV to moderate.

Ha2: T-IPV moderates the relationship between S-IPV and PTG and reflects the greatest effect in T-IPV Stage 1, with diminishing effects in Stage 2 and beyond.

Assumption Testing for Moderated Multiple Regression Analysis

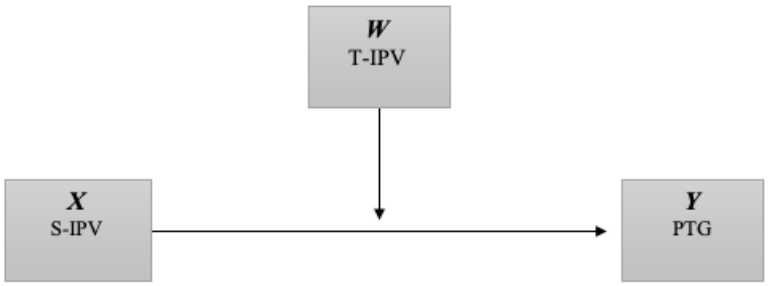
A moderation analysis is used to determine whether a particular variable (T-IPV) influences or is related to the size of another variable's (S-IPV) effect on the dependent variable (PTG; Hayes, 2018). Moderation, interaction) uses linear regression analysis to estimate the moderated effects (Hayes, 2018). This study seeks to determine whether T-IPV influences S-IPV and its effect on PTG, and if so, what levels of T-IPV are most impactful.

The moderation analysis was tested using the Hayes PROCESS macro (version 4.2) in SPSS. Three scales were analyzed to address Hypothesis Two: PTG, S-IPV, and T-IPV (see Figure 8). More assumptions were tested for this moderation analysis, including screening the data for multivariate outliers and assessing the data for normal distribution, linearity

(noncollinearity), homogeneity of variance (homoscedasticity), and homogeneity of regression slopes (collinearity).

Figure 8

Conceptual Diagram for Hayes Process Model 1



In this simple moderation model, W is reflected as a moderator of the X →Y relationship, or X and W interact in their influence on Y.

Multivariate Outliers

Data were screened for multivariate outliers using the Mahalanobis *d* statistical test (Leys et al., 2018; Mahalanobis, 1936). Three variables were evaluated, PTG, S-IPV, and T-IPV, based on a chi-square distribution of $p < .001$. Mahalanobis *d* ranged from 3.1246 to .3423, all of which were above $p < .001$, indicating no outliers were identified (see Table 12).

Table 13

Mahalanobis d Test for Multivariate Outliers - PTG, S-IPV, T-IPV

Mah_d	ProbMah_d	Outlier
3.12494	.20962	.0000
2.33384	.31132	.0000
2.18168	.33593	.0000
1.93567	.37991	.0000
1.61095	.44688	.0000
.47065	.79032	.0000
.34227	.84271	.0000

Normality of Distribution

With multiple regression analysis, the *Y* criterion variable should be quantitative with scores that are normally distributed. PTG was tested for normal distribution under Hypothesis One and found to be within normal range. The multivariate regression analysis adds two predictor variables which must also be checked for normality of distribution (S-IPV and T-IPV). First, both S-IPV and T-IPV were evaluated for non-normal distribution using the Kolmogorov-Smirnov and Shapiro-Wilk scores. The results indicate non-statistically significant values for both variables, S-IPV (p =.116; p = .170), and T-IPV (p = .149; p = .262), which rejects the hypothesis for non-normal distribution (see Table 14).

Table 14

Test of Normality for S-IPV and T-IPV

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	*df*	*p*	Statistic	*df*	*p*
S_IPV	.276	7	.116	.866	7	.170
T_IPV	.264	7	.149	.887	7	.262

a. Lilliefors Significance Correction

Next, each predictor variable was evaluated for normal distribution. S-IPV was visually evaluated for normal distribution using a histogram (see Figure 9) and Q-Q plot (see Figure 10). Both graphics reveal a somewhat normal-looking distribution for S-IPV.

Figure 9

Histogram of S-IPV

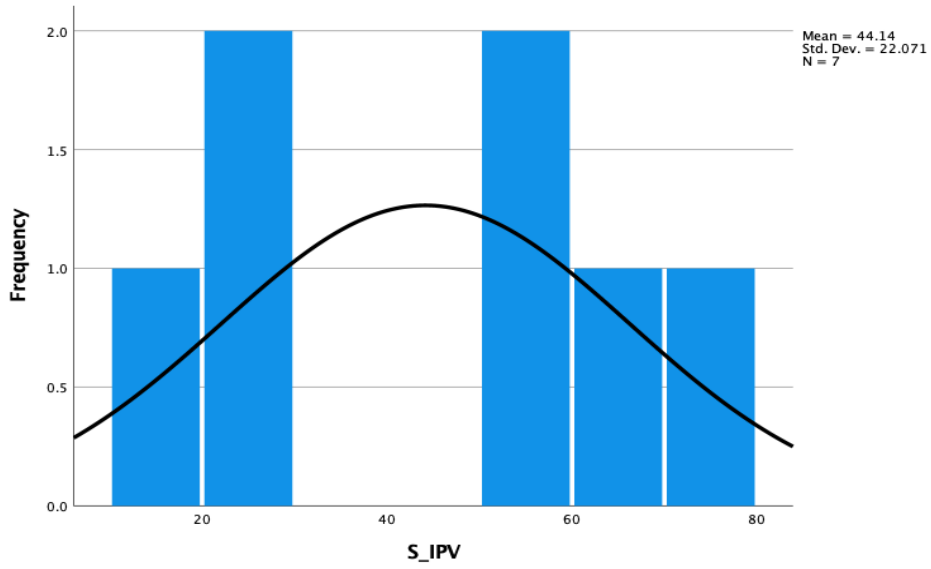
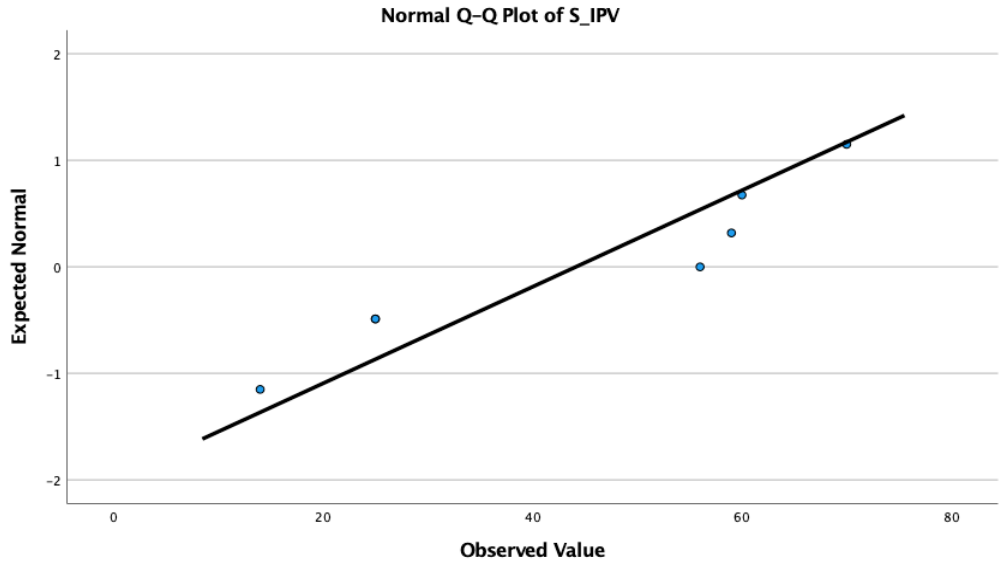


Figure 10

Q-Q Plot of S-IPV



Descriptive statistics reflect S-IPV to be slightly positively skewed (-.330) but well within the range for normal distribution (+2 to -2; Hair et al., 2022). The platykurtic value for S-IPV (-2.110) is beyond generally acceptable to being somewhat flat (see Table 15).

Table 15

Descriptive Statistics for S-IPV

	N	Min.	Max.	Mean	*SD*	Skewness		Kurtosis	
						Statistic	*SE*	Statistic	*SE*
S-IPV	7	14	70	44.14	22.071	-.330	.794	-2.110	1.587
Valid N (listwise)	7								

The moderating predictor variable (T-IPV) was also evaluated for normality of distribution using a histogram (see Figure 11) and Q-Q plot (see Figure 12). Both graphics revealed a normal distribution for T-IPV.

Figure 11

Histogram for T-IPV

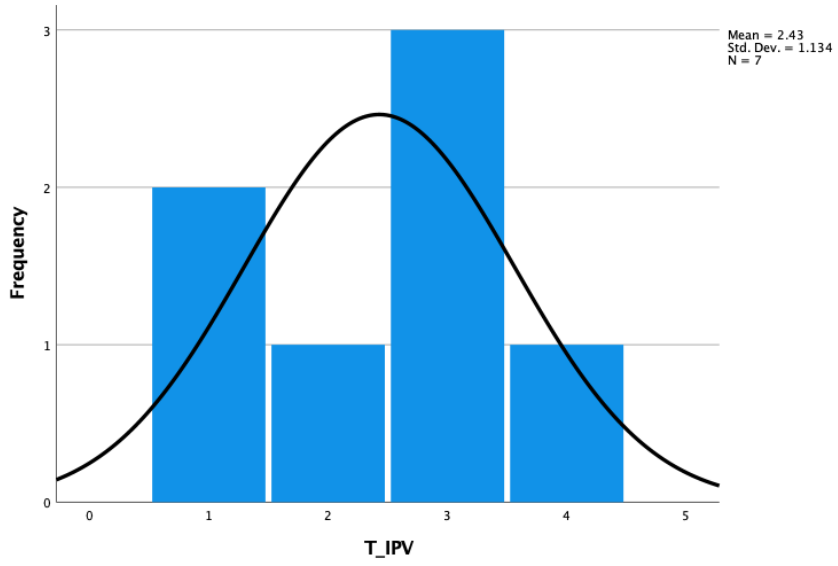
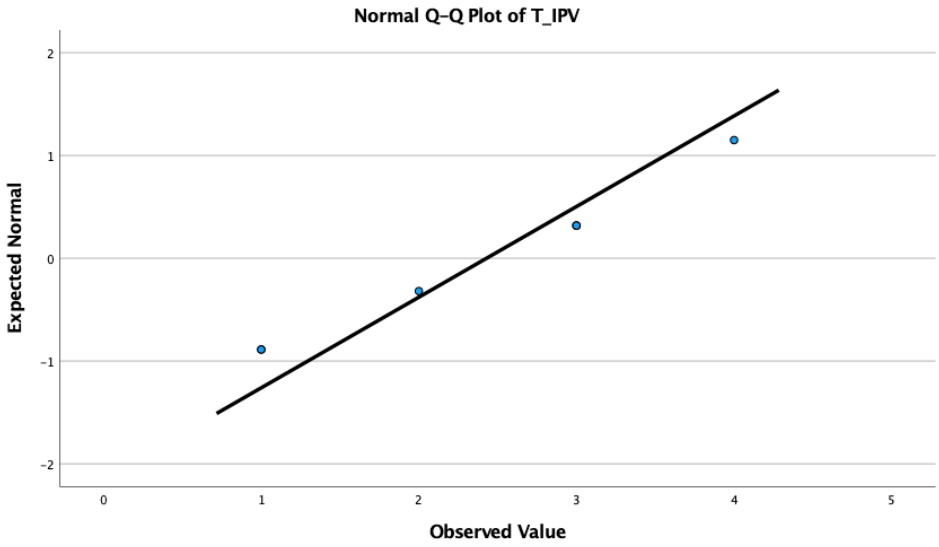


Figure 12

Q-Q Plot of T-IPV



Descriptive statistics reflect T-IPV to be slightly positively skewed (-.235) but well within the range for normal distribution (+2 to -2; Hair et al., 2022). The platykurtic value for T-IPV (-1.227) is generally acceptable (see Table 16).

Table 16

Descriptive Statics for T-IPV

	N	Min.	Max.	Mean	*SD*	Skewness		Kurtosis	
						Statistic	*SE*	Statistic	*SE*
T-IPV	7	1	4	2.43	1.134	-.235	.794	-1.227	1.587
Valid N (listwise)	7								

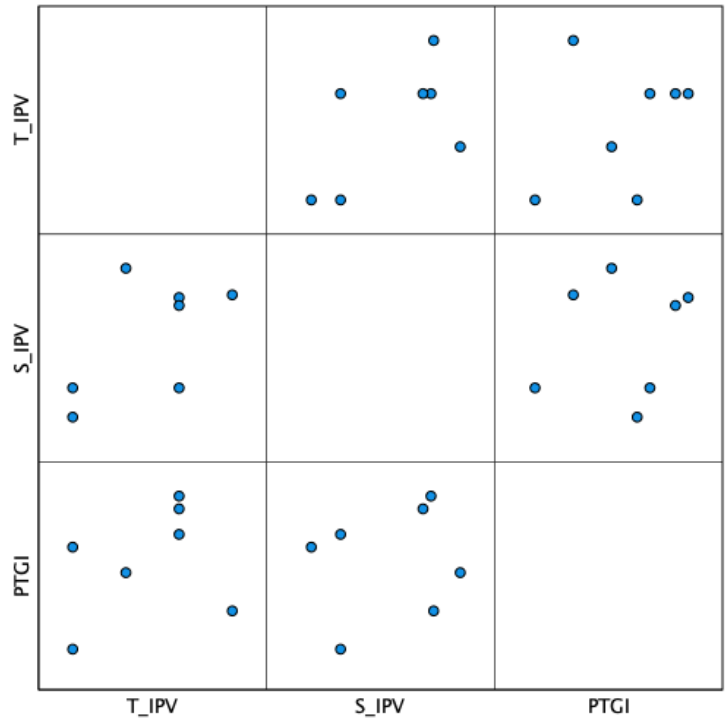
Linearity

Warner (2013) deems the assumption of linearity can be assessed by visually examining bivariate scatter plots for all possible combinations of variables: (S-IPV, T-IPV), (S-IPV, PTG, and (T-IPV, PTG). Using the matrix scatter plot feature in SPSS, one diagram of all pairs of

variables can be seen at once (see Figure 13). However, the small sample size causes difficulty in finding linearity from the scatter plots.

Figure 13

Matrix of Scatter Plots for PTG, S-IPV, and T-IPV



Note: The matrix of scatter plots provides visuals for every combination of the variables.

Cook's Distance is designed to detect the influence of one variable over another variable in a linear regression model (Cook, 2000). Values for Cook's Distance are considered non-influential when they are less than 1.0 (PennState Eberly College of Science, n.d.). SPSS residual statistics for this multivariate regression model reveal Cook's Distance minimum (.013) and maximum (.730) values reflect no undue influence of one variable on another in this regression analysis. Therefore, linearity is assumed (see Table 17).

Table 17

Residual Statistic for Regression Analysis

Residuals Statistics[a]					
	Minimum	Maximum	Mean	*SD*	*N*
Predicted Value	8.34	11.84	10.00	1.324	7
Std. Predicted Value	-1.253	1.390	.000	1.000	7
Standard Error of Predicted Value	2.252	4.103	3.236	.686	7
Adjusted Predicted Value	5.67	16.92	10.49	3.420	7
Residual	-5.839	4.357	.000	4.113	7
Std. Residual	-1.159	.865	.000	.816	7
Stud. Residual	-1.586	.980	-.040	1.051	7
Deleted Residual	-10.924	5.595	-.490	6.903	7
Stud. Deleted Residual	-2.253	.974	-.193	1.264	7
Mahal. Distance	.342	3.125	1.714	1.007	7
Cook's Distance	.013	.730	.223	.268	7
Centered Leverage Value	.057	.521	.286	.168	7

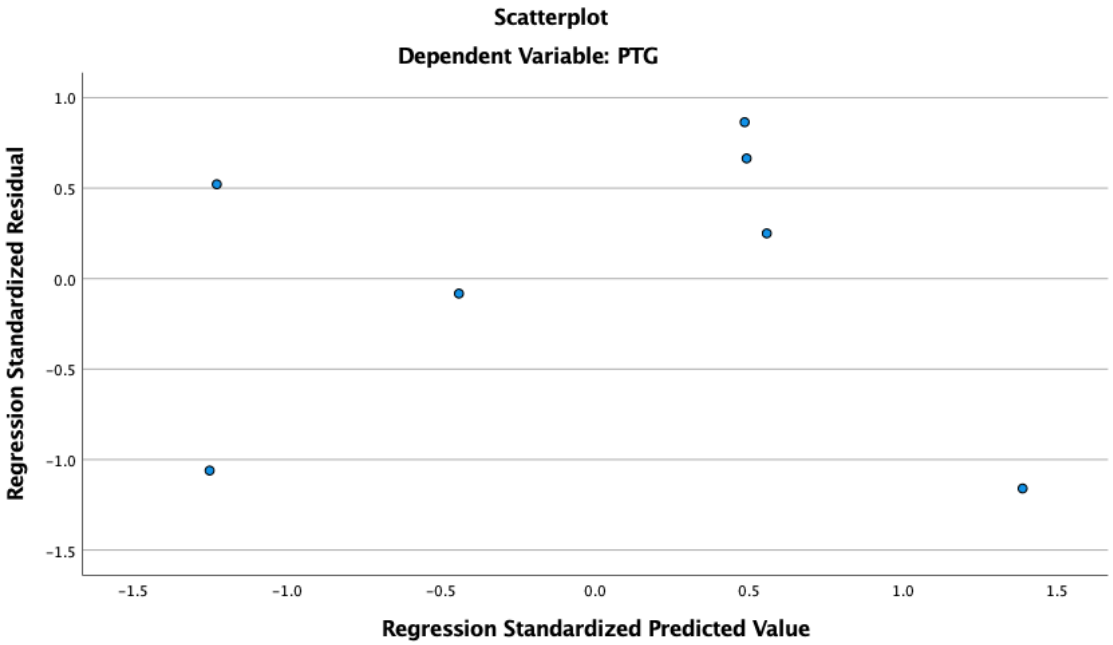
a. Dependent Variable: PTG

Homogeneity of Variance (Homoscedasticity)

The homoscedasticity plot provides a visual of what appears to be non-clustering or non-bunching of data points, indicating unequal variance or heteroscedasticity (see Figure 14). Heteroscedasticity occurs when the "variance in *Y* scores is greater for some values of *X* than others" which creates an issue with prediction errors (Warner, 2013, p. 166). When the assumption of homoscedasticity is not met, Hayes (2018) recommends selecting the HC3 (Davidson-MacKinnon) option in the PROCESS macro settings to help overcome the failure to determine heteroscedasticity in the data assumption tests (also see Hayes & Cai, 2007). By selecting the HC3 option, the PROCESS macro generates standard errors using "heteroscedasticity-consistent covariance matrix estimators" (p. 576).

Figure 14

Homoscedasticity Plot



Note: Due to small sample size there is non-clustering or non-bunching of data points, which may be an indication of unequal variance or heteroscedasticity

Homogeneity of Regression Slopes (Multicollinearity)

In regression analysis, multicollinearity occurs when predictor variables are closely correlated with other predictor variables such that "the values of one can be accurately predicted by that of another," which produces a confounding situation for the researcher (Johnston et al., 2018, p. 1958). In the multiple regression analysis, the variance inflation factor (VIF) is used to report multicollinearity. A VIF score begins at 1.0 and has no upward limit, and a score of 2.5 or greater indicates significant collinearity, making it challenging to separate the effects of one predictor from another (Johnston et al., 2018). Some researchers consider a VIF value of less than 10 as an indicator of the absence of multicollinearity between predictor variables (Johnston

et al., 2018). Both predictor variables (S-IPV and T-IPV) had VIF scores (1.53 and 1.53) that can conservatively be interpreted as an indication of a lack of collinearity (see Table 18).

Table 18

Multiple Regression Collinearity Statistics

Coefficients[a]								
		Unstandardized Coefficients		Standardized Coefficients			Collinearity Statistics	
Model		B	*SE*	ß	*t*	*p*	Tolerance	VIF
1	(Constant)	7.212	5.152		1.400	.234		
	S_IPV	-.003	.115	-.014	-.024	.982	.652	1.534
	T_IPV	1.199	2.246	.315	.534	.622	.652	1.534

a. Dependent Variable: PTG

Data Analysis for Multivariate Regression

A multiple regression model was tested to evaluate whether T-IPV moderates the relationship between S-IPV and PTG. The PROCESS procedure for SPSS Version 4.2 beta (Hayes, 2022) was used for the regression analysis. The HC3 (Davidson-MacKinnon) option was selected in the SPSS settings to allow the PROCESS macro to generate standard errors using "heteroscedasticity-consistent covariance matrix estimators" (Hayes, 2018, p. 576). This action was recommended by Hayes (2018) to help overcome the failure to determine heteroscedasticity in the data assumption tests. Three variables were used in this Model 1 analysis: one predictor, S-IPV (*X*), one moderator, T-IPV (*W*), and one criterion, PTG (*Y*). Once the variables were entered into the SPSS settings for the simultaneous regression model, both predictor variables (X and W) were automatically mean-centered, and the output was generated.

SPSS output from the PROCESS regression analysis has been recreated for easier viewing (see Table 19; original content in Appendix J). The model summary provides an

overall total for predicting the interaction of T-IPV and S-IPV on PTG. This study's findings indicate that 17% of the variance in PTG is due to the interaction of T-IPV and S-IPV: $F(3,3) = .04$, $p = .986$, $R^2 = .17$; however, it is not statistically significant. Broken down by variables, the interaction of S-IPV, $b = -.03$, $t(3)$, $= -.04$, $p = .97$, indicates almost no influence on PTG, but it is not significant. The interaction of T-IPV, $b = .99$, $t(3)$, $= .13$, $p = .91$, indicates that as time increases by one level (.99), PTG only slightly increases (.13), and this finding is also not significant. The interaction of T-IPV with S-IPV on PTG, $b = -.07$, $t(3)$, $= -.12$, $p = .91$, is not significant. The test of highest order unconditional interactions between S-IPV and T-IPV, R^2-chng = .08 F(1,3) = .04, $p = .910$, accounted for 8% of the variance in PTG, but it is not significant.

Table 19

PROCESS Matrix Output for Regression Analysis

PROCESS Procedure for SPSS Version 4.2
Model 1, HC3

Model Summary

R	R^2	*MSE*	*F* (HC3)	*df* 1	*df* 2	*p*
-0.4161	0.1732	30.8682	0.0432	3.0000	3.0000	0.9859

Model

	b (Coeff)	*SE* (HC3)	*t*	*p*	CI LL	CI UL
constant	10.8783(a)	11.4972	0.9462	0.4139	-25.8457	-47.6023
S-IPV	-0.0274	0.6409	-0.0427	0.9686	-2.0744	2.0196
T-IPV	0.9932	7.8005	0.1273	0.9067	-23.9230	25.9094
Int_1	-0.0694	0.5638	-0.1231	0.9098	-1.8704	1.7315

Test(s) of highest order unconditional interactions(s):

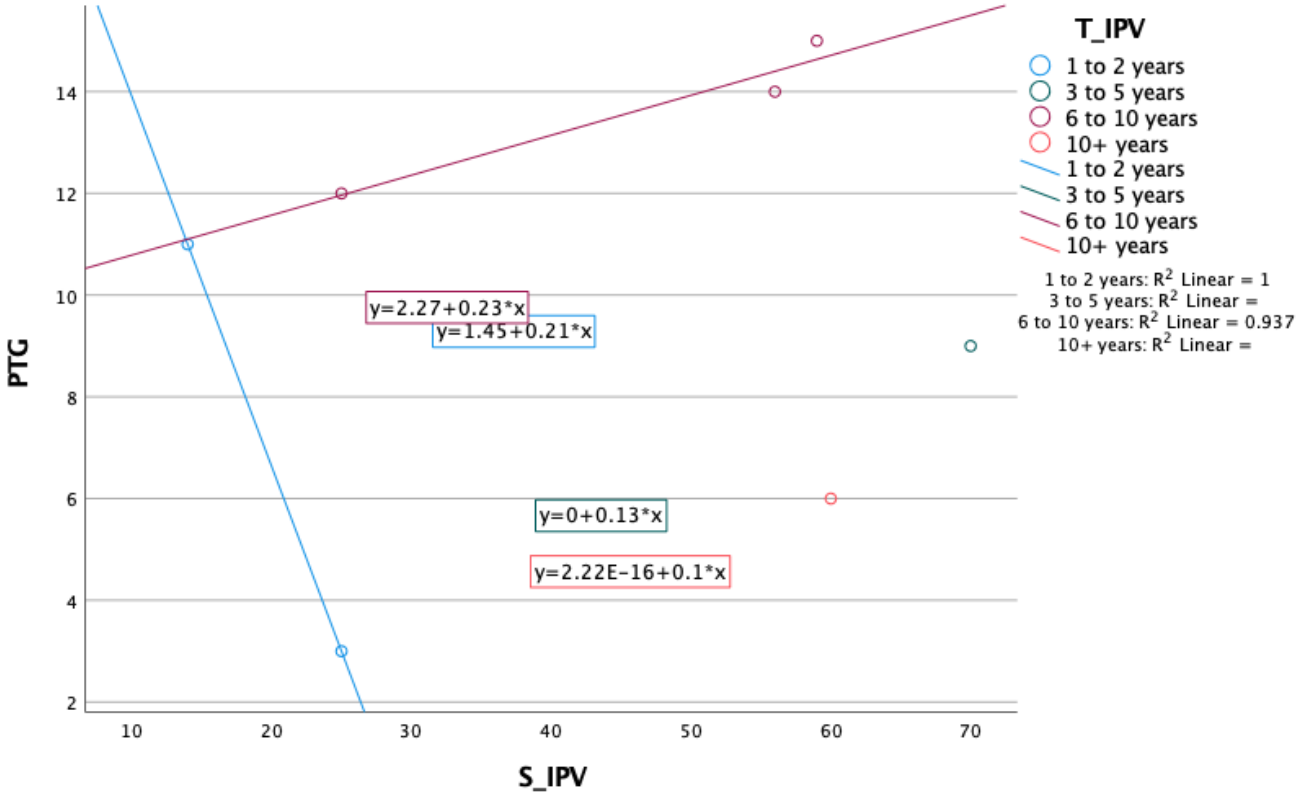
	R^2-chng	*F* (HC3)	*df* 1	*df* 2	*p*
X*W	0.0793	0.0152	1.000	3.000	0.9098

Focal predict: S-IPV (X)
Mod var: T-IPV (W)

Had significant moderating effects been found between any of the variables, the SPSS PROCESS output would have included conditional effects of the focal predictor at values of the moderator(s) using the Johnson-Neyman method (http://processmacro.org/faq.html). Because the moderating effects were not found to be statistically significant (p = .986; from the Model Summary), the conditional effects data was not included in the output for this regression analysis. Therefore, the researcher created a simple slopes graph of the interaction of T-IPV, S-IPV with PTG using the PROCESS matrix data provided for visualizing the conditional effect of the focal predictor (see Appendix J). Fit lines were added to aid in identifying any moderation effects, but the dots are too sparse to make a qualified determination (see Figure 15).

Figure 15

PROCESS (HC3) Visual Output of Moderation Analysis



The results of the regression analysis provide ambiguous data for accepting or rejecting the null hypothesis. Unfortunately, a low sample size in a regression analysis lacks sufficient statistical power to produce the results needed to report accurate results by detecting an effect when one exists (Gaskin & Happell, 2014). Furthermore, statistical power provides the ability to correctly reject a null hypothesis when it is truly false (Bezeau & Graves, 2001). Faber and Fonseca (2014) warn against "using a sample smaller than the ideal" because it "increases the chance of assuming as true a false premise" (p. 28). Because this study used a sample size of $N = 7$ (43 less than the recommended sample size), any result produced toward identifying a moderation effect of T-IPV on S-IPV or PTG is highly likely to have resulted in a Type II error by accepting the null hypothesis when it is, in fact, false (Warner, 2013). Therefore, in light of the insufficient interaction outcome and nonsignificant statistical power, the findings are inconclusive regarding whether T-IPV moderates the relationship between S-IPV and PTG.

Summary

The problem is the lack of empirically validated interventions that offer spiritual solutions to promote PTG in Christian women who seek recovery from IPV. The purpose of this study was to evaluate the efficacy of a biblically based PDP for promoting PTG in Christian women who have experienced IPV. The study also sought to discover if there was a predictive linear relationship between T-IPV and S-IPV that influenced PTG. Data analysis was performed beginning with a paired samples *t* test comparing the change in values, pre-PDP to post-PDP, for the PTG total and each of its subscales: relating to others, new possibilities, personal strength, spiritual growth, and appreciation for life. The results recorded statistically significant changes between the total PTG pretest and posttest conditions, $t(5) = -2.41$, $p = .030$ (one-sided), with the posttest scores being 14% greater than the pretest scores. There was also a significant

improvement in four of the five subscales, pretest to posttest, including relating to others, new possibilities, personal strength, and spiritual growth, but not in appreciation for life.

To determine if there was any moderation effect of S-IPV and T-IPV on PTG, a multivariate regression analysis was conducted using the PROCESS macro (Hayes, 2018). There was insufficient data to determine whether there was any moderation effect and whether it was statistically significant.

CHAPTER FIVE: CONCLUSIONS

Overview

This chapter provides the conclusion to whether the biblically based PDP effectively promotes PTG in Christian women who have experienced IPV, and what influence, if any, T-IPV has between S-IPV and PTG. The findings of the research study are discussed in context with the existing literature and in keeping with each research question: (1) Does the PDP improve any of the subscales of PTG in Christian women who have suffered IPV? (2) Does T-IPV moderate the relationship between S-IPV and PTG? Following the discussion of findings, information is provided concerning the implications of how this research contributes to the fields of behavioral sciences and biblical counseling, as well as limitations and recommendations for future research.

Discussion

The purpose of this quantitative pretest-posttest study was to evaluate the efficacy of a biblically based PDP for improving any of the subscales of PTG in Christian women who have experienced IPV and to determine if there was a predictive linear relationship between T-IPV, S-IPV, and PTG). There were seven participants ($N = 7$) who were all women, age 19 or older, with experiences of IPV in their lifetime but not within the past 12 months. Demographics of the participants revealed they were all White, Non-Latino, who ranged in age from 30 to 69; five were married or in a domestic partnership, and two were divorced. The 12-month free-from-abuse limitation was set by the researcher as a precaution against retraumatizing participants who might be vulnerable to the rumination of past IPV events (Becker-Blease & Freyd, 2006; Edwards, Probst, et al., 2013; Morales-Campos et al., 2009; Valpied et al., 2014).

Participants were recruited through Southern Baptist churches within one county of the Southeastern U. S. The participants enlisted anonymously for the study using a dedicated research website that provided access to the pre-qualification questions, consent form, demographic data, and the pretest-posttest assessments. Participants were required to attend the biblically based PDP in between collecting pretest and posttest data. Nine women completed all pre-PDP data requested and attended the PDP, but only seven also completed the posttest. The webmaster collected and forwarded the raw data to the researcher for data screening and testing using IBM SPSS Statistics (Version 28.0). The results of the analyses have been organized by research question.

Research Question One

A paired samples *t* tests were conducted to determine (a) whether the PDP promoted improvement in total PTG, and (b) to determine which subscales reflected posttest increases by participants. The findings were statistically significant for a positive change in posttest total score values. The null hypothesis was rejected because at least one of the subscales reflected a positive difference in posttest scores. Indeed, four of the five subscales reflected a statistically significant increase in posttest scores compared to the pretest, including relating to others, new possibilities, and spiritual growth, and personal strength, but not in appreciation for life. The findings of this study align well with the literature concerning the effectiveness of positive religious coping toward promoting PTG. In a longitudinal study of 23 women victimized by IPV, Valdez and Lilly (2015) found that the majority (87%) of the participants reported significant improvement in PTG posttests, with positive world assumptions accounting for approximately 37% of the variance in PTG scores. The first study to quantitatively evaluate PTG in survivors of IPV (60 women), found growth was experienced (M = 68.08, SD = 24.95) with 67% reporting a

moderate degree of change (Cobb et al., 2006). They also found that women who experienced more severe levels of abuse also experienced greater positive changes in the PTG subscale appreciation for life (Cobb et al., 2006). The women in the current study reported less severe levels of IPV, none had experienced any physical or sexual violence with their partners, which may explain why appreciation for life was the only subscale that did not see posttest improvement.

It is difficult to know if appreciation for life would have revealed a positive change in the posttest scores had more time been allowed for participants to pursue constructs of the PDP; only two days had lapsed between attending the PDP and completing the posttest assessment. Tedeschi and Calhoun (2004) have found that certain personality types, who cognitively process a traumatic event through rumination, are likely to experience PTG as they struggle to construct a new assumptive world. This process of growth has been referred to as "a journey, rather than a destination" because it involves healing from numerous aspects of emotional harm over time (Bryngeirsdottir & Halldorsdottir, 2021, p. 1). Researchers agree it is the trauma itself that creates the struggle within oneself to strengthen their ability to cope and see life with new eyes that are resilient to new threats of adversity (Bryngeirsdottir & Halldorsdottir, 2021; Cobb et al., 2006; Tedeschi & Calhoun, 1995, 2004). In a 2012 study of hurricane Katrina survivors, Bosson and colleagues detailed how purposeful cognitive processing produced PTG through positive religious coping. It is also within Christian circles that patriarchal religious beliefs become negative attributes that influence men to perpetrate power and control over their God-fearing submissive wives (DeRose et al., 2021; Glanville & Dreyer, 2013; Harper, 2017; Moder, 2019). Thankfully, Christian men are responding to the call for more men to become actively engaged

in the prevention of IPV on an individual, faith-based, and community level (Bent-Goodley et al., 2015).

Research Question Two

To learn if T-IPV had a moderation relationship between S-IPV and PTG, a Model 1 multivariate regression analysis was conducted using the PROCESS macro (Hayes, 2018). This is the simplest form of regression that involves one criterion variable (PTG) and two predictor variables (S-IPV and T-IPV), one of which is designated as the moderator (T-IPV). Still, both are measured for moderating effects on each other and the criterion variable (Hayes, 2018). Unfortunately, the sample size was too small to indicate moderation, leaving the findings inconclusive for accepting or rejecting the null hypothesis, and no moderating effects would be noted. Sample size determines statistical power, which is needed to produce accurate results by detecting an effect where one exists and by accepting the null when it is false (Gaskin & Happell, 2014).

Implications

This research study extends current literature on PTG in survivors of IPV and supports the schema reconstruction theory to PTG (Janoff-Bulman & Sheikh, 2006) within a Christian worldview framework. The PDP uses biblically based teachings, for restructuring an IPV survivor's assumptive world through an organized system of religious beliefs. Christianity speaks the God who created human beings, relates with them on a person level, and provides for their ultimate good at great sacrifice to himself. Biblical teachings help to rebuild shattered assumptions through personal transformation on a cognitive and spiritual level that produces meaning and purpose in life that can produce PTG in women who seek to overcome IPV.

This study offers an intervention for professional counselors, licensed marriage and family counselors, pastors, ministry leaders, biblical counselors, and life coaches who assist women seeking to recover from the trauma of exposure to IPV. The PDP is designed to help participants discover meaning and purpose for their lives as they rebuild shattered identities caused by trauma (see Giesbrecht & Sevcik, 2000; Janoff-Bulman, 1989; Leo et al., 2021; Simonic, 2020). The literature reports discovering how IPV survivors seek and find the strength to cope with IPV through religious and spiritual teachings and practices (Bloom, 2021; Liebert, 2019; Simonic, 2021). More specifically, Christian women tend to consult with their pastors and church leaders for spiritual solutions that address the trauma of IPV (Houston-Kolnik et al., 2019; Pandya, 2017; Simonic, 2020, 2021).

It was unsurprising to find that even over such a short time to process the information learned during the PDP, women responded positively, as reflected by their PTG posttest scores. This can largely be attributed to how the PDP addresses the main obstacles women encounter during their healing process following IPV. Bryngeirsdottir and Halldorsdottir (2022) identified 14 of these major issues, including feelings of shame, suicidal thoughts, broken self-identity, insecurity, feeling alone and isolated, emotional connection to others, and more. The PDP offers hope for overcoming all of these obstacles and more through direct and indirect biblical teaching on transforming one's identity to become more like Christ.

The focus of the PDP was on providing a theologically sound approach for recreating one's personal identity according to God's design expressed through biblical principles of personhood, e.g., "God created man in his own image. . ." (Gen 1:27). Since the awakening of the scientific community to the spiritual needs of human beings, Christians may now approach mental health issues through spiritual interventions that have been empirically validated to

rebuild their assumptive worlds (El-Khoury et al., 2004; Fallot & Heckman, 2005; Giesbrecht & Sevcik, 2000; Gillum et al., 2006). Numerous studies have confirmed using positive aspects of religion/spirituality to overcome adversity (Ai & Park, 2005; Anderson et al., 2012; Fowler & Rountree, 2010; Leo et al., 2021; Simonic, 2020). Numerous Christian scientist-practitioners have invested many years toward researching religious and spiritual applications for mental health issues such as depression, anxiety, unforgiveness, eating disorders, schizophrenia, alcoholism, anger, and marital issues involving various religious teachings from Christianity and other religions (Aten & Worthington, 2009; Aten et al., 2011; Post & Wade, 2009; Richards & Worthington, 2010; Wade et al., 2007; Worthington et al., 1996). Their research has brought much-needed credit to many religious interventions by producing empirical validation of their outcomes against those of clinicians. The current study adds to the existing literature by sharing the findings of another biblically based intervention for promoting PTG in Christian women who have experienced IPV.

In a country where religious faith means so much to so many people, it is important for Christian women to be able to seek solutions from IPV centers and women's shelters that offer solutions that honor a Christian worldview. On the contrary, researchers report the tension that often exists between IPV response centers and religious communities (Anderson et al., 2012; de la Rosa et al., 2016; Maldonado, 1999). Bloom (2021) noted that the largest network of IPV providers, the YWCA, was built on the foundation of Christianity. Yet today, in the United States, they utilize liberal ideals of social justice in lieu of the faith-based practices that historically offered a welcoming environment for Christian women (Bloom, 2021; Izzo, 2018; see www.YWCA.org). Thankfully, there is a move in the American Counseling Association toward once again including faith-based initiatives in counseling practices (Shaler, 2019). The

challenge is for Christian researchers to offer proven faith-based interventions that both secular and Christian counseling programs can use to treat IPV and other mental health issues among Christian women.

This study also calls attention to the need for Christian pastors and church leaders to inform themselves about violence against women. Countless women have shared their experiences of being overlooked and ignored when they sought comfort from their church leaders (Drumm et al., 2014; Houston-Kolnik et al., 2019; Miles, 2011; Zust et al., 2017). Pastors have admitted feeling inadequately prepared to respond to women victimized by IPV, especially when the perpetrators attend their churches, serve on their staff, teach Bible study classes, etc. (Bloom, 2021; DeRose et al., 2021; Houston-Kolnik & Todd, 2016; Jankowski et al., 2018; Pandya, 2017; Simonic, 2020; Zust et al., 2017). It is time for church leaders to break the holy hush of Christian women who suffer IPV in silence (Houston-Kolnik et al., 2019) by being willing to see these women (Luke 7:44), grow in knowledge about IPV and its existence within the Christian church, learn how to apply the balm of Gilead to their wounds, and become equipped to offer valid Christ-centered solutions to enable the transformation of another child of God into a healthy ambassador for Christ.

There is literature to support how positive aspects of Christianity can prevent IPV or provide a pathway to recovery from IPV (Simonic, 2020), but scant research offers empirically validated Christian interventions for promoting PTG in women recovering from IPV (Bloom, 2021; Houston-Kolnik et al., 2019; Leo et al., 2021; Pandya, 2017; Simonic, 2020). Even considering the small sample size of this study, the findings validate the efficacy of a biblically based solution for promoting PTG in Christian women who have experienced IPV.

Limitations

Clearly low sample size presents a problem with power and results in this study, which has already been discussed. Because of the small sample size, the results of this study may not generalize to all IPV survivors. The sample size also limited the researcher's ability to empirically examine the moderation effects, if any, that time and severity produced toward the change in PTG. More time should have been given to promote the study before the PDP event date. Perhaps a direct response-type promotion would have produced better participation by offering something for the women to download by visiting the research website, such as fast facts about IPV, ten ways to put the perpetrator in his place, or a coupon for a free Chick-fil-a sandwich. Inserts in the church worship guide, though many churches have strict policies about what can be included in the worship guide. Also, the use of a more personal promotional flier may have gained greater interest toward visiting the website. Whereas the IRB's approved wording reads less personable and more clinical/legal, which does not appeal to the masses. Many ideas will likely come to mind as others read this paper and consider more successful ways to promote the research study. One last finding was discovered with great disappointment as the researcher had long-term commitments from several people serving on staff at large churches, who ultimately chose not to promote the research.

However, another reason for the low sample size may point to the population targeted for this study: Christian women. It has come to the researcher's attention that some women invited to participate in this study felt uncomfortable being seen attending an event designated for women who have experienced IPV. One potential participant, who attends the researcher's church, privately shared her concern about "outing" her husband as a perpetrator of IPV if she were to participate in the event and be recognized by another participating church member.

Another potential participant shared how she might as well have a big red “A” engraved on her forehead to be seen at a group meeting of IPV survivors. Sadly, these women have historically been overlooked and misunderstood by other Christians and church leaders, and now there is a stigma attached to being identified as a victim of IPV.

Women feel a certain sense of shame following experiences of IPV, which produces pronounced negative effects on their sense of well-being (Bryngeirsdottir & Halldorsdottir, 2022). In retrospect, holding the PDP in a church setting may have caused these women to fear being “outed” as women who let their husbands abuse them. The PDP would likely be better attended in an environment that not only assures anonymity between the researcher and participants but also between participants from other participants. The solution may be to hold virtual events. Women could anonymously attend the PDP without being seen using a group video application such as Zoom or MS Teams. In the same regard, prerecorded videos of each session of the PDP could be uploaded to the research website for women to view when it is convenient for them over a specified time.

In hindsight, the researcher should have planned for a more extended recruitment period. More women may have participated had there been an online option for attending the PDP anonymously. In addition, the event could have been designed to host women who had and had not experienced IPV, so the IPV victims did not feel spotlighted at the event. Statistics reveal that one in two (50%) of all women have experienced psychological IPV, and one in three (33%) have experienced stalking, physical, or sexual IPV (Smith et al., 2018), including Christians (Simonic, 2021; Westenberg, 2017). So, if a large group of women (150) could be gathered for the PDP, with a magnetic theme and fancy decorations, it is pretty plausible that 50 (33%) attendees would be qualified to participate in the research study.

Internal consistency of the PTGI presents another limitation for achieving the desired value changes in scores from pretest to postttest. Cronbach alpha scores ranked three of the eight subscales as good to better, while the remaining subscales were rated less than good. However, there has been extensive testing of the PTGI that has proven the 21-item questionnaire to be internally consistent (Lenz et al., 2021; Nunnally & Bernstein, 1994; Tedeschi & Calhoun, 1996). Conversely, other assessments for measuring PTG may offer better results for future studies.

Recommendations for Future Research

While the current study was designed for women who already identify as Christians, the researcher believes that the PDP has beneficial for those seeking to find a higher power for direction in their lives. This would make it a good tool for use in a mixed setting of believers and unbelievers pursuing healing from the emotional wounds of IPV and seeking meaning and purpose in life. Other spiritual/religious interventions should be tested as well. It is also desirable to study PTG among women from various multicultural backgrounds. Researchers should consider offering an online option for attending the PDP to provide attendees anonymity from other participants. Prerecorded video sessions could also be uploaded online for participants to view at a convenient time. Online formats would remove the fear attendees may have of being visually associated with an IPV group. A multi-week delivery of sessions would allow participants more time to cognitively process the material before completing posttest assessments. The researcher also recommends a mixed methods design to enhance the information learned from the study by including a post-PDP survey to gain insight into the participants' feelings about what they gained from the PDP and how they will use it moving forward.

Summary

The problem is the need for empirically validated interventions that offer spiritual solutions to promote PTG in Christian women who seek recovery from IPV. This study aimed to evaluate the efficacy of a biblically based PDP for promoting PTG in Christian women who have experienced IPV. The study also desired to know if there was a predictive linear relationship between T-IPV, S-IPV, and the change in the total and subscale scores of the PTG. Using a paired samples *t* test, the researcher reported increased PTG in four of the five subscales, all except appreciation for life, but did not establish the statistical significance of those findings. Further, due to the low sample size, the researcher could not successfully conduct the regression analysis to determine the moderation of variables T-IPV and S-IPV. The conclusion of this study is that the PDP was successful in promoting PTG in this sample of participants; White Christian women who had experienced IPV more than 12 months ago. These findings cannot be generalized to a larger population. Therefore, it is recommended that this study be reproduced with a larger sample size, including Christian women of multiple races/ethnicities, various faiths. Also, consider offering online options for attending the PDP this study evaluated or use a different spiritual/religious intervention. A mix-methods study would allow participants to share how their experience with the intervention and how they planned to use the information in the future. Finally, the researcher recommends using at least a 4-week delivery for the intervention to give participants time to cognitively process the teachings and establish necessary changes that promote greater PTG.

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Appendix A

Intimate Partner Violence Checklist

Below are listed various forms of behavior. Please rate if your partner (or ex-partner) has had some of these behaviors with you and with what frequency? Please indicate frequency from 0 to 7: 0 = *never happened to me* to 7 = *happened to me every day*.

Sexual violence

_____Intimately touched you when you did not want to
_____Verbally forced you to have sexual intercourse when you did not want to
_____Physically forced you to have sexual intercourse when you did not want to

Physical violence

_____Slapped you or hit you with a fist
_____Used a knife or fired a gun against you
_____Pushed, grabbed, or shoved you
_____Kick, bit, choked or burned you
_____Hit or tried to hit you with some object

Economic violence

_____Took money from your purse, wallet, or bank account without your permission and/or knowledge
_____Restricted your access to personal money
_____Refused to get a job so you had to support your family alone
_____Demanded to know how your money was spent
_____Forbid you to have a job or to study

Psychological violence

_____Ignored you, refused completely to talk or discuss an issue with you
_____Insulted or was offensive to you (said that you are worthless, dumb, ugly etc.)
_____Screamed and yelled at you
_____Tried to restrict contact with your family or friends
_____Was overly jealous without a reason
_____Damaged your personal belongings
_____Threatened to hurt you physically
_____Stalked you, bothered you with phone call, messages, e-mail's etc.

Email approval from Dr. Rita Zukauskiene to use the forgoing 21-item Intimate Partner Violence Inventory.

[External] RE: 21-Item abuse severity scale

Rita Žukauskienė <rzukausk@mruni.eu>
Tue 10/4/2022 6:13 AM
To: Dooley, Jerra L <jdooley1@liberty.edu>

You don't often get email from rzukausk@mruni.eu. Learn why this is important

[EXTERNAL EMAIL: Do not click any links or open attachments unless you know the sender and trust the content.]

Dear Jerra:

Sorry, my previous message was sent accidentally

Of course you can use our scale. Please finbd below very rough translation from Lithuanian to English, of course some of them should be better worded or found English versions using the information in our paper, where we wntion which scales were used

Hope it helps
Warm regards
RIta

Appendix B

Posttraumatic Growth Inventory (PTGI)

Post Traumatic Growth Inventory

Client Name:_____ Today's Date:_____

Indicate for each of the statements below the degree to which this change occurred in your life as a result of the crisis/disaster, using the following scale.

0 = I did not experience this change as a result of my crisis.
1 = I experienced this change to a very small degree as a result of my crisis.
2 = I experienced this change to a small degree as a result of my crisis.
3 = I experienced this change to a moderate degree as a result of my crisis.
4 = I experienced this change to a great degree as a result of my crisis.
5 = I experienced this change to a very great degree as a result of my crisis.

Possible Areas of Growth and Change	0	1	2	3	4	5
1. I changed my priorities about what is important in life.						
2. I have a greater appreciation for the value of my own life.						
3. I developed new interests.						
4. I have a greater feeling of self-reliance.						
5. I have a better understanding of spiritual matters.						
6. I more clearly see that I can count on people in times of trouble. Text						
7. I established a new path for my life.						
8. I have a greater sense of closeness with others.						
9. I am more willing to express my emotions.						
10. I know better that I can handle difficulties.						
11. I am able to do better things with my life.						
12. I am better able to accept the way things work out.						
13. I can better appreciate each day.						
14. New opportunities are available which wouldn't have been otherwise.						
15. I have more compassion for others.						
16. I put more effort into my relationships.						
17. I am more likely to try to change things which need changing.						
18. I have a stronger religious faith.						
19. I discovered that I'm stronger than I thought I was.						
20. I learned a great deal about how wonderful people are.						
21. I better accept needing others.						

Post Traumatic Growth Inventory Scoring

The Post Traumatic Growth Inventory (PTGI) is scored by adding all the responses. Individual factors are scored by adding responses to items on each factor. Factors are indicated by the Roman numerals after each item below. Items to which factors belong are not listed on the form administered to clients.

PTGI Factors

Factor I: Relating to Others
Factor II: New Possibilities
Factor III: Personal Strength
Factor IV: Spiritual Change
Factor V: Appreciation of Life

1. I changed my priorities about what is important in life. (V)
2. I have a greater appreciation for the value of my own life. (V)
3. I developed new interests. (II)
4. I have a greater feeling of self-reliance. (III)
5. I have a better understanding of spiritual matters. (IV)
6. I more clearly see that I can count on people in times of trouble. (I)
7. I established a new path for my life. (II)
8. I have a greater sense of closeness with others. (I)
9. I am more willing to express my emotions. (I)
10. I know better that I can handle difficulties. (III)
11. I am able to do better things with my life. (II)
12. I am better able to accept the way things work out. (III)
13. I can better appreciate each day. (V)
14. New opportunities are available which wouldn't have been otherwise. (II)
15. I have more compassion for others. (I)
16. I put more effort into my relationships. (I)
17. I am more likely to try to change things which need changing. (II)
18. I have a stronger religious faith. *(N)*
19. I discovered that I'm stronger than I thought I was. (III)
20. I learned a great deal about how wonderful people are. (I)
21. I better accept needing others. (I)

PTGI References of Potential Interest

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Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry,* 15,1-18.

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Tedeschi,R. G., & Calhoun, L. G. (2009). The clinician as expert companion. In C. L. Park, S.C. Lechner, M. H. Antoni, & A Stanton (Eds.) *Medical illness and positive life change: Can crisis lead to personal transformation* (pp. 215-235)? Washington, DC: American Psychological Association.

In Reciprocation

There is no charge for the PTGI, and there is no charge for the reproduction of the scale for use in research. In reciprocation, we would like you to send us a gratis copy of any manuscripts, theses, dissertations, research reports, preprints, and publications you prepare in which our materials, or any version of them, is used. Both L. G. Calhoun and R. G. Tedeschi can be contacted at: Department of Psychology - UNC Charlotte - Charlotte, NC 28223 USA.

https://www.emdrhap.org/content/wp-content/uploads/2014/07/VIII-B_Post-Traumatic-Growth-Inventory.pdf

Appendix C

Site Permission

November, 2022

Name
Church Name
Address 1
Address 2

Dear Pastor,

As a graduate student in the Community Care and Counseling department at Liberty University, I am conducting research as part of the requirements for a doctoral degree. The title of my research project is *Efficacy of a Christian Intervention to Promote Posttraumatic Growth in Women Recovering from Intimate Partner Violence*. The purpose of my research is to study the effectiveness of a biblically based personal development program to address women's shattered assumptions and restore their identity in Christ.

I am writing to request your permission to conduct the biblical study for my research in the choir room at your church. The tentative date of the study is as early as Saturday, February, 11, 2023 and as late as Saturday, February 25, 2023. The room will need to be available for use from 8:00am to 1:00pm; no setup is required. In addition, I am requesting your support by helping to promote the need for research participants. I will provide a Participant Recruitment Flyer to be emailed to women who attend your church. This letter will provide a link to a secure website that will allow ladies to sign up to participate in the research study anonymously. Participants will be asked to answer qualifying questions to confirm they are an adult female, at least 19 years old, having experienced IPV but not in the last twelve months, and identify as Christian. Participants will be required to sign an informed consent, provide brief demographic data, and complete two short assessments before attending the personal development program, and one final assessment upon completion of the event (all online). Participation in this anonymous research study is voluntary, and participants are welcome to discontinue participation at any time. Fees will not be paid for participation and all materials will be supplied.

Thank you for considering my request. If you choose to grant permission, respond by email to [redacted]. A permission letter is attached for your convenience. I trust that the results of this research will provide an empirically proven biblical solution for promoting posttraumatic growth in women who have been traumatized by intimate partner violence.

Kindest regards,
Jerra Dooley, MA-PC
Liberty University Doctoral Candidate
[redacted]

[Please provide this document on official letterhead or copy and paste into an email.

[Date]

Jerra Dooley, MA-PC
Liberty Doctoral Candidate
Liberty University
Jdooley1@liberty.edu

Dear Jerra,

After carefully reviewing your research proposal entitled *Efficacy of a Christian Intervention to Promote Posttraumatic Growth in Women Recovering from Intimate Partner Violence*, [I/we] have decided to grant you permission to use our facility for this research study.

Check the following boxes, as applicable:

☐ [[I/We] will provide our membership list to Jerra Dooley, and Jerra Dooley may use the list to contact our members to invite them to participate in her research study.

☐ [[I/We] grant permission for Jerra Dooley to contact women on our membership rolls to invite them to participate in her research study.]

☐ [[I/We] will not provide potential participant information to Jerra Dooley, but agree to [[send/provide] her study information to women on our membership rolls on her behalf.]

☐ [[I/We] are requesting a copy of the results upon study completion and/or publication.]

Sincerely,

[Official's Name]
[Official's Title]
[Official's Company/Organization]

Appendix D

Participant Recruitment Flyer

Christian Women Needed for Doctoral Research Study

EFFICACY OF A CHRISTIAN INTERVENTION TO PROMOTE POSTTRAUMATIC GROWTH IN WOMEN RECOVERING FROM INTIMATE PARTNER VIOLENCE

Qualifications for Participation

- Are you a female who is at least 19 years of age or older?
- Have you experienced abuse by an intimate partner in your lifetime?
- Has it been at least 12 months since you last experienced intimate partner violence?
- Do you identify as a Christian?

If you answered **yes** to the questions listed above, you are eligible to participate in the research study.

Purpose of the Study

The purpose of my research is to measure the effectiveness of a biblically based personal development program for promoting posttraumatic growth in Christian women victimized by intimate partner violence (IPV).

Participant Expectations

- Participants will be asked to sign up anonymously through our secure research study website.
- Upon agreeing with the informed consent, participants will be required to:
  - Answer four qualifying questions, provide brief demographic information, and complete two pretest assessments (about 20 minutes).
  - Attend a 3-hour biblically based personal development seminar conducted on (day, date, time) at (church name), which includes discovering your identity and purpose in Christ.
  - Complete one posttest assessment (about 10 minutes) within 24 hours after attending the event.
- There is no fee for participation and all materials will be supplied.
- Participation is voluntary and you may drop out at any time.

Signup to Participate

If you would like to participate, please visit www.womensresearch.center. Once on the research website, you will be asked to read the informed consent. If you agree to participate, click the "I Agree" button at the end to proceed to the pretest portion of the research. You will then be asked to create a unique identifier that protects your anonymity when submitting the pretest/posttest data.

Researcher Conducting the Study

Jerra Dooley, Doctoral Candidate, School of Behavioral Sciences
Department of Community Care and Counseling, Liberty University

For more information, please contact Jerra Dooley at [redacted]
or use the anonymous portal on the website for more information.

Liberty University IRB – 1971 University Blvd., Green Hall 2845, Lynchburg, VA 24515

Appendix E

Screening Questions

Are you a female who is 19 years of age or older? (Yes) (No)

Have you experienced intimate partner violence in your lifetime? (Yes) (No)

Has it been at least 12 months since you last experienced intimate partner violence? (Yes) (No)

Do you identify as a Christian? (Yes) (No)

Appendix F

Demographic Survey

Please answer the following questions by selecting one item per question.

Age: (19 to 29) (30 to 39) (40 to 49) (50 to 59) (60 to 69) (70 and up)

Race or Ethnicity: (please select which option you most identify with)

(Asian) (Black, Non-Latino) (Latino, any race) (White, Non-Latino) (Other)

Relational status:

(Single, never married) (Married, or in a domestic partnership)

(Widowed) (Divorced) (Separated)

How long has it been since you last experienced partner abuse?

(1 to 2 years) (3 to 5 years) (6 to 10 years) (10 years or more)

Appendix G

Informed Consent

Title of the Project: Efficacy of A Christian Intervention to Promote Posttraumatic Growth in Women Recovering from Intimate Partner Violence
Principal Investigator: Jerra Dooley, MA, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must be 19 years old, be female, identify as a Christian, and have experienced abuse by an intimate partner in your lifetime but not within the past 12 months. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about and why is it being done?

The purpose of this research study is to evaluate the effectiveness of a biblically based personal development seminar in promoting posttraumatic growth following the trauma of intimate partner violence.

In addition, this study will inform pastors, church leaders, biblical counselors, and clinical counselors of the successful integration of faith-based programs for Christian women who are recovering from intimate partner violence (IPV).

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to complete the following tasks.

- Take a pretest. The pretest includes demographic questions, the Intimate Partner Violence Checklist, and the Posttraumatic Growth Inventory. The pretest will take you about 20 minutes to complete.
- Attend a one-time, 3-hour personal development program seminar that includes discovering your identity and purpose in Christ.
- Return to this website to take the posttest that involves answering the Posttraumatic Growth Inventory items once more. The posttest will take you about 10 minutes and should be completed within 24 hours of attending the seminar.

How could you or others benefit from this study?

The direct benefit you should expect to receive from taking part in this study includes a possible change in how you feel about personal strength, new possibilities, improved relationships, spiritual growth, and appreciation for life.

Benefits to society include an increased understanding of the effectiveness of biblically based interventions for addressing posttraumatic stress in Christian women victimized by IPV. In addition, this study will provide evidence to the existing scholarly literature on how the severity of abuse and time since last episode of IPV affects posttraumatic growth.

What risks might you experience from being in this study?

The potential for risks associated with this study is not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine psychological examinations or tests.

How will personal information be protected?

The records of this study will be kept private. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be anonymous. Participants will be asked to place a self-created code on the pre-test and post-test.
- The data will be stored on the researcher's password-locked computer, kept in a locked safety box in her home, and will not be used in future presentations. After three years, all data will be deleted from her computer.

Is the researcher in a position of authority over participants, or does the researcher have a financial conflict of interest?

The researcher has no known conflicts of interest. However, in full disclosure, the researcher serves as the pianist at the host church and serves as a certified biblical counselor at another church in the area. To limit potential or perceived conflicts, the researcher will not know the identity of any participants. This disclosure is made so that you can decide if this relationship will affect your willingness to participate in this study. No action will be taken against an individual based on her decision to participate or not participate in this study.

Is study participation voluntary?

Participation in this study is voluntary. Your decision on whether or not to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time prior to submitting the demographic questions and assessments without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study prior to completing the pre-test, please exit the survey and close your internet browser. Your responses will not be recorded or included in the study. If you choose to exit the study after completing the post-test, please inform the researcher by contacting her using the contact information included below. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Jerra Dooley. If you have questions, you are encouraged to contact her directly using her phone number, [redacted], or her email address, [redacted]. You may also contact the researcher's faculty sponsor, Dr. Pamela Moore, at [redacted].

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, you are encouraged to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

Before agreeing to be part of the research, please be sure that you understand what the study is about. You can print a copy of this document for your records. If you have any questions about the study later, you can contact the researcher using the information provided above.

Appendix H

PDP Brief Outline

Only You Can Be You: Discovering Your S.H.A.P.E. and Purpose for Life (Rees, 2005)

a. Session One – You are Significant to God

b. Session Two – Your God given S.H.A.P.E.

c. Session Three – How Your S.H.A.P.E. Determines Your Purpose

d. Session Four – Planning for the Future

Appendix I

IRB Approval

[External] IRB-FY22-23-514 - Initial: Initial - Exempt

do-not-reply@cayuse.com <do-not-reply@cayuse.com>
Fri 1/20/2023 10:08 AM

To: Dooley, Jerra L <jdooley1@liberty.edu>;Moore, Pamela (Community Care and Counseling) <pmoore@liberty.edu>

[EXTERNAL EMAIL: Do not click any links or open attachments unless you know the sender and trust the content.]

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

January 20, 2023

Jerra Dooley
Pamela Moore

Re: IRB Exemption - IRB-FY22-23-514 EFFICACY OF A CHRISTIAN INTERVENTION TO PROMOTE POSTTRAUMATIC GROWTH IN WOMEN RECOVERING FROM INTIMATE PARTNER VIOLENCE

Dear Jerra Dooley, Pamela Moore,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under the following exemption category, which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:104(d):

Category 2.(i). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording).
The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects.

Your stamped consent form(s) and final versions of your study documents can be found under the Attachments tab within the Submission Details section of your study on Cayuse IRB. Your stamped consent form(s) should be copied and used to gain the consent of your research participants. If you plan to provide your consent information electronically, the contents of the attached consent document(s) should be made available without alteration.

Please note that this exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us at

irb@liberty.edu.

Sincerely,
G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research
Research Ethics Office

Appendix J

PROCESS Output

```
Run MATRIX procedure:

*************** PROCESS Procedure for SPSS Version 4.2 beta ***************

          Written by Andrew F. Hayes, Ph.D.       www.afhayes.com
    Documentation available in Hayes (2022). www.guilford.com/p/hayes3

**************************************************************************
Model  : 1
    Y  : PTG
    X  : S_IPV
    W  : T_IPV

Sample
Size:  7

**************************************************************************
OUTCOME VARIABLE:
 PTG

Model Summary
          R       R-sq        MSE     F(HC3)        df1        df2          p
      .4161      .1732    30.8682      .0432     3.0000     3.0000      .9859

Model
             coeff    se(HC3)          t          p       LLCI       ULCI
constant   10.8783   11.4972      .9462      .4139   -25.8457    47.6023
S_IPV       -.0274      .6409     -.0427      .9686    -2.0744     2.0196
T_IPV        .9932     7.8005      .1273      .9067   -23.9230    25.9094
Int_1       -.0694      .5638     -.1231      .9098    -1.8704     1.7315

Product terms key:
 Int_1    :        S_IPV    x        T_IPV

Test(s) of highest order unconditional interaction(s):
       R2-chng     F(HC3)        df1        df2          p
X*W      .0793      .0152     1.0000     3.0000      .9098
----------
    Focal predict: S_IPV    (X)
          Mod var: T_IPV    (W)

Data for visualizing the conditional effect of the focal predictor:
Paste text below into a SPSS syntax window and execute to produce plot.

DATA LIST FREE/
   S_IPV      T_IPV      PTG       .
BEGIN DATA.
   -22.0713    -1.1339     8.6190
      .0000    -1.1339     9.7521
    22.0713    -1.1339    10.8852
   -22.0713      .0000    11.4824
      .0000      .0000    10.8783
    22.0713      .0000    10.2742
   -22.0713     1.1339    14.3457
      .0000     1.1339    12.0045
    22.0713     1.1339     9.6632
END DATA.
GRAPH/SCATTERPLOT=
 S_IPV    WITH     PTG     BY       T_IPV    .

********************* ANALYSIS NOTES AND ERRORS ************************

Level of confidence for all confidence intervals in output:
```

```
  95.0000

NOTE: A heteroscedasticity consistent standard error and covariance matrix estimator was used.

NOTE: The following variables were mean centered prior to analysis:
          T_IPV    S_IPV

------ END MATRIX -----
```