Pastoral Care for Intimate Partner Violence: An Examination of Attitudes and Behaviors

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A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

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I have no known conflict of interest to disclose.

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ABSTRACT

Domestic violence or intimate partner violence (IPV) is willful intimidation, physical assault, battery, sexual assault, and other abusive behaviors. They are utilized as a part of a systematic pattern of power and control perpetrated by one intimate partner against another. Domestic violence can affect anyone, regardless of social status, how they identify themselves, or how others identify them. Religious affiliation is no exception to these abusive exploits; however, your spiritual practices may aid in the recovery and escaping IPV. This dissertation addressed the ministerial process of counseling congregants victimized by intimate partner violence. At the same time, examining the attitudes of those in pastoral leadership positions, the proposed training required to support IPV victims adequately, and the beneficial resources provided. The literature review is an accumulation of pertinent information anchored in a feminist theory whose framework is augmented with theological or biblical support.

The proposed quantitative research used a cross-sectional study of the correlational strength between categorical variables and the relational effect of statistical tests employed to test competing hypotheses: the null and alternative hypotheses. A Multiple regression analysis addressed the following research questions: What is the relationship between the attitudes toward IPV and the level of assistance provisions for IPV victims among pastoral care leaders? What is the relationship between IPV training, knowledge of resources, service awareness, and the level of assistance provisions for IPV victims among pastoral care leaders?

Keywords: Attitudes, Domestic Violence, Intimate Partner Violence, Pastoral Care

Table of Contents

List of Tables

List of Figures

List of Abbreviations

Anno Domini (AD)

Acquired Immunodeficiency Syndrome (AIDS)

American Psychiatric Association (APA)

Battered Women Syndrome (BWS)

Before Christ (BC)

Center for Disease Control and Prevention (CDC)

Domestic Violence (DV)

Domestic Violence Prevention Enhancements and Leadership Through Alliances, Focusing on Outcomes for Communities United with States (DELTA FOCUS)

Diagnostic and Statistical Manual of Mental Health Disorders (DSM)

Family Violence Prevention and Services Act (FVPSA)

Federal Bureau of Investigation (FBI)

General Education Development (GED)

Human Immunodeficiency Virus (HIV)

Hypothalamic-Pituitary-Adrenal Axis (HPA axis)

Intimate Partner Violence (IPV)

Lesbian, Gay, Bisexual, and Transgender (LGBT)

National Center on Elder Abuse (NCEA)

National Coalition Against Domestic Violence (NCADV)

National Intimate Partner and Sexual Violence Survey (NIPSVS)

National Network to End Domestic Violence (NNEDV)

New Revised Standard Version (NRSV)

Pastoral Care Leadership (PCL)

Post-Traumatic Stress Disorder (PTSD)

Rape, Abuse, and Incest National Network (RAINN)

Relational-Cultural Theory (RCT)

Sexual Transmitted Disease (STD)

Sexually Transmitted Infection (STI)

Shatter the Silence, Talk About It, Alert the Public, Refer, and Train self and others Education and Intervention Model (START)

Substance Abuse and Mental Health Services Administration (SAMHSA)

Substance Use Disorder (SUD)

Survivor Therapy Empowerment Program (STEP)

United States (U.S.)

Wellness Recovery Action Plan (WRAP)

World Health Organization (WHO)

CHAPTER ONE: INTRODUCTION

Overview

The research presented in this dissertation proposal provided information indicating the attitudes projected toward victims of intimate partner violence (IPV) from pastoral care leadership members (ordained and non-ordained). This includes any religious staff member positioned to provide service awareness, the resources provided, and the level of IPV training received to prepare for the counseling path to recovery. According to the Centers for Disease Control and Prevention (CDC, 2020), intimate partner violence is a serious, preventable public health problem that affects millions of Americans. Violence may occur among heterosexual or same-sex couples and does not require sexual intimacy. Intimate partner violence can be connected to physical, mental, and sexual health difficulties. It results in a higher risk for addiction-forming coping mechanisms with alcohol, tobacco, and drugs. Pastors may be the first to hear of the violence that is being endured to cleanse the soul, mind, and spirit.

This chapter introduced pastoral leaders of the Episcopal denomination and others in a position that offers counseling, referral, and information to those subjected to an IPV incident. Additionally discussed was background information relative to the nature of intimate partner violence, the problem with inadequate pastoral assistance, and its significance in the absence of victims receiving beneficial aid to recover. This chapter also offered definitions of intimate partner violence, its various categories, and pertinent terms related to the act. Throughout this dissertation, this project aimed to demonstrate a need to enhance the knowledge of members under the Episcopal pastoral care regarding IPV and how to provide prevention and intervention strategies to facilitate this behavioral practice among their congregant members and others who require assistance.

Background

The World Health Organization (WHO) extends the definition of intimate partner violence as a behavior by an intimate partner that causes physical, sexual, or psychological harm, including physical aggression, sexual coercion, psychological abuse, or controlling behaviors. Globally, one in three women worldwide who have been in a relationship have experienced physical and sexual violence by their intimate partner or sexual violence by a non-partner across their lifetime (WHO, 2021). Exposure to this type of abuse has serious consequences for women's health, with fatal injuries being the most extreme outcome.

Intimate Partner Violence is a significant global health issue and public health problem affecting individuals of all ages and walks of life. As many as one in two female murder victims are killed by their intimate partners, in contrast to one in 13 of all murdered men in the United States (Ertl et al., 2019). Intimate Partner violence occurs in all countries, cultures, religions, and socioeconomic groups (Stewart et al., 2021). It impacts society and comes with tremendous costs, impacting national budgets and overall development (WHO, 2021). According to WHO and its partners warn that the COVID-19 pandemic has further increased women's exposure to violence due to measures such as lockdowns and disruptions to vital support services (WHO, 2021). In 2018, the United Nations Office on Drugs and Crime reported that the home is the single most dangerous place for women. Females run a greater risk of assault, physical injury, and murder in their homes than in any other setting (Fox, 2018).

Prenatal stress can have physiological effects on unborn children, making them susceptible to harmful activities that influence early life events. These stressors can alter the fetus' genetic makeup. Epigenetic factors can activate or repress genes, leading to individual modifications in phenotypes (appearance, physiology, cognition, and behavior). The ability to

revert or normalize the epigenetic factors is possible if environmental changes (no abuse/peaceful) are implemented. Enduring abuse during pregnancy can cause the mother anxiety, which then transfers to the baby in the form of behavioral or emotional problems. The hypothalamic-pituitary-adrenal axis (HPA axis) is the pathway to producing cortisol (stress hormone) that works with the HPA axis to control a person's mood. The methylation process helps the body operate both physically and mentally. When methylation interacts with a gene promoter, it tries to extinguish gene transcription. Therefore, prenatal stress can change gene expression, causing cardiovascular, immune, and psychologically vulnerable phenotypes. Religious institutions can play an essential primary and secondary role in prevention.

Historical Context

According to Trieu (2019), the history of battered women dates as far back as 753 BC during the Reign of Romulus, the first king of Rome. During the reign of Romulus, and under the law of chastisement, there was an acceptance and disregard for wife-beating. Under these laws, the husband had an absolute right to physically discipline his wife since, by law, husbands could be held liable for crimes committed by their wives. This designed law protected husbands from harm caused by their wives' actions. These laws permitted the husband to beat his wife with a rod or switch if the circumference was no more significant than the perimeter of the base of a man's right thumb, hence the rule of thumb. Wife beating in 1200 AD was common in Europe and was endorsed by the church as the loving husband correcting his wife's faults. In the 14th Century, the Roman Catholic church's rules of marriage exhorted Christian husbands to beat their wives soundly, not out of malice or rage, but out of concern. This will be for your benefit and her spiritual well-being (Trieu, 2019). Today, the Catholic Church teaches that domestic violence against women is never justified inside and outside of the home. The Women’s Suffrage

Movement is part of the history of intimate partner violence reform. That led to the United Nations considering domestic violence an international human rights issue in 1993 (Woodlock et al., 2023).

Laws on Violence Against Women

Any type of violence is illegal. Laws about violence against women give additional support to women and families affected by violence. The most significant laws related to violence against women are the Violence Against Women Act and the Family Violence Prevention and Services Act (FVPSA) (U.S. Department of Health & Human Services, 2020).

Violence Against Women Reauthorization Act 2013

The leading federal law against violence against women is the Violence Against Women Reauthorization Act of 2013 (PDF, 410 KB). Domestic violence and abuse were previously established as being against the law. This law provides services and support for victims of domestic violence and sexual assault (U.S. Department of Health & Human Services, 2020).

The direct services provided for individual women by this law include free rape exams; no charge for prosecution or civil protection orders in domestic violence; programs to meet the needs of immigrant women and women of different races and ethnicities; programs and services for women with disabilities; legal aid for survivors of violence; services for children and teens; and protections for victims who are evicted from their homes because of events related to domestic violence or stalking (National Network to End Domestic Violence, 2013).

The Family Violence Prevention and Services Act (FVPSA)

The Family Violence Prevention and Services Act (FVPSA) helps victims of domestic violence and their children by providing shelters and resources. Under the FVPSA, the Administration for Children and Families, part of the U.S. Department of Health and Human

Services, funds national, state, and community programs, such as state domestic violence coalitions and the Domestic Violence Resource Network. The Domestic Violence Resource Network includes national resource centers on domestic violence and the National Domestic Violence Hotline.

Local Laws About Violence Against Women

Each community has slightly different laws about violence. However, no one ever has the right to hurt you physically. In all communities, one should call 911 if in immediate danger. Violence is a criminal act. One must contact the local police to report violence and be protected by the law. Some communities have outdated or limited local laws about sexual assault.

The legal definition of rape in an individual's local community may be slightly different than what one might expect. The U.S. Department of Justice (a federal agency) defines rape as the penetration, no matter how slight, of the vagina or anus with any body part or object or oral penetration by a sex organ of another person, without the consent of the victim (U.S. Department of Justice, 2012). The federal government uses this legal definition to collect information about rape from local police. Even though local laws can be slightly different from community to community, one must not be afraid to report violence to the police. The police will file a report, which starts a legal process to get help and protection under the law (U.S. Department of Health & Human Services, 2020). This dissertation study focused on the laws about domestic violence in the State of Kansas and in the State of Virginia.

Kansas Codes

Crimes involving physical injury, insulting physical contact, or fear of harm committed against a family or household member or someone with whom the offender is or was involved in a dating relationship are considered domestic violence offenses. In Kansas, domestic violence

crimes can include battery, assault, rape, stalking, and protection order violations. This article discussed Kansas' criminal penalties for domestic violence crimes (McClain, 2021).

Safety and Privacy Considerations for Victims

When seeking help online or over the phone, consider the privacy or lack thereof on your computer, smartphone, or tablet. Some victims utilize the same device(s), network, or phone plan as their abuser. They are allowing the abuser to view the victim's search or call history, enabling them to track all online activity. This is accomplished due to smart devices containing cameras or GPS tracking applications that can be used to locate and monitor your whereabouts. An abuser can even slip a small tracking device into your car, bag, pocket, or other belongings without your knowledge. If one is concerned about personal privacy or safety, several organizations provide assistance and resources, including National Domestic Violence Hotline and Rape, Abuse, and Incest National Network (RAINN). You can also check out Nolo's Resources for Victims of Crime.

Defining Domestic Violence in Kansas

Kansas law defines what constitutes domestic violence, what acts, and by whom. A domestic abuse offense need not be labeled as such. Instead, the prosecutor looks at the factors and circumstances involved in the crime when determining whether to charge the crime as a domestic violence offense (Kansas Legislature, 2011-2012). According to the Kansas Legislature, 2011-2012, domestic violence involves a defendant's act or threat of violence against a victim who is a family or household member or current or former dating partner. These acts could include hitting, kicking, hair pulling, threats of such acts, or other violence. The definition of domestic violence also includes nonviolent crimes directed at these same individuals, such as damaging their property (say, slashing someone's tires) or harassing them.

The key is that the crime or threat is directed at someone who shares one of the following relationships with the offender: A dating relationship, which refers to a social relationship of a romantic nature, and family and household members are individuals who share one of the following relationships: Current or former spouses; parents of the same child; current or former co-residents; parents or stepparents and children or stepchildren, and pregnant women and the alleged fathers.

Domestic Battery and Aggravated Domestic Battery are some of the most common domestic violence offenses classified as domestic battery (McClain, 2021). Domestic battery involves an offender knowingly or recklessly causing bodily harm to a family or household member or current or former dating partner (McClain, 2021). It can also involve physical contact in a rude, insulting, or angry manner. A more severe form of battery is the aggravated domestic battery. This occurs when a defendant knowingly impedes the normal breathing or circulation of the blood by blocking the victim's nose or mouth (McClain, 2021).

Penalties for Domestic Battery and Aggravated Domestic Battery

Domestic battery carries both misdemeanor and felony penalties, depending on the nature and severity of the offense and the defendant's previous domestic-related convictions. The judge can also order a defendant to pay restitution to the victim for any expenses resulting from the domestic violence crime, such as hospital bills, counseling, and repair or replacement of damaged property (McClain, 2021).

Misdemeanor Domestic Battery

Domestic battery starts as a class B person misdemeanor conviction. An offender faces 48 hours to six months in jail, plus a $200 to $500 fine. A second conviction in five years carries

a class A person misdemeanor penalty, punishable by 90 days to one year in jail and a $500 to $1,000 fine. This repeat offender must serve a mandatory five-day sentence (McClain, 2021).

Felony Domestic Battery and Aggravated Domestic Battery

An offender on their third or subsequent domestic battery conviction within five years is guilty of a personal felony and faces a mandatory 90 days and up to one year in jail and a fine of $1,000 to $7,500. The law makes aggravated domestic battery a severity-level seven-person felony, which carries penalties of up to 13 months in prison and a $100,000 fine (Kan. Stat. §§ 21-5111, -5414, -6611, -6804 (2021)).

Additional Domestic Violence-related Crimes and Penalties

Domestic violence crimes involve more than battery crimes. Related offenses include stalking, assault, and violating a protection from abuse order (Kan. Stat. §§ 21-5412, -5427, -5924, -6602, -6611 (2021)).

Arrest, Bail, and Firearm Restrictions

In addition to imprisonment and monetary penalties, Kansas law establishes the following conditions, restrictions, and penalties for domestic violence cases. Whether an offense constitutes domestic violence depends on the factors involved and not how the crime is labeled (McClain, 2021).

Arrests

When a police officer determines there is probable cause to believe a domestic violence crime has occurred, the officer must arrest the offender. The officer can make the arrest regardless of the crime's severity and even if they did not witness the unlawful conduct (McClain, 2021).

Bail and Pretrial Release

Pretrial release conditions in domestic violence cases typically include restrictions such as ordering the offender to stay away from and not contact the victim and prohibiting any use of firearms. For a person's felony or misdemeanor, the no-contact condition must last for at least 72 hours, whether the victim wants it or not. Judges determine the bail amount and any conditions based on a defendant's flight risk and risk of harm to the victim and others. Other conditions can include drug and alcohol monitoring, house arrest, mental health counseling, or anger management (McClain, 2021).

Firearms Restrictions

Kansas prohibits offenders convicted of a misdemeanor for a domestic violence offense from possessing any firearm for at least five years after the conviction. Additionally, federal law contains a firearms restriction provision as well (Kan. Stat. §§ 21-6301, 22-2307, 22-2802; 18 U.S.C. §§ 921, 922 (2021)).

Virginia Codes

According to the Virginia Codes: §18.2-51.2. A. Aggravated malicious wounding is the penalty for any person who maliciously shoots, stabs, cuts, or wounds any other person or causes bodily injury by any means with the intent to maim, disfigure, disable, or kill. They shall be guilty of a class two felony if the victim is thereby severely injured and left to suffer permanent and significant physical impairment. §18.2-57.2 A. Assault and battery against a family or household member; penalty, any person who commits an assault and battery against a family member or household member is guilty of a class 1 misdemeanor—Virginia House bill 708: 2014 legislation–domestic violence and sexual violence and stalking. Assault and battery against a family or household member; Enhanced penalty for previous convictions–adds unlawful

wounding in violation of § 18.2-51 and strangulation in violation of § 18.2-51.6. Any person who, without consent, impedes the blood circulation or respiration of another person by knowingly, intentionally, and unlawfully applying pressure to the neck of such person, resulting in the wounding or bodily injury of such person, is guilty of strangulation, a Class 6 felony. They added to the list of offenses a person previously convicted of two such crimes within 20 years. Such violations occurred on different dates, enhancing the penalty of assault and battery against a family or household member from a Class One misdemeanor to a Class Six felony.

Spiritual Mandate

Despite what was condoned by the church centuries ago, domestic violence should be a concern for every religious leader. Domestic violence victims are more likely to disclose abuse to someone in their faith community than they are to seek help from law enforcement (Sheltering Wings, 2020). Pastors have a spiritual mandate to ensure the safety of their congregation (Sheltering Wings, 2020). By acknowledging the reality of domestic violence, they communicate what a victim sees and that their church is safe. Churches can prevent abuse by sharing healthy relationships in marriage preparation courses and youth groups. The church works to shepherd family units to reflect the love and compassion of Christ. As such, a healthy, God-centered family is the foundational building block and the most important institution in society and is supported in the Bible in the book of Romans, "Be devoted to one another in love. Honor one another above yourselves. Never be lacking in zeal, but keep your spiritual fervor, serving the Lord" (*New International Version*, 1978/2011, Romans 12:10-11). The church also plays a vital role in providing a safe home and a loving family for men, women, and children who are victims of domestic violence (Sheltering Wings, 2020).

Victims and predators experience religious duress. This fear comes during the training and indoctrination when learning how to address and cope with the psychological effects of intimate partner violence. Fear can block progressive movements toward healing. Stunting their emotional growth can distort perceptions of reality. Such patterns will prohibit any spiritual guidance from penetrating through their emotional blockers.

Violence Against Women Within Black Communities

Violence against women and religious participation are two phenomena that are pervasive across many Black communities. Black women experience intimate partner violence at a rate higher than most racial groups in the United States. Estimates suggest that Black women are 35% more likely than their White counterparts to be victimized by an intimate partner and two times more likely than any other racial group (Tedder & Smith, 2018). Although many African American women highly depend on their faith and church to navigate their experiences with IPV, limited consideration gives Black clergy leaders a role in responding to IPV against women (Tedder & Smith, 2018).

A high level of church involvement among Black members suggests the Black church's potential to address domestic violence. However, little research has examined this topic. An exploratory study determined how aware African American churches are of victims in their congregation and how they respond to them (Williams & Jenkins, 2019). The results showed that these churches might underestimate the number of victims, infrequently address domestic violence from the pulpit, and sometimes provide potentially harmful interventions (i.e., couples' counseling or lack of safety risk assessment). Respondents thought their church's faith leader could improve their response to domestic violence with more training for clergy and knowledge of domestic violence resources (Williams & Jenkins, 2019).

Domestic abuse is one of the least addressed issues affecting the Christian family today (June & Black, 2002). Protestant pastors want to be helpful in domestic violence but are often unaware of how or where to start. Most say their church, about 87%, would be a haven for victims of domestic violence, but many are unaware that anyone in their church has been a victim of domestic violence. Approximately half, 52%, say they plan to help if a victim comes forward (Smietana, 2017).

Domestic abuse is one of the least addressed issues affecting the Christian family today. To the law enforcement authorities and the social service providers, it appears to be a taboo subject from the pulpit to the pew. To many outside the church community, it seems the church and its families are untouched by this problem (June & Black, 2002). Women have a one in four chance and men one in 10 of experiencing this traumatic experience, and it affects the mental health of victims adversely. As the number of reported incidents of domestic abuse increases nationally, so does the percentage of individuals in their congregations directly affected by domestic abuse. These increased incidents and the rise of individuals affected by domestic violence appear to be a natural correlation, so in keeping with the ministry of reconciliation, the church is needed to serve as a healing station for sin-sick, broken people (June & Black, 2002).

Psychological Aggression Experience

More than 43 million women and 38 million men experience psychological aggression by an intimate partner in their lifetime (Smith et al., 2018). Approximately 41% of female IPV survivors and 14% of male IPV survivors experienced a physical injury related to IPV. It is essential to acknowledge that IPV can extend beyond physical injury and result in death. Data from U.S. crime reports suggest that abusers kill 16% (about one in six) of victims of homicide.

(Breiding et al., 2014). Unfortunately, the police authorities often view domestic problems as a dispute rather than a crime of attack (June & Black, 2002).

Intimate Partner Violence Statistics

Statistics indicate that in the United States, more than 10 million adults experience IPV/domestic violence (DV) annually (Black et al., 2011). If each of these adults experienced only one incidence of violence, an adult in the U.S. would experience violence every three seconds. However, because IPV is a pattern, many individuals experience repeated acts of abuse annually, so an incident of abuse happens far more frequently than every three seconds (Smith et al., 2018). About one in four women and one in 10 men experienced contact with sexual violence, physical violence, and stalking by an intimate partner during their lifetime with 'IPV-related impact' such as being concerned for their safety, post-traumatic syndrome disorder (PTSD) symptoms, injury, or needing victim services (Smith et al., 2018), the number of intimate partner violence victimizations in the U.S. increased 42% (Morgan & Oudekerk, 2019). On a typical day, domestic violence hotlines nationwide receive over 19,000 calls (National Network to End Domestic Violence, [NNEDV], 2020). In 2018, intimate partner violence accounted for 20% of all violent crimes (Morgan & Oudekerk, 2019). Intimate partner violence is most common among women between 18 and 24, and 19% of intimate partner violence involves a weapon (Morgan & Oudekerk, 2019). Moreover, almost half of the pastors are unaware of such occurrences, pastors (47 percent) say they don’t know if anyone in their church has been a victim of domestic violence in the last three years. A third (37 percent) say a church member has been a victim of domestic violence. Fifteen percent say no one has experienced domestic violence. (Smietana, 2017).

Situation of Self

During a seminary experience, intimate partner violence (IPV) was never explored or addressed in any pastoral care classes, nor was it explicitly managed during chaplaincy training. This topic, IPV referred to as "battered women," was introduced while studying to become a health educator in the late 1970s. Initial exposure to this issue was during an undergraduate internship with the Women's Center, a local community-based organization that served every woman with information, referrals, and services. However, after 40 years, this researcher recognized this behavior continues to be prevalent locally as well as globally.

Problem Statement

Intimate partner violence (IPV) is not confined to any one religious, ethnic, economic, or educational background, age, physical abilities, or lifestyle. Women are the most frequent victims of domestic abuse, but elder and child abuse are also common. Men are often the perpetrators in violent events but are also identified as victims. According to the (CDC, 2020), approximately one in four women and nearly one in 10 men have experienced intimate partner violence (IPV), sexual violence, physical violence, or stalking by an intimate partner in their lifetime.

Law enforcement authorities, social service agencies, and community organizations are unable to meet the deepest hurts of families caught in the cycle of domestic violence. For too long, pastors and lay leaders have not permitted the facilitation of sermons, classes, and seminars within the church, therefore negating that the church is the place to bring the problem of domestic abuse to discussion and action (Smietana, 2017). The literature review indicates findings from clergy leaders' narratives suggests that they serve primarily four roles when responding to intimate partner violence against women: spiritual advisor, pastoral care/counselor,

compassionate leaders, and uninformed responders. Black clergy acknowledge the prevalence of intimate partner violence within their communities and are trained in pastoral counseling. However, they lack the knowledge and training to respond specifically to intimate partner violence (Tedder & Smith, 2018).

Discussions have centered on the need for IPV training for pastoral care leaders, given their position within the church. As a result, studies show that clergy leaders have primarily indicated a need for help understanding the basics of IPV and identifying gaps in their practices with abused women (Tedder & Smith, 2018).

Therefore, this dissertation study recognizes an indication from pastoral leaders that they find it challenging to believe members of their congregations are victims of IPV because they do not think IPV occurred in the church. Many leaders want to be helpful and address the issue of IPV but often do not know where to begin with rendering assistance. They are unaware that no one in their congregations is or has been a victim of IPV. They are not inclined to render services or assistance due to their lack of IPV training and an awareness of outside IPV resources and services.

Some pastors indicated that they would be willing to speak more about the issue, develop a plan, and offer their church as a haven if it were not for their lack of experience or awareness (Smietana, 2017). Therefore, this dissertation study examined pastoral leaders' attitudes toward IPV, IPV training, and IPV resources and services awareness and the level of assistance provisions for IPV victims. Additionally, this project determined if there was support for consideration of this issue from pastors that allowed and brought healing to their congregant members and others who might present with this issue and need assistance.

Purpose Statement

This quantitative study examined the attitudes and behaviors of the Episcopal Church's pastoral care leaders (i.e., the ordained Bishops, priests, and deacons; non-ordained Vestry, laypersons, and staff) toward IPV. Efforts identified their respective deficiencies and examined their IPV training needs, IPV resources, and services awareness, as well as how they influence the level of assistance provided to congregant members or individuals whom IPV has victimized.

Significance of the Study

The significance of this study was to enable pastoral leaders to recognize their attitudes towards IPV. The study allowed them to enhance their level of IPV educational information and their awareness of IPV resources and services. It was also an effort to heighten their consideration of the level of provisional assistance for congregant members or individuals victimized by intimate partner violence. When it comes to domestic violence, many pastors are hindered by their attitudes when confronted with the issue of IPV. When such situations arise, they may want to be helpful but often do not know or are unaware of how or where to start, and usually choose not to get involved. Pastoral leaders of the church may minimally show signs and interest in a victim's safety and refer the victim/survivor to an agency that can help. Most say their church would be a haven for victims of domestic violence, but many are unaware whether anyone in their church is or has been a victim of domestic violence. Few pastors say they have the capacity or a plan to help if a victim comes forward (Smietana, 2017).

Research Questions

The study seeks to answer these questions:

RQ1: What is the relationship between the attitudes toward IPV and the level of assistance provisions for IPV victims among pastoral care leaders?

RQ2: What is the relationship between IPV training, knowledge of resources, service awareness, and the level of assistance provisions for IPV victims among pastoral care leaders?

Definitions/Categories of Violence

Domestic Violence (DV)

Domestic violence is the willful intimidation, physical assault, battery, sexual assault, or other abusive behavior as part of a systematic pattern of power and control perpetrated by one intimate partner against another. It includes physical violence, sexual violence, threats, and economic and emotional/psychological abuse. The frequency and severity of domestic violence varies dramatically (National Coalition Against Domestic Violence, 2020).

Intimate Partner Violence (IPV)

Intimate partner violence is a new term that has appeared under a variety of names, including domestic abuse, wife-beating, spousal abuse, and domestic violence (Levers, 2012). Intimate partner violence is abuse or aggression that occurs in a romantic relationship. An intimate partner refers to both current and former spouses and dating partners. Intimate Partner Violence includes the following: physical violence, hitting, kicking, or using another type of physical force; sexual violence, forcing or attempting to force a partner to take part in a sex act, sexual touching, or a non-physical sexual event (e.g., sexting) when the partner does not or cannot consent; stalking, a pattern of repeated, unwanted attention and contact by a partner that causes fear or concern for one's safety or the safety of someone close to the victim; and psychological aggression (including coercive tactics), the use of verbal and non-verbal communication with the intent to harm another person mentally, emotionally, or to exert control over another person by a current or former intimate partner (National Center of Prevention and Control, 2020).

Abuser (Batterer)

An abuser utilizes abusive behavior to gain or maintain power and control over another intimate partner (National Coalition Against Domestic Violence [NCADV], 2019).

Battering

Battering is a pattern of behavior used to establish power and control over another person through fear and intimidation, often including the threat or use of violence (NCADV, 2019).

Cycle of Violence

A three-step circular pattern that may begin with tension builds until the abuser loses control; battering occurs when the batterer sometimes feels that the victim deserves it or that they need to teach the victim a lesson. Rationalizing and minimizing the consequences of abuse are expected, and remorse: The batterer is sorry and asks for forgiveness. The tension is gone, and they ask for reconciliation. The batterer may promise it will never happen again and behave lovingly and contritely. The victim usually accepts this, hoping the terror of everything will finally end (Walker, 2017).

Destruction of Property or Pets

Destruction of property or pets demonstrates another form of abusive behavior. The destruction of property often communicates the message, this time, the property; next time, it might be you (June & Black, 2002).

Intimate Partner (Victim)

An intimate partner may be a current or former spouse, boyfriend, or girlfriend, and the term assumes that the partnership may be either heterosexual or homosexual (CDC, 2020). An intimate partner is a person with whom one has a close personal relationship characterized by the partners' emotional connectedness, regular contact, ongoing physical contact, sexual behavior,

identity as a couple, and familiarity and knowledge about each other's lives. The relationship need not involve all these dimensions (Black et al., 2011).

Intimate Partner Relationships

Intimate partner relationships include current or former spouses (married spouses, common-law spouses, civil union spouses, domestic partners, boyfriends/girlfriends, dating partners, ongoing sexual partners, and intimate partners) that may or may not be cohabiting. Intimate partners can be opposite or same sex (Black et al., 2011).

Suppose the victim and the perpetrator have a child in common from their previous relationship, and they are not currently in a relationship with each other; then, by definition, they fit into the category of a former intimate partner. Some states differ as to what constitutes a common-law marriage. A common-law marriage is a legal concept that applies to couples in relationship appearances of marriage but is not fully state-issued and sanctioned by the state (such as by issuing a marriage certificate). A valid common-law marriage typically confers both the benefits and the obligations of a formal marriage (Pandolfi, 2021). Kansas and New Hampshire are both states that recognize common-law marriage. However, New Hampshire only recognizes common-law marriage for estate purposes (Pandolfi, 2021).

Pastoral Care

Pastoral Care provides support, comfort, and spiritual counseling to congregant members and others who require assistance within the community (Gordon et al., 2020).

Pastoral Care Leadership

The Pastoral Care leadership consists of the pastor, assistant, associate pastor, ministers, diaconate, chaplains, and laypersons who perform pastoral care (Gordon et al., 2020).

Pattern of Violence

A pattern of violence determines the way violence is distributed over time in terms of frequency, severity, or type of violent episode (i.e., physical violence, sexual violence, stalking, and psychological/emotional aggression (Black et al., 2011).

Perpetrator

A person who inflicts IPV (Black et al., 2011).

Physical Violence

Physical violence is the intentional use of physical force with the potential to cause death, disability, injury, or harm. Physical violence includes but is not limited to scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, hair-pulling, slapping, punching, hitting, burning, use of a weapon (gun, knife, or other objects), and use of restraints or one's body, size, or strength against another person. Physical violence also includes coercing other people to commit any of the above acts (Black et al., 2011; CDC, 2016).

This category is when non-accidental acts of physical force that have reasonable potential to result in bodily harm to an intimate partner or evoke significant fear in the partner have occurred during the past year. Intentional acts of physical force include shoving, slapping, hair pulling, pinching, restraining, shaking, throwing, biting, kicking, hitting with the fist or an object, burning, and poisoning. Also, physical force applies force to the throat, cutting off the air supply, holding the head underwater, and using a weapon (DSM-5, APA, 2013).

Psychological/Emotional Aggression

This abuse encompasses non-accidental verbal or symbolic acts by one partner that have reasonable potential to result in significant harm to the other partner. Use of verbal and non-verbal communication to a) harm another person mentally or emotionally and b) exert control

over another person. Psychological abuse includes expressive aggression (e.g., name-calling, berating or humiliating the victim, interrogating the victim). Coercive control restricts the victim's ability to come and go freely; unwarranted restrict the victim's access to or use of economic resources; isolates the victim from family, friends, or social support resources; and obstructs the victim's access to assistance (e.g., law enforcement, legal, protective, or medical resources). They threaten the victim with physical harm or sexual assault (e.g., control of reproductive or sexual health; harming, or threatening to harm, people or things that the victim cares about). The exploitation of victims' vulnerabilities (e.g., trying to make the victim think that they are crazy, immigration status, disability); presenting false information to the victim to make them doubt their memory or perception (e.g., mind games) (APA, 2013; CDC, 2016).

Psychological abuse involves trauma to the victim caused by verbal abuse, acts, threats of acts, or coercive tactics. Perpetrators use psychological abuse to control, terrorize, and denigrate their victims. It frequently occurs before or concurrently with physical or sexual abuse (National Coalition Against Domestic Violence [NCADV], 2019).

It also involves the systematic destruction of a person's self-worth through harassment, threats, and food and sleep deprivation (June & Black, 2002). It can include but is not limited to, humiliating and shaming the victim, making the victim feel diminished or embarrassed, threatening the victim's children, and stalking (Franklin & Fong, 2011).

Sexual Violence

Sexual violence is a sexual act committed or attempted by another person without freely given consent from the victim or against someone unable to consent or refuse. It includes voluntary or involuntary use of alcohol and drugs. Forced alcohol/drug-facilitated penetration of a victim; forced or alcohol/drug-facilitated incidents in which the victim was made to penetrate a

perpetrator or someone else; non-physically pressured unwanted penetration; intentional sexual touching; or non-contact acts of a sexual nature. Sexual violence can also occur when a perpetrator forces or coerces a victim to engage in sexual acts with a third party (APA, 2013; CDC, 2016).

When forced or coerced, sexual acts with an intimate partner that have occurred during the past year. Sexual violence may involve using physical force or psychological coercion to compel the partner to engage in a sexual act against their will, whether or not there is an act of completion. Also included in this category are sexual acts with an intimate partner who cannot consent due to incapacitation, lack of consciousness, or awareness (APA, 2013; CDC, 2016).

Spiritual Abuse

Spiritual abuse is the use of spiritual power, position, or information to control, intimidate, or manipulate another person within a religious organization or a personal relationship (e.g., church leaders demand entire income; use scriptures by distorting the Word of God and the character of God). Spiritual abuse is not limited to one religion, denomination, or group of people. It can happen in any religious group as an element of intimate partner violence that concerns crossing relationships of all ages, genders, socioeconomic classes, ethnic groups, and locations (Brennan, 2020; June & Black, 2002; NCADV, 2017).

Spousal Neglect

Partner neglect is any egregious act or omission in the past year by one partner that deprives a dependent partner of basic needs and thereby results or has reasonable potential to result in physical or psychological harm to the dependent partner. This category uses the relationship context where one partner relies highly on the other for care or assistance navigating ordinary daily activities. For instance, when a partner is incapable of self-care owing to

substantial physical, psychological/intellectual, or cultural limitations (e.g., inability to communicate with others and manage everyday activities due to living in a foreign culture) (APA, 2013).

Violent Episode

A single act or series of acts of violence is perceived to be connected and may persist for minutes, hours, or days. A violent episode may involve single or multiple types of violence (e.g., physical violence, sexual violence, stalking, and psychological aggression) (Black et al., 2011).

Summary

Pastoral care leaders often find themselves able to counsel, refer, and offer information to victims and survivors of IPV. They usually express their inability to address the issue. This chapter provided relative background information, the problem, the purpose of the study, its significance, and the definitions of domestic violence and IPV.

CHAPTER TWO: LITERATURE REVIEW

Overview

This review discusses the literature on the theoretical contexts or framework for understanding intimate partner violence (IPV). The literature review discusses the individual and societal consequences of intimate partner violence in physical, psychological, sexual, and financial contexts. Specific information reviewed addressed current knowledge and the understanding of pastoral care leadership regarding the dynamics of abusive relationships, providing information on IPV resources and services, and determining their attitudes, capacities, and motivations to address IPV proactively.

The information examined also addressed the implications of the cycle of violence, property destruction, social cost, and the potential for multiple losses. Although limited, the review presents secular, non-secular prevention, and protective strategies on how individuals who are subjected to intimate partner violence can adhere to various measures; this will allow for self-preservation while being reinforced with a personal positive self-worthiness perspective.

Theoretical Framework

Feminists who support feminism, a political movement that exists to rectify inequalities between men and women, found that women were beaten at the hands of their partners. There is no single causal factor related to domestic violence, and scholars have concluded that there are numerous factors that contribute to domestic violence. Drawing on feminist theory, they helped explain the relationship between patriarchy, a social system in which men hold primary power and control, and domestic violence (NCADV, 2017).

Intimate partner physical abuse is not bound to age, socioeconomic status, race, ethnicity, sex, sexual orientation, gender identity, religion, or nationality; it exists in all communities.

Physical abuse is not simply a maladjusted person's occasional expression of frustration or anger, nor is it typically an isolated incident. Physical abuse is a tool of control and oppression and is a choice made by one person in a relationship to control another (NCADV, 2015). While IPV victims/survivors include both males and females, women experience victimization at higher rates than men, and the impact of violence on women is generally more profound than on men (Black et al., 2011). Perpetrators who are physically violent toward their intimate partners are often sexually abusive (NCADV, 2017). Victims who are both physically and sexually abused are more likely to be injured or killed than victims who experience one form of abuse. Abusers assault people of all genders, races, ages, social classes, and ethnicities (NCADV, 2017).

Feminist Theory

According to Crossman (2020), feminist theory is a significant branch of sociology that shifts its assumptions, analytical lens, and topical focus away from the male viewpoint and experiences toward those of a woman. In doing so, feminist theory illuminates social problems, trends, and issues that may be otherwise overlooked and misidentified by the historically dominant male perspective (Crossman, 2020).

Fundamental tenets within the feminist theory include discrimination and exclusion based on sex and gender, objectification (especially sexual objectification), structural and economic inequality, power and oppression, patriarchy, gender roles, and stereotypes (Crossman, 2020). Feminist theory of gender-based oppression has evolved to account for additional factors and complexities that intersect with gender to place women and other vulnerable groups at a disadvantage in establishing equitable power relationships with their partners and in society (Kelly, 2011). These groups, such as black feminists, Chicana/Latina feminists, Native Americans, and other indigenous feminists, along with women of disabilities, are also included

in the vulnerable intersectionality of being abused, silenced, and pushed to invisibility by intersecting oppression based on societal identity (Kelly, 2011).

The feminism theory is assumed to be relevant only to women, specifically to White women. The inclusive feminists' theory involves a commitment to end all forms of oppression and is attentive to the intersections of racism, ethnocentrism, sexism, and other forms of inequality. Although sexual violence is disproportionately perpetrated by men against women, both men and women can be victims/survivors of sexual violence, and both can be perpetrators of sexual violence (Enns, 2020). Four major factors have influenced the development of sexuality within the women of Latin cultures in the United States: historical influences, immigration, language, and the psychological effects of oppression. Latin women experience a unique combination of power and powerlessness, which is characteristic of their culture. They practice discussing personal problems only with women within their respective Latin cultures. As they go through the experience of acculturation, Latina women must often make a choice relative to their sexual behavior and how critical such expressions are contingent upon their exposure to different and respective experiences and values (Espin, 2018). Most feminist theorists throughout history have been women. However, all genders have been found to work in this discipline.

Shifting the social theory away from the perspective and experiences of men, feminist theorists have been able to create social theories that are more inclusive and creative than those that assume that the social actors are always men (Crossman, 2020). Seeing women through the lens of male psychology emphasized separation and autonomy as an alternative rather than the central relationships viewed by women's experience of themselves and the world. Traits typically pathologized (needing other people, attending to the messages of emotion, wanting to participate

in growth, and fostering relationships for all involved) were revisited by Jean Miller, a noted feminist and psychoanalyst, and her colleagues who discovered strengths where others had seen weakness. The resulting work of this group is known as Relational-Cultural Theory (RCT) and has offered new understandings of women's and men's development with a particular emphasis on the impact of power and marginalization on personal and collective well-being (Jordan, 2017).

Feminist theory architectural principle conceived multifaceted, multi-sited projects rather than bounded fields (Ferguson, 2015). Feminism would not exist as a theoretical endeavor without the political struggles for women's empowerment that have emerged in all regions of the world (Disch & Hawkesworth, 2016). Feminists and scholars have divided the movement's history into four "waves." The first wave refers mainly to women's suffrage movements of the nineteenth and early twentieth centuries (primarily concerned with women's right to vote). The second wave refers to the ideas and actions associated with the women's liberation movement beginning in the 1960s (which campaigned for legal and social rights for women). The third wave depicts feminism as more inclusive and racially diverse than previous waves. The fourth wave encourages women to be politically active and passionate about the previous wave’s issues, such as the wage gap and ending sexual violence. Its main goals are to call out social injustices and those responsible for them, as well as to educate others on feminist issues and to be inclusive to all groups of women (Guy-Evans, 2024).

Intimate partner violence (IPV) is a severe social problem affecting millions in the United States and worldwide. The image of violence enacted by a male aggressor on a female victim dominates public perceptions of IPV. There is research that examines how this heteronormativity influences reporting and responding to partner violence when those involved do not fit the

stereotype of a typical victim of IPV. Research and theory have helped us to understand the power dynamics of heterosexual IPV; this study encourages greater attention to the unique issues and power dynamics of IPV in sexual minority populations. It also examines the similarities and differences of IPV within heterosexual and gender minority relationships (Russell, 2020).

Feminist Therapy

Several noted psychoanalysts and social activists founded feminist therapy, Jean Baker Miller, Carol Zerbe Enns, Olivia M. Espin, and Laura S. Brown in the late 1960s (Brown, 2018; Corey, 2012). Feminist practice is psychology derived from the realities that lie outside, beneath, and at variance from the vision of the dominant patriarchal mainstream (Brown, 2018). It is an integrative and competency-based paradigm that perceives human beings as responsive to the problems of their lives, capable of solving those problems, and desirous of change. It is also a politically informed model that observes human experience within the framework of societal and cultural realities and through power dynamics informing those realities (Brown, 2018).

The fundamental concepts of feminist therapy are the view of human nature, the feminist perspective on personality development, and the principles of feminist therapy. The principles of feminist therapy consist of the following: the personal is political, commitment to social change, women's and girl's voices and ways of knowing are valued, and their experiences are honored; the counseling relationship is egalitarian, and a focus on strengths and a reformulated definition of psychological distress and all types of oppression are recognized (Corey, 2012).

Some of the main therapeutic goals in feminist therapy are empowerment, going for change rather than adjusting to the problem, social change, valuing diversity, and knowing and keeping independence and interdependence separated (Corey, 2012). Techniques to accomplish these include eliminating the Diagnostic and Statistical Manual (DSM). The feminist therapist

thinks race, culture, and gender influence symptoms a client may have (Corey, 2012). Feminist therapists do not use specific but client-specific techniques depending on each client's needs (Brown, 2018).

Theological Framework/Biblical Support

Theological issues confronting victims and survivors varied as they sought faith-based help. However, three recurring themes present significant barriers to victim safety, which are the biblical principle of forgiveness, a mandate for female submission, and the primacy and sanctity of marriage (Drumm et al., 2017). Based on the teachings and their understanding of the Bible, many women do not believe there is an alternative to their violent marriage or partner relationship.

Marriage is a mature covenant between a man and a woman before God. It is a lifelong commitment based on love, trust, and a mutual self (June & Black, 2002). According to scripture, divorce is not a viable option (New International Version, 1978/2011, 1 Corinthians 7:10). Therefore, some women and men choose to preserve the status quo of the family at all costs. A misrepresentation of Christ's teachings on marriage may leave the abused wife in the bondage of guilt, self-blame, suffering, and feeling abandoned by God. Men and women must submit to each other as they submit to Christ. The husband is considered the authority of the household, and there is an expectation that wives must extend obedience to their husbands, relinquishing all power (New International Version, 1978/2011, Ephesians 5:21-24). Wives are subservient to their husbands as they would be to Christ. Husbands are to love their wives gently (New International Version, 1978/2011, Colossians 3:18-19). Husbands and wives must cherish each other and be faithful to one another (New International Version, 1978/2011, 1 Corinthians 7:4).

Victims suffering at the hands of an intimate partner often need and seek help from an array of professionals and organizations (Choi, 2015a). Organizations that victims and survivors of IPV regularly turn to for help include faith communities and local churches (Postmus et al., 2014). Victims and survivors of IPV who have reached out to churches or members of the clergy for help have reported mixed experiences regarding effectiveness and did not always perceive the church as helpful, recalling negative interactions and outcomes (Postmus et al., 2014). These variations in receiving appropriate help may be due in part to the gendered nature of IPV and the demographic makeup of the clergy profession. As mentioned, many IPV help seekers are women, while most clergy members are men (Faith Communities Today, 2015).

Female ministers experienced the dichotomy of being a woman and being a minister during their encounters with victims and survivors of sexual abuse or rape. As women, they tended to become emotionally involved in the suffering of the victims and survivors. As ministers, they experienced prayer and scripture reading in collaboration with counseling promoted healing. They also experienced how victims and survivors perceived them as approachable because of their gender, but less because of their status as ministers (Van Wyk, 2018).

Related Literature

Attitudes and Theological Beliefs

Moder (2019) purports that domestic abuse is a common occurrence for women in the Christian church. Often based on the understanding of Jesus, subordinate to God the Father in the trinity, the correlated praxis of the church has commonly been the subject of suffering women at the hands of men–even at the cost of their lives–thus mimicking the death of Christ. Underlying this dark reality is a long history of patriarchal theological interpretations that have depicted God

as the dominant male figure that subjects women to the male hierarchy as a subordinate. This male-dominated culture theology is profoundly flawed, and the subsequent praxis of women's subordination severely challenges liberal feminists, and rightly so, for the sake of women's survival and flourishing (Moder, 2019).

The socialization of women's self-silencing by religion has complicated pastoral care interventions for those who are victims of IPV, particularly in the context of marriage. Pastoral caregivers need to explore and extend caregiving to victims who are self-silenced. Findings indicated that women force silence on themselves in the context of domestic violence by not speaking about the abuse in a marriage. Self-silencing was justified by those interpreting the Biblical text that addresses marriage naively (Chisale, 2018). To keep peace in the household with their wives, men felt compelled to move to a quieter place in the home (*New International Version*, 1978/2011, Proverbs 21:9). Comparatively, women followed the example of Christ, who remained silent during his pain of affliction on the Cross, by keeping quiet during times of duress (*New International Version*, 1978/2011, Isaiah 53:7.

Religious leaders of the Pakistani Islamic faith met to gain their perspective and understanding relative to domestic violence of IPV. Most leaders considered marital inequality the norm and believed the husband should have a commanding position in the household. They were quick to blame women for the violence inflicted on them, criticizing the "modernization" of women or women being "too independent." Most of them felt that she deserved "mild violence" if she defied the role of an "ideal wife," but all agreed that severe damage to her health was un-Islamic and illegal. All believe women have many rights in Islam, but a woman's freedom must remain confined to the limits of religion and culture (Ali et al., 2020). The Islamic culture compels victimized women of violence to pray and remain patient. Some faiths do not consider

counseling programs or alternative treatments as options. The culture also emphasizes marriage preservation rather than dissolution (Ali et al., 2020).

Described as a "Holy Hush," past research indicated a general silence and reluctance to address intimate partner violence (IPV) in religious congregations. Twenty Protestant Christian religious leaders were interviewed about how well they understood and responded to IPV. Based on thematic content analysis, the study revealed some challenges, tensions, and complexities that may be barriers to leaders speaking about and responding to IPV and how some religious leaders attempted to overcome these challenges (Houston-Kolnik et al., 2019). The results revealed that religious leaders understood violence on a gradation scale from less to more severe and linked a need for any response based on the level of violence. Religious leaders expressed tension between their leadership role and responding to IPV. Furthermore, religious leaders acknowledged their need for more excellent training and connections with service providers. They also reported not being connected to other IPV resources or organizations within the community (Houston-Kolnik et al., 2019).

There is a complex intersection of religion, internal displacement, and sexual violence between sexual violence survivors and faith leaders within the community, determined by data collection from interviews and focus groups. The qualitative empirical data retrieved was used to unpack the displaced survivor's experiences and needs to reflect on the church's response to internally displaced and sexual violence survivors more broadly (Le Roux & Valencia, 2019). When churches offer a spiritual response to a traumatic event and its consequences, a sense of community and belonging can contribute to the displaced survivors' coping ability and healing process. A theological approach to sexual violence can ensure that sexual violence prevention and response is seen as part of a church's core mandate and mainstreamed in its activities by

leveraging its ability to influence community and individual beliefs and behaviors. Churches can counter the inter-generational cycle of intra-familial violence that so often emerges or occurs in settings of internally displaced persons (Le Roux & Valencia, 2019).

Traumatic Consequences of IPV on Individuals

Intimate partner violence is a significant public health problem affecting millions of people in the United States each year. A 2015 survey report from the National Intimate Partner and Sexual Violence Survey (NIPSVS) found that 43.6 % of women and 24.8% of men experienced contact with sexual violence, physical violence, and stalking by an intimate partner during their lifetimes (Smith et al., 2018). Intimate Partner Violence has been linked to severe long-term physical and mental health consequences and has an estimated lifetime economic burden of $3.6 trillion (about $11,000 per person in the U.S.) (Peterson et al., 2018a).

Physical Effects

The physical effects of IPV are often first discovered in medical settings like emergency rooms, physician's offices, or clinics. Identifying and treating IPV-related injury and illness hinder victims when they are reluctant to report their partners' violence to medical personnel. They fear that police and legal intervention may follow, further jeopardizing their physical safety and financial security. Additionally, the shame and social stigma attached to being battered by a partner or spouse prevent many victims from seeking medical help for all but the most severe injuries, often attributed to falls or other accidents. Suppose the victim is also a member of a minority population. In that case, the personal experience of racism and prejudices realistically may contribute to an individual's reluctance to seek help for physical problems associated with IPV (Levers, 2012).

Psychological and Emotional Effects

Psychological violence should be considered one of the more severe forms of IPV, which can affect the mental health of victims. The effect of psychological violence on mental health is more prominent than initially thought. The impact of psychological violence on mental health is more prominent than initially thought (Langdon, 2014). Despite its high prevalence and severe health consequences, IPV remains neglected mainly as a physical and mental health priority, including in psychiatry. Psychiatrists and other mental health professionals need to be knowledgeable about IPV and its mental health sequelae (Stewart & Vigod, 2017). Empowerment is one of the significant factors in healing from all forms or types of violence and abuse, especially intimate partner violence (IPV). Feeling and being in charge of one's own life is the most potent cure for depression and the most damaging mental health issues one might experience (Walker, 2017). Intimate partner violence (IPV) has been known to adversely affect the mental health of victims in comparison with those who have never experienced IPV or those experiencing other traumatic events. The most significant outcomes were associations between IPV experiences with depression, post-traumatic stress disorder (PTSD), and anxiety (Langdon, 2014). Additional psychological consequences that may manifest are psychosis, antisocial behavior, suicidal behavior or ideations, self-harm behaviors, low self-esteem, inability to trust others, sexual dysfunction, emotional detachment, sleep disturbances, flashbacks, replaying the assault in the mind, appetite disturbances, and obesity disorder (Stewart & Vigod, 2017). According to Alhalal, 2018, “intimate partner violence is a public health issue found to be related to obesity.” Obese women had significantly higher levels of IPV, physical child abuse, depressive symptoms, and PTSD symptoms (Alhalal, 2018).

As indicated in the study by Ouellet-Morin et al. (2015), women who experience violence perpetrated by their partners suffer multiple negative consequences. This study also showed that women victims of intimate partner violence are at increased risk for poor mental health. This research disentangled the effect of partner violence on new-onset depression and psychosis spectrum symptoms of the impact of child maltreatment and other confounding factors, including substance abuse and antisocial personality (Briere & Jordan, 2004; Ouellet-Morin et al., 2015). Intimate partner violence (IPV) is a trauma experienced mainly by females at the hands of males, but one that exists as a form of the power differential that can include same-sex couples as well (Levers, 2012). Approximately four out of 10 women reported being the victim of violence from their partner in 10 years. Women who were abused in childhood and adulthood were four to seven times more likely to suffer from depression than never-abused women. Depression and Post-Traumatic Stress Disorder (PTSD) are known to have a high degree of comorbidity, the most prevalent mental health problems associated with IPV, with the occurrence of PTSD in battered women being statistically much higher than in non-abused women (Levers, 2012). Women victims of IPV account for more than their share of depression. When IPV stops among women and their partners, psychological difficulties are reduced (Ouellet-Morin et al., 2015).

As indicated earlier, according to the NCADV, 2020, women have a one-in-four chance of experiencing IPV. Those who do are at increased risk of developing physical and mental health problems, including traumatic brain injury, chronic pain, gastrointestinal disorders, obesity, depression, post-traumatic stress disorder, and substance-related disorders (Wong & Mellor, 2014). Intimate partner emotional abuse, as well as the absence of a partner caring and showing respectful behavior, may lead to physical and mental health symptoms in addition to diminished quality of life. Depression is an independent risk factor for cardiac disease and is

common among victims of childhood abuse and IPV. Women with depression need focused and specialized preventive care (Lutwak, 2018).

Women who develop symptoms of post-traumatic stress disorder (PTSD) and depression after interpersonal trauma are at heightened risk for future IPV victimization (Iverson et al., 2011). They also tend to have more medical conditions and worse physical problems, bodily pain, and lower energy levels than women with depression alone. Individuals with PTSD are 80% more likely than those without PTSD to have symptoms that meet diagnostic criteria for at least one other mental disorder (e.g., depressive, bipolar, anxiety, or substance use disorders) (APA, 2013). Post-Traumatic Stress Disorder is more prevalent among females than among males across the lifespan. Females in the general population experience PTSD for a longer duration than males. At least some of the increased risk for PTSD in females appears to be attributable to a greater likelihood of exposure to traumatic events, such as rape and other forms of interpersonal violence (APA, 2013).

Research has demonstrated that Battered Women Syndrome (BWS) has seven groups of criteria that have been tested scientifically and can be said to identify the syndrome. The first four groups of symptoms are the same as for the PSTD criteria. The subsequent three criteria groups are present in victims of IPV (Walker, 2017). The seven criteria identified both in the battered woman syndrome and PTSD are the following: Intrusive recollections or re-experiencing of the traumatic event (s); high levels of avoidance behavior and emotional numbing; high levels of anxiety and hyperarousal; cognitive difficulties, including attention and concentration; disruption of interpersonal relationships from loss of power and control and isolation; distorted body image and somatic complaint; and sexual issues (Walker, 2017). The likelihood of PTSD being the response continues to occur throughout the relationship. The Duros

analysis of PTSD revealed that the most recent battering incidents reporting sexual abuse produced the most severe PTSD in the women who experienced such circumstances (Walker, 2017). The analysis results are consistent with the literature on temporal proximity as a significant factor in the development of PTSD symptomatology. Research suggests that traumatic events produce inflammatory responses in the body that mediate the response between traumatic stressors and health problems (Kendall-Tackett, 2009). Women exposed to IPV and other forms of lifetime trauma may be at risk for adverse mental health. Exposure found that most participants identified other traumatic events as more disturbing than IPV-related trauma. The risk for PTSD increased with age, suggesting that the cumulative effect of trauma, including IPV, increased the risk for PTSD over a lifetime (Kostello et al., 2016). Chronic illnesses such as cardiovascular disease, asthma, diabetes, and gastrointestinal disorders are associated with high levels of stress. Thus, body reactions associated with PTSD and IPV or battered women syndrome (BWS), such as anxiety attacks, phobias, sexual problems, sleep problems, anger, and hypervigilance (jumpy, easily startled), are often misdiagnosed or ignored until it is too late to avoid the chronic disease (Skaine, 2015; Walker, 2017).

When PTSD co-occurs with substance abuse and other health concerns, the psychological issues both become challenging to treat and less likely to get attention from caregivers (Cohen et al., 2013). Having these symptoms suggests that there may be a need for programs to reduce the trauma responses for comprehensive integration with medical and psychological services, especially for IPV victims. Studies have shown strong associations between intimate partner violence (IPV) and both post-traumatic stress disorder (PTSD) and substance use disorders (SUD) (Cohen et al., 2013).

The association of alcohol and other drug substances with domestic violence has long been known by those who work with victims and the perpetrators. The use of alcohol and other drug substances, such as amphetamines and cocaine derivatives, are directly associated with violent behavior even though there is no clear cause-and-effect relationship, or the strength of the relationship known. The explosion of oxycodone, morphine, and other designer drugs is also associated with violence. Investigators have begun to look at additional substance abuse risk factors in acute IPV incidents, finding that men who use alcohol are significantly associated with a greater risk of injuries that require emergency room attention. At the same time, there is no similar relationship between IPV and substance abuse (Walker, 2017).

A recent Center for Disease Control and Prevention (CDC) study found that women who drink one drink per day on average or binge drink often have IPV in their history. Heavy and binge drinking contributes to increased risk and severity of violence in intimate relationships. However, its role in initiating and escalating intimate partner violence (IPV) is not well understood (Wilson et al., 2017). For some women, alcohol plays a central role in the cycle of violence, abuse, and fear (Wilson et al., 2017). The research also found that women find it more difficult to leave a domestic violent relationship with substance abuse problems. Consistent with the literature reviewed, alcohol abuse is a risk factor for IPV, especially among alcoholic men. It was evident in the regression analysis conducted that alcohol was the most prevalent and the most significant predictor of how badly abuse affected women. The density of bars was positively associated with IPV-related emergency department (ED) visits. The density of off-premise outlets was negatively related to IPV-related ED visits; this association was weaker and smaller than the bar association (Cunradi et al., 2012). Alcohol intoxication impairs cognition, and the possibility exists that while under the influence of alcohol, the abuser may demonstrate

fewer inhibitions or judgment when "beating" their female counterpart, which may lead to a more severe degree of injury. Research over the past 40 years regarding the relationship between IPV and substance abuse revealed that few programs helped the combined issues (Walker, 2017).

Sexual Effects

Intimate partner violence (IPV) is a significant global health issue associated with an increased HIV-related risk and vulnerability to HIV infection. IPV against women was associated with the presence of HIV-risk behaviors, such as a history of sexually transmitted infections (STIs), multiple sex partners, inconsistent condom use, partners with known HIV risks, and inability to negotiate safer sexual practices. This outcome highlights a need to develop effective interventions aimed at eliminating IPV to decrease the disproportionate burden of adverse health outcomes, including STIs/HIV among women (Shrestha & Copenhaver, 2016). IPV undermines women's ability to enact safer sex and increases their vulnerability to HIV and other sexually transmitted diseases (STD) (Mittal et al., 2012). Survivors of IPV have an elevated risk for adverse sexual health outcomes, including human immunodeficiency virus (HIV) and sexually transmitted infection (STI). Given the unique risk contexts for survivors, there is a need for effective sexual health interventions that consider the imbalances of power for women who are survivors of IPV (Bagwell-Gray, 2019). HIV prevention efforts promote the use of condoms to prevent the spread of HIV and other STDs. Thus, a woman's agency to practice healthy sexual behaviors necessarily involves negotiation with another person. Healthy sexual behaviors pose unique challenges for women who have limited power in relationships (Swan & O'Connell, 2012). IPV led to secondary HIV risk as women experienced forced sex, often with little power to negotiate condom use (Hatcher et al., 2015).

Despite progress against intimate partner violence (IPV) and HIV/AIDS in the past two decades, both epidemics remain major public health problems, particularly among women of color (Stockman et al., 2013). Intimate Partner Violence is associated with fear of violent consequences to requests for condom use, and such fear is associated with inconsistent condom use. Women who reported IPV also reported more significant difficulties in negotiating safer sex behaviors with their abusers. Fear of violent consequences hinders their ability to protect themselves against HIV infection. The results were consistent with the fear of violent consequences mediating the relationship between IPV and condom use (Mittal et al., 2012).

Stalking

Stalking is a course of conduct including intimidation, surveillance, or harassment that places a person in reasonable fear of material harm to their health or safety or the health or safety of an immediate family member, household member, spouse, or intimidating partner or pet. Stalking is a serious crime. Former and current intimate partners often use stalking to terrorize their victims (NCADV, 2020). It is a pattern of repeated, unwanted attention and contact that causes fear or concern for one's safety or the safety of someone else (e.g., a family member or close friend) (Black et al., 2011; CDC, 2016).

Cyberstalking, a pattern that utilizes a wide array of computers and equipment, including the Internet, global positioning systems, cell phones, and tiny digital cameras, is a more recent means of exploiting the vulnerabilities of individuals with repeated, unwanted attention and contact (Kentucky, KRS 508, 130-150, 2009).

Financial Effects

One of the most successful reliefs for women subjected to IPV and their children has been the provision of a shelter or safe home concept. For domestic violence victims, the

equivalent of hospitalization is a battered women's shelter where women can remain with their children until they can make some decisions as to where they want to live. In the United States, shelter stays are relatively short compared to other countries, especially where obtaining adequate housing is an issue (Walker, 2017). Today, battered women's shelters are on-location and supported in most countries. Although inadequate to meet everyone's needs, the presence of just one shelter indicates to the entire community that abuse against women is unacceptable. Community support is vital when cultural and religious messages conflict, sometimes facilitating more abuse. Women are sent back to the violent home with the perpetrator while seeking help (Walker, 2017).

Battered women's shelters are particularly helpful for poor or isolated women who have no knowledge of or access to services for themselves or their children. It is critical that women who lack support networks, changing gender roles, and tensions between traditional gender norms and those of the "modern" city report key contributors to IPV programs. Urban poverty and unemployment, food insecurity, and housing instability also played a role (Cardoso et al., 2016). Rapid urbanization is a vital driver of urban populations' unique health risks. One of the most critical health hazards facing urban women is intimate partner violence (Cardoso et al., 2016). Victims of IPV rates were highest in the poorest neighborhoods (Bonomi et al., 2014). Economic conditions influence marital quality and relationship instability. Similarly, researchers have identified low income and poverty as significant risk factors for IPV (Copp et al., 2016). Unemployment and economic hardship at the household level were positively related to abusive behavior. Further, rapid increases in the unemployment rate increased men's controlling behavior toward romantic partners even after adjusting for unemployment and economic distress at the household level. These findings demonstrated that the uncertainty and anticipatory anxiety

accompanying sudden macroeconomic downturns negatively affect relationship quality, above and beyond the effects of job loss and material hardship (Schneider et al., 2016). Intimate partner violence is contact with sexual violence, physical violence, or stalking victimization with related impact (e.g., missed workdays). Costs included attributable impaired health, lost productivity, and criminal justice costs from the societal perspective (Peterson et al., 2018b). Women in the U.S. need assistance with applying for government financial assistance, housing, medical care for themselves and their children, food stamps, and other benefits until they can sustain themselves. Perpetrators destabilized by their mental health conditions or substance abuse cannot be depended upon to provide adequate monetary resources to support themselves and their families financially, as required (Walker, 2017).

Women in rural communities who are exposed to intimate partner violence (IPV) have fewer resources when seeking help due to limited health services, poverty, and social isolation. Rural primary care physicians may be critical sources of care for IPV victims (McCall–Hosenfeld et al., 2014). A physician may suspect IPV when patients present with symptoms of mood swings, anxiety, or somatic disorders. Responses to IPV included validation, danger assessment, safety planning, referral, and follow-up planning. Perceived barriers for rural women seeking help for IPV include traditional gender roles, lower education, economic dependence on their partner, low self-esteem, and patient reluctance to discuss IPV. Physicians created a "safe sanctuary" to discuss IPV and suggested improved public health education and referral services to overcome barriers. Interventions to enhance IPV-related care in rural communities should address obstacles at multiple levels, including physicians' and patients' comfort with discussing IPV. Provider training, community education, and improved access to referral services are

critical areas where IPV-related care needs improvement in rural communities (McCall–Hosenfeld et al., 2014).

Intimate Partner Violence is a significant public health concern that has profound impacts on women across the globe. Though it cuts across race, socioeconomic status, age, geography, and sexual orientation, those communities plagued by poverty experience disproportionate rates. Poverty creates unique circumstances of vulnerability for individuals, families, and communities disproportionately experienced by Black communities in both developed and developing countries. The impact of poverty in Black communities is significant and pervasive, with deep historical roots. Both IPV and poverty have profound effects on women's physical and psychosocial health and well-being. Black women who live at the intersection of experiencing poverty and IPV are in an especially disadvantaged position (Gillum, 2019). However, when their children were age three, more than one in five mothers were living with a partner who abused them. The prevalence of any IPV was highest among Hispanic (26%) and foreign-born (35%) mothers (Golden et al., 2013).

Some philosophies support the empowerment of women to make their own decisions. Policies and programs that reduce economic hardship among women with young children, promote women's financial independence, and foster gender equity in romantic partnerships can potentially reduce multiple forms of IPV (Golden et al., 2013). These policies and programs also suggest giving women an opportunity to exhaust all their options before giving up on a relationship that brought them so much pleasure and pain. The courage and dignity these women demonstrate while at their most significant point of frustration can be appreciated, especially when they finally choose to be free and safe from violence (Walker, 2017).

The relationship between women's asset ownership and IPV is inconclusive. On the one hand, women's asset ownership may be protective against IPV or force them to leave the abusive situation. When women have legal documentation of asset ownership and separation laws support women's inheritance of assets, theory predicts that losses for men increase if women were to leave relationships, discouraging perpetration. Conversely, in societies where asset ownership is a marker of men's dominance or violence control victims, women's property ownership may transgress historical or rigid gender norms, leading male partners to assert their control through violence perpetration (Peterman et al., 2017).

Spiritual Effects

Individuals who use violence against their intimate partner(s) sometimes use religion as a mechanism of control. However, discussion on religious/spiritual (R/S) abuse in the context of intimate partner violence and abuse (IPV/A) has been limited within academic literature. The attack on one's spirituality or faith is unique enough to explore separately from typical psychological or emotional abuse. Because many victims experience IPV/A, consistent reports use religious faith and clergy as critical sources of support (Davis & Johnson, 2020). There are clergy who view R/S abuse as a spiritual problem and characterize the behavior as a misinterpretation of God's Word. They emphasize the importance of victim-survivors knowing the Word of God for themselves as a resource to counter R/S abuse. Victims highlighted a need and desire for clergy-specific training, yet data analyses also revealed that fellow clergy members' perpetration of R/S abuse was a barrier to addressing the problem. Understanding religious leaders' perspectives on this specific form of abuse expands knowledge of how IPV/A and potential intervention strategies (Davis & Johnson, 2020).

There are times or indications when no pastors feel adequately prepared to counsel victims and survivors of domestic violence. When the couple had children, pastoral counseling focused on keeping the children safe by calling child protective services. The evangelical Christian pastors challenged victims and survivors who blamed themselves for the violence and chose to stay with a violent partner instead of leaving. The pastors worked to help the victims/survivors understand that the violence was not their fault, to empower and remind them how valuable they were to God (Zust et al., 2017).

According to a study conducted by LifeWay in 2014, results revealed that Protestant churches rarely discussed domestic violence. In that study, four in 10 pastors said they seldom or never addressed the issue. Another 22% discussed the issue once a year. When it comes to domestic violence, some Protestant pastors want to be helpful but often do not know where to start. Most say their church would be a haven for victims of domestic violence. However, many do not know if anyone in their church has been a victim of domestic violence, and only half say they have a plan to help if a victim comes forward. Most pastors want their churches to be a haven but do not have a plan to get there. When it comes to domestic violence, Protestant pastors want to be helpful but often do not know where to start (Smietana, 2017).

Some leaders of the church quote carefully selected Bible verses claiming that Eve was created second to Adam and was responsible for the original sin. As a result, some of these same leaders also purport women are subservient to their husbands and are prohibited from proclaiming the word, serving as deacons, pastors, or chaplains in the military service (New International Version 1978/2011, Corinthians 14:34-35).

An assessment of the contemporary epidemic of intimate partner violence explores how and why cultural and religious beliefs serve to excuse battering and work against survivors'

attempts to find safety. Theological interpretations of sacred texts have been used for centuries to justify or minimize violence against women. The authors, Nienhuis and Kienzle (2018), recovered historical and especially medieval narratives whose protagonists endure violence framed by religious texts or arguments. The medieval theological themes that redeem battering in saints' lives—suffering, obedience, ownership, and power—continue today in most religious traditions (Nienhuis & Kienzle, 2018). Examining medieval attitudes and themes sharpens the readers' understanding of contemporary violence against women. They analyzed historical and modern narratives from a religious perspective, which grounds the unique approach, according to Nienhuis and Kienzle, one that forges a new path in grappling with partner violence. Medieval and contemporary narratives demonstrate that women in abusive relationships feel the burden of religious beliefs that forbid wives to endure suffering and maintain stable marriages. Religious leaders have reminded women of wives' responsibility for obedience to husbands, even in the face of abuse. In some narratives, however, women create safe places for themselves. Some exemplary communities call upon religious belief to support their opposition to violence. Such models of historical resistance reveal precedents for response through intervention or protection (Nienhuis & Kienzle, 2018).

Black women who are victims of IPV often rely on faith when exposed to IPV; however, the faith community's role in the lives of IPV victims is less clear. A community-based approach examines the faith community's role in addressing IPV in heterosexual relationships in North Minneapolis, where poverty and IPV among Blacks are disproportionately high compared to other groups and cities in Minnesota (Raymond et al., 2016). Although informal help-seeking with family elders is the preferred method, African women immigrants, in light of limited family

support available in the United States, often seek help from faith-based leaders (Ting & Panchanadeswaran, 2016).

Religious beliefs play a significant role in the lives of victims of domestic violence. Victims find strength in their faith and would rather endure the violence at all costs to keep their families or marriages together than compromise their faith by leaving (Zust et al., 2018). Christian women in a conservative faith community who experience IPV use the spiritual coping processes for survival and healing. Women accept their husband's authority within the household through their sacrifice of suffering (New International Version, 1978/2011, 1 Peter 3:1). Using data from 42 in-depth qualitative interviews of survivors of IPV, the findings reveal a pattern of spiritually based survival and resilience strategies women used while coping with and eventually escaping their traumatic lives. The analysis notes the central role of spirituality as a means women used to move from dealing with survival to resilient self-efficacy and healing (Drumm et al., 2017).

Immigration is one of many risk factors for IPV due to the resulting stressors of acculturation and discrimination, in addition to economic changes in the family. Little is known about African immigrant survivors of IPV in the United States, specifically in terms of women's experiences with faith-based leaders when seeking help. Although informal help-seeking with family elders is the preferred method, in light of the limited family support available in the United States, women often seek help from faith-based leaders. African immigrant women who experience IPV experience feelings of blame, stigmatization, being misunderstood, and lack of practical help. However, women's self-isolation did not preclude them from engaging in spiritual behaviors, forgiveness, and beliefs in God's benevolence and future justice (Ting & Panchanadeswaran, 2016). A growing body of research focusing on Black individuals' mental

health shows that this group relies heavily on their religious/spiritual beliefs and practices to cope with mental health issues, including depression.

Unfortunately, the psychotherapy literature provides little guidance on incorporating religion/spirituality into psychotherapy with Black women. With the growing cultural diversity of the U.S. population, there has been more emphasis on providing patient-centered, culturally sensitive care, which involves respecting and responsiveness to individual patient preferences, needs, and values (Mengesha & Ward, 2012). This study examined the differences between shelter and faith-based service utilization and satisfaction in a shelter sample (N=73). Multiple regression used techniques to determine findings. The findings suggest survivors with higher spirituality were more likely to utilize faith-based resources than shelters. Those who experienced greater IPV reported dissatisfaction with faith-based resources. These results suggest that spirituality should be incorporated into shelter services to meet survivors' spiritual needs, and faith-based services should adequately address IPV (Fowler et al., 2011).

The Consequences of IPV on Society

Domestic violence is prevalent in every community and affects all people regardless of age, socioeconomic status, sexual orientation, gender, race, religion, or nationality. Physical violence is often accompanied by emotionally abusive and controlling behavior as part of a much larger, systematic pattern of dominance and control. Domestic violence can result in physical injury, psychological trauma, and even death. The devastating consequences of domestic violence can cross generations and last a lifetime (NCADV, 2020).

The costs associated with intimate partner violence exceeded $8.3 billion (about $26 per person in the U.S.), which included $460 million for rape, $6.2 billion for physical assault, $461 million for stalking, and $1.2 billion (about $3.7 per person in the U.S.) in the value of lost lives.

The annual cost of Domestic Violence worldwide is approximately $4.4 trillion (about $14,000 per person in the U.S.) (Barta, 2018). The annual cost of healthcare for female IPV victims in the U.S. is $4.1 billion (about $13 per person in the U.S.) (Barta, 2018). Increased yearly healthcare costs for victims of IPV can persist as much as 15 years after the abuse ends. Victims of severe IPV lose nearly 8 million days of paid work, the equivalent of more than 32,114 full-time jobs and almost 5.6 million days (about 15,000 years) of household productivity each year (Barta, 2018; CDC, 2015).

Cycle of Violence

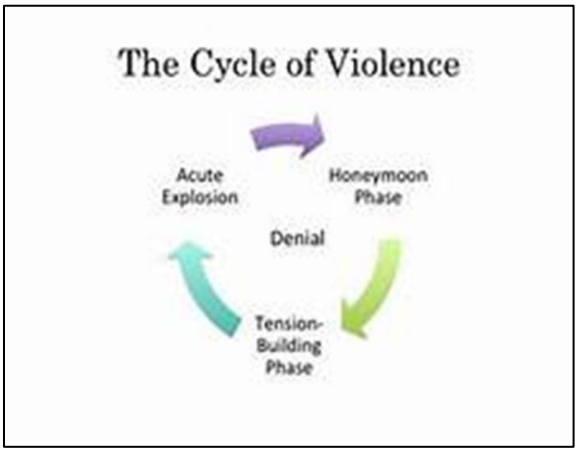

Figure 1. The Cycle of Violence (Study.com/cimages).

Dr. Lenore Walker developed the theory of the cycle of violence relative to intimate partner violence. It has three distinct phases that are generally present in violent relationships, including tension building, violent episodes, and remorseful or honeymoon phase (Skaine, 2015; Walker, 2017; Women's Center of Youth and Family Services [WYFS], 2021).

Phase One: Tension Building. Phase one depicts the feelings of a woman as angry, unfairly treated, hopeless, tense, afraid, embarrassed, humiliated, disgusted, and depressed. The behavior that is manifested is nurturing, submissive, walking on eggshells, being scared to express feelings, and using alcohol or drugs to avoid the situation. The perpetrators have feelings of tenseness, frustration, disgust, self-righteousness, or jealousy. The behavior displayed is

verbal abuse, fits of anger, silence, controlling, arrogant, possessive, demanding, irritability, and the use of alcohol or drugs (Skaine, 2015; Walker, 2017; WYFS, 2021).

Phase Two: Violent Episode. Phase two is the victim's feelings of frightened, trapped, helpless, or numbness. They may try to protect themselves, retaliate by hitting back, submit helplessly, get away, or seek help. The perpetrator feels angry, enraged, right, jealous, or frustrated. They may display behavior that is viewed as dangerously violent, has a deliberate desire to hurt or kill, is out of control, and is irrational (Skaine, 2015; Walker, 2017; WYFS, 2021).

Phase Three: Remorseful or Honeymoon. Phase three is when victims feel relieved, angry over the incident, resentful, guilty, hopeful, and in denial over the seriousness of the incident. The victims offer excuses for the batterer, may be withdrawn, try to solve or prevent future incidents, and hope and believe changes will last. Where on the other hand, the perpetrator feels apologetic, remorseful, forgetful about the degree of violence, self-righteousness, and unable to understand why the woman is still angry. Their behaviors may include making promises to change, blaming her or others for the problem, and using alcohol or drugs as an excuse (Skaine, 2015; Walker, 2017; WYFS, 2021).

It is easy to pretend that the abuse was an exception once the calm phase begins. Victims are emotionally manipulated to believe that nothing happened or believe it was their fault and not blame the abuser for the incident. Unfortunately, this phase of calm in abusive situations does not last forever, and when the specific stressor is present, the abuse can begin once again (Makin Wellness, 2019).

Significant interactions correlate between childhood experiences of corporal punishment and perceptions of parental warmth and support and impulsiveness during discipline in

predicting attitudes toward spanking. Those who report experiencing more corporal punishment, but more parental warmth/support hold more favorable attitudes toward spanking. Those who received more corporal punishment during childhood with parental impulsiveness hold less favorable attitudes toward spanking (Bell & Romano, 2012).

Traumatic Brain Injury

Traumatic Brain Injury (TBI) is an alteration in brain function or other evidence of brain pathology caused by an external force such as a blow or injury to the head, severe rotation of the neck, and acceleration/deceleration movement (Menon et al., 2010). It is a leading cause of disability worldwide and is more prevalent than breast cancer, spinal cord injury, HIV/AIDS, and multiple sclerosis combined (Haag et al., 2016). Classifications of severity are assessed through tests measuring the loss of consciousness, post-traumatic amnesia, and post-incident deficits. Severe consequences of IPV are being overlooked and misdiagnosed, thus causing survivors to have long-term debilitating effects on overall function and independence and may masquerade as several other physical, social, and mental health issues, preventing survivors from receiving appropriate intervention by health and community professionals (Iverson & Pogoda, 2015; St. Ivany & Schminkey, 2016).

Research and guidance for professionals in this community are limited despite the resounding call throughout the literature for increased awareness of this population across diverse fields of practice, study, and triage sites (Haag et al., 2019).

Abused women often report a wide range of physical and psychological symptoms that present challenges to providers. Specifically, injuries to the head or strangulation may initiate neurological changes that contribute to central nervous system (CNS) symptoms. These symptoms are all often attributed to mental health diagnoses in this population. Women who

reported both probable TBI and IPV were more likely than their abused counterparts who reported no TBI to report CNS symptoms. Clinicians who work with this population of women should be aware of TBI as an etiology for symptoms in abused women (Campbell et al., 2018).

Child Exposure and Abuse

Intimate partner violence is often associated with the abuse of children. Child abuse becomes a significant public health issue because witnessing violence in the home as a child is a vital risk factor for involvement in abusive relationships as an adult. In addition, when experiencing abuse as a child it has been associated with other risk factors such as depression, substance abuse, poor school performance, and high-risk sexual activity (CDC, 2016).

The CDC reports that at least one in 7 children has experienced child abuse or neglect in the past year. In 2018, 1,770 children died of abuse and neglect in the U.S. Rates of child abuse and neglect are five times higher for children of low socioeconomic status than for children in families with higher socioeconomic status (U.S. Health & Human Services, 2020). In the U.S., the total lifetime economic burden associated with child abuse and neglect was approximately $428 billion in 2015 (Peterson et al., 2018a). Child abuse and neglect can have a tremendous impact on lifelong health and well-being if left untreated. For example, childhood exposure to violence increases the risks of injury. Future victims and perpetrators of violence become victims of substance abuse, sexually transmitted infections, delayed brain development, lower educational attainment, and limited employment opportunities (Fortson et al., 2016). Children are specifically vulnerable to abuse during COVID-19. Research shows that increased stress levels among parents are often a predictor of physical abuse and neglect of children. Stressed parents may be likely to respond to their children's anxious behaviors or demands in aggressive or abusive ways. The support systems that many at-risk parents rely on, such as extended family,

child care and schools, religious groups, and other community organizations, are no longer available in many areas due to the stay-at-home orders. Child protective agencies are experiencing strained resources with fewer workers available, making them unable to conduct home visits in areas with stay-at-home orders. Since so many children have not gone back to school, teachers and school counselors cannot witness the signs of abuse and report them to the appropriate authorities. Also, many at-risk families may not have access to the technology children need to stay connected with friends and extended family (APA, 2020).

High numbers of women and men reported childhood abuse and IPV and received no assistance in healing from the psychological effects. When seen in medical clinics, these victims often are too late to stop a disease process that prevents and treats an early PTSD response. The Centers for Disease Control and Prevention (CDC) suggested that high-risk behavioral activities coexist with PTSD (Walker, 2017). Children are increasingly exposed to and recognized as victims of IPV as a type of child maltreatment with a level of impairment similar to other kinds of abuse and neglect (MacMillan et al., 2013).

Examining the relations between childhood maltreatment, daily life hassles, and intimate partner violence among low-income, suicidal, abused African American women (N = 208) indicated a significant association between childhood maltreatment and intimate partner violence. Women who experienced childhood maltreatment were more likely to experience IPV as adults than those who reported no childhood maltreatment history. Also, bootstrapping analyses revealed that daily life stressors mediated the link between childhood maltreatment and physical and nonphysical forms of IPV. These findings highlighted the importance of thoroughly assessing the history of childhood maltreatment, current IPV, and the nature and extent of daily hassles. When working with low-income Black women and helping all abused women with a

history of childhood maltreatment cope effectively with the daily life hassles they encountered (Patel et al., 2012).

Coronavirus Disease 2019 (COVID-19)

The Corona Virus Disease-19 (COVID-19) is a disease new in humans caused by a new coronavirus that humans have not seen. Because it is a new virus, scientists are learning more each day. Although most COVID-19 have mild symptoms, COVID-19 can cause severe illness and even death. Some groups, including older adults and people with certain underlying medical conditions (e.g., cancer, chronic kidney disease, hypertension or high blood pressure, obesity, pregnancy, sickle cell anemia, and type two diabetes mellitus), are at increased risk of severe illness. The World Health Organization (WHO) announced on February 11, 2020, an official name for the disease-causing the 2019 novel coronavirus outbreak, first identified in Wuhan, China. The new name for this disease is coronavirus disease 2019, abbreviated as COVID-19 (CDC, 2021).

The COVID-19 pandemic has required more individuals to stay home to protect themselves and others within their communities. However, the home may not be safe for many families who experience domestic violence, including intimate partners and children. COVID-19 has caused significant economic devastation, disconnected many from community resources and service systems, and created widespread uncertainty and panic. Such conditions may stimulate violence in families where it did not exist before and worsen situations in homes where mistreatment and violence have been a problem (Substance Abuse and Mental Health Services Administration [SAMHSA], 2021).

According to the National Coalition Against Domestic Violence (NCADV), An average of 20 individuals are abused physically every minute by their partners. Additionally, there are 10

million victims (about half the population of New York) of domestic violence in the U.S. Domestic violence takes a significant toll on communities of color. Despite the growing awareness around domestic violence, these statistics have raised the alarm about a growing crisis. Communities already struggle to access resources in mental health and health care (NCADV, 2021). There is an increasing need for more advocacy for those who experience domestic violence daily (NCADV, 2021).

The literature indicates that some researchers express their concerns regarding various potential alcohol-related problems, which include a rise in domestic violence during the pandemic (de Lima et al., 2020; Fatke et al., 2020; Ramalho, 2020; Sacco et al., 2020; van Gelder et al., 2020). Furthermore, there is a potential risk increase of harm befalling children and the link between increased alcohol consumption and suicide as well as other mental health issues (Conejero et al., 2020; Green, 2020; Gunnell et al., 2020; Holmes et al., 2020; Sherman, 2020).

Destruction of Property and Pets

Destruction of property is another form of abusive behavior. Animal abuse or animal cruelty harms animals. It includes neglect, beating, torturing, and killing of the animal. Animal abuse, while problematic, is also often seen as a precursor to abuse directed against humans (Skaine, 2015). Approximately 71% of women pet owners in shelters reported that their pets had been threatened, injured, or killed by their abuser (Bershadker, 2019).

Elder and Intergenerational Abuse

The population is aging globally, and it is essential to understand that older women experience IPV. According to the Centers for Disease Control and Prevention, 2016, elder abuse refers to an intentional act or failure to act by a caregiver or another person in a relationship involving an expectation of trust that causes or creates a risk of harm to an older adult. It also

considers an older or elderly adult as any person whose chronological age is 60 years or older. Age 60 was selected as the lower boundary for classification as an older adult because it is the age of first eligibility for services furnished under the Older Americans Act and for inclusion in activities and programs covered in the Elder Justice Act (CDC, 2016). The legal definition of a vulnerable adult varies by state. However, *vulnerability* defines a person susceptible to mistreatment and who cannot protect him or herself because of age, disability, or both. Types of abuse that apply to older or vulnerable adults include physical abuse, sexual abuse, emotional or psychological abuse, neglect, abandonment, and financial or material exploitation (CDC, 2021; National Center on Elder Abuse, [NCEA], n.d.).

Data suggest IPV victims who commonly experience IPV are older women (lifetime prevalence 16.9% - 54.5%), but that their age and life transitions mean that they may experience abuse differently than younger women. The risk factors for elder abuse include isolation and lack of social support, functional impairment, and poor physical health. Older adults, lower income, and living in a shared living environment with a large number of household members (other than a spouse) are at an increased risk of financial and physical abuse (United States Preventative Task Force [USPTF], 2019). They also face unique barriers to accessing help, such as disabilities and dependence on their partners (Pathak et al., 2019).

The issue of elder abuse is still a problem that requires resolution. Most authorities believe most incidents are not reported. Professionals miss the signs of elder abuse and fail to report it to the authorities. Many professionals lack training in identifying these signs. Older people may be reluctant to report abuse themselves because of fear of retaliation, lack of physical and cognitive ability to report, or do not want to get the abuser (90% of whom are family members) in trouble (NCEA, n.d.). Available data indicate that the highest rates of elder abuse

are among women aged 80 and older. In 90% of cases, the perpetrator is a family member, often a spouse or adult child (NCEA, n. d.).

Incest

Incest is the act of sexual intercourse between first-degree relatives, individuals who share 50% of their genes (Herzog, 2012). Incestuous relationships include parents (and stepparents, in some cases) with their children, siblings with siblings, and uncles and aunts with nieces and nephews. Families may attempt to hide the relationship, and physicians may not acknowledge evidence that the sexual acts had occurred. Children usually do not report their abuser because of their loyalty to the abuser or fear of reprisal for themselves or family members. Role confusion is a product of incest. Incestuous families use secrecy, deception, isolation, and worthlessness. Initial treatment should protect society from the offender and the offender from abusing again. Treatment should change harmful behaviors while preserving the family without risking the child's safety (Skaine, 2015).

Prevention/IPV Self-Care

Victims and survivors seek value in the eyes of God and that they are worthy to seek protection and assistance. It is pertinent that women learn to recognize the cycle of violence and allow time to remove themselves from a harmful situation for safety. The CDC developed and promulgated several preventative strategies and techniques for advocates and providers teaching safe and healthy relationship skills, engaging influential adults and peers, disrupting the developmental pathways towards IPV, creating protective environments, strengthening economic support for families, and supporting survivors to increase safety and lessen harms (CDC, 2020).

God judges that the suffering faithful are worthy of His kingdom. He will inflict retribution on those who inflict pain and suffering on those who offer no provocation and give them earned relief (New International Version, 1978/2011, 2 Thessalonians 1:5-7).

Rural Domestic Violence

Rural living may present additional problems for victims of domestic violence and healthcare providers practicing in rural settings. Victims in this locale may experience more psycho-social and physical health outcomes due to the lack of services and the ability to access available health services (Edwards, 2015). Unfortunately, research on the specific problems of domestic violence in rural areas demonstrates that IPV services are generally less well-funded and comprehensive than in urban locales. What is available suggests some critical differences between domestic violence in rural, suburban, and metropolitan areas and highlights details that merit further research. The rates of domestic violence in rural, suburban, and urban locales appear to be similar. However, victim experiences may be different (e.g., sexual IPV and IPV perpetrated by a spouse/ex-spouse), and intimate partner homicide may be higher in rural locales. Rural victims of domestic violence may have lower levels of education and fewer employment opportunities, and their incomes are usually lower (Edwards, 2015). Rural IPV perpetrators may perpetrate more chronic and severe IPV, which could be due to the higher rates of substance abuse and unemployment documented among rural perpetrators and more compromised community responses to IPV in rural locales. (Edwards, 2015). Intimate Partner Violence victims experience homelessness and receive fewer economic and social support options. This creates an attitude among rural victims toward less engagement or supports less government involvement in IPV issues. While protective orders appear to be equally effective in rural and urban areas, rural victims encounter more challenges obtaining the orders and getting them enforced, and they

experience more personal distress and fear than do their urban counterparts (Logan, 2009; Logan & Walker, 2011; Rural Health Information Hub [RHIB], 2016).

A 2005 Federal Bureau of Investigation (FBI) statistics study demonstrated that the more rural the area (based on population size and distance from a central urban area), the more likely a family member murders a family member or intimate partner. During the years 1980 to 1999, the overall rates for family and intimate partner murders declined regardless of place, whereas rates of intimate partner murders increased only in rural living (Gallop-Black, 2005).

According to the RHIB, 2016, isolation-emotional, physical, and economic factors into why some victims stay in abusive relationships; the geographical circumstances of rural living can exacerbate this factor. Abusers employ numerous behaviors to create isolation for their victims. They limit a victim's access to transportation (family vehicles or public transportation), prevent her from obtaining a driver's license, ridicule her in front of others, or accuse her of flirting. Thus, making her less likely to invite others home or go out herself. When leaving the house, they removed the telephone (landline or cell service) so they could not communicate with others. The realities of rural living may compound these abusive behaviors. Rural living experiences many other limitations, including access to routine health care; long response times for police and medical emergency teams; weather and road conditions; weapons and dangerous tools more commonly available; seasonal work; an increase in alcohol use during the winter; economic conditions of farm life, there is only a single income, all property ownership is contingent upon the land value and all family members are required to work it to stay solvent. The conditions mentioned above may leave the woman feeling "trapped" with her abuser for long periods. Often, when a farm is the only source of income, the emotional conditions of farm life, strong ties to animals and land, and intimidation of travel to a "big city," the issuance of a

restraining order is not practical in prohibiting or keeping the perpetrator away, (Wellness Recovery Action Plan [WRAP], n.d.).

Victims who live in rural areas face many challenges. Their capacity to obtain routine health care is often taxing due to limited access to insurance resources, the unpreparedness of health care providers to do routine IPV screening, and tight-knit communities that discourage victims from reporting abuse (Wellness Recovery Action Plan [WRAP], n.d.). Patients experiencing abuse may have complaints or injuries that include arthritis, irritable bowel syndrome, stomach ulcers, chronic pain, migraines, and eating disorders. One study found that approximately 64% of rural women with an STD are involved in abusive physical and sexual relationships. Other closely associated complaints include insomnia, depression, post-traumatic stress disorder, panic disorder, and substance abuse (WRAP, n.d.)

Church, community-based organizations, and healthcare providers need to identify domestic violence victims and be prepared to offer assistance that addresses rural women's particular needs and problems. Additionally, rural women's safety plans and escape options may need to be adjusted to meet the specific realities of their situations. Placing shelters in rural areas is also more difficult because they are harder to hide (WRAP, n.d.).

A wide-ranging literature review of a 2012 research project focused on the rural Appalachian setting found that the results were sometimes contradictory, and many variables could work. Results did not necessarily bear out some conclusions that seemed intuitively expected. Findings on rural/urban differences in barriers to screening patients for IPV did not materialize in the independent survey. Overwhelmingly, the barriers most cited by healthcare professionals were a belief that patients would be noncompliant with recommendations and a lack of confidence in dealing with these problems (Tedder, 2012).

Non-Secular Strategies and Resources

The literature regarding intimate partner violence and communities of faith is growing. The article *Pastors More Likely to Address Domestic Violence, Still Lack Training*, written by Bob Smietana (2018), affirms the presence of IPV in communities of faith and the need for heightened education, particularly for faith community leaders and parishioners. This article, The Development of a Culturally Competent Intimate Partner Violence Intervention—S.T.A.R.T.©: Implications for competency-based Social Work Practice written by K.B. Stennis et al. (2015), also notes a lack of training within the communities and the need for culturally sensitive training materials and models that consider the role of religion and spirituality. This same article fills the gap by describing the development of the Education and Intervention Model, Shatter the Silence, Talk About It, Alert the Public, Refer, and Train self (S.T.A.R.T.©), and others. This model was initiated about 15 years ago as a religiously sensitive, spiritually based, multi-dimensional intimate partner violence education and intervention model that evolved from one community's experience, collegial reflections, community discussions, and training sessions (Stennis et al., 2015).

Specifically, subjected individuals and families seek church assistance for domestic violence. When the issue of IPV is addressed, the pastoral care leadership realizes there is an opportunity for it to provide safety as a significant priority and minimally help provide safe harbors for women and their families. Pastoral care ministries avail themselves to provide the most appropriate counseling measures possible. Churches offer a network of information relative to emergency provisions. These provisions include parenting and nutrition classes, food assistance, counseling, education programs, and services. , meals on Wheels, drug abuse counseling, General Education Development (GED) preparation, job training, credit counseling,

financial literacy and budget training, sexual assault crisis counseling, pregnancy counseling, child sexual abuse, sexual assault, and dating violence prevention, medical, legal and any essential services and resources that might be available to help women and families. Sustaining themselves safely until more permanent decisions and accommodations are necessary (CDC, 2020; Walker, 2017). Programs and services empower and inspire all generations and institutions in the community to work together and promote peace. They also recommend that faith-based organizations partner with other community-based coalitions. The Chamber of Commerce, local parents and guardians, law-enforcement officials, interfaith community coalitions, Volunteers in Service to America, Planned Parenthood, County Court-Appointed Special Advocates, Young Men Christian Association, Young Women Christian Association, The Urban League, and local municipal youth centers, facilitate positive changes in individuals, families, and communities at large (CDC, 2020).

Secular Strategies and Resources

Abused women seek psychological services for various reasons, usually to provide some assistance in coping with challenging life situations. Sometimes, she will seek out services for the violence itself, while another reason gets them there. Problems with the courts, substance addiction, psycho-physiological pain complaints, and health issues are frequent indirect reasons to seek out the assistance of someone, usually a therapist, to whom they can speak. Pleading by family, friends, lawyers, and shelter staff and her determination to stop the abuse are the usual direct reasons (Walker, 2017). Women commonly reported to informal sources (i.e., family, friends, neighbors) across all IPV subgroups. The most frequently reported formal sources for women and men were health professionals (i.e., doctors, nurses, counselors, psychologists) and the police. However, the importance of almost all of the traditional sources (e.g., health

professionals, police, lawyers, shelters, and crisis centers) increased as the severity of the violence and control increased. Women who experienced the most severe pattern of violence and control reported to shelters and crisis centers (Ansara & Hindin, 2010).

Some organizations do not provide direct services for domestic violence but can provide a plethora of resource information (hotline/helpline numbers and website addresses) to the respective individuals experiencing the victimization. They can provide resource information to those who render advocacy and direct services to those in need (NCADV, 2021).

Some women abuse substances as a means to self-medicate from the symptoms or effects of PTSD and IPV. They need specialized treatment for the abuse they have experienced in addition to treatment for alcohol, substance, and other drugs (Walker, 2017).

Many trauma intervention programs go beyond healing from PTSD and other symptoms to assisting the survivors in rebuilding their resilience and moving towards wellness. Victims of traumatic events may lose resilience when faced with new traumatic events (American Psychiatric Association, 2013). The Diagnostic and Statistical Manual of Mental Health Disorders (5th ed.) suggested that one of the results of trauma is the belief that one has a shortened lifespan. So, adding a component to treatment that helps survivors rebuild their resilience is a critical intervention (Walker, 2017).

Many mental health needs for battered women use a public health model featuring primary, secondary, and tertiary levels of prevention of any impact or at least stopping any development of different symptoms and intervention to improve any symptoms at the earliest point possible. Mental health clinicians have learned that the needs of the trauma survivor go beyond intervention to prevent other traumatic reactions by developing resilience and well-being (Walker, 2017).

Although not all women who have suffered from IPV need psychotherapy or medication to heal from their abuse experience, they should access appropriate and effective treatment. For example, the Survivor Therapy Empowerment Program (STEP) is a carefully designed, evidence-based psychotherapeutic program. This program uses techniques to work with individuals or groups of abused women who have experienced IPV or other forms of physical, sexual, and psychological abuse (gender violence). STEP helps women better understand how the violence they have experienced has impacted their lives and what they can do about it. The program's psychotherapeutic focus deals with how people think about what has occurred and how it affects their feelings and behavior. It is a program based on feminist and trauma theory that presents education about common issues for abused victims that can then be discussed as it relates to the woman herself. In this program, they can learn new skills or reinforce old skills to help them make better choices for their future. In addition to reducing anxiety, a significant component of PTSD and IPV, the women like the program and attend when they can (Walker, 2017). These applied interventions can be implemented in individual or group settings with or without medication or other adjunctive treatment. Mental health treatment can take place in various settings, such as battered women's shelters, community mental health centers or clinics, hospitals, jails, and prisons. Most importantly, interventions to strengthen and empower women will enable them to progress with a better quality of life (Walker, 2017).

During the therapeutic justice movement era, the criminal justice system supported many domestic violence cases that deluged the courts in the 1980s. A high influx of perpetrators created a precedent for a problem-solving court to defer the arrestees and address the issue. A developed policy eliminated the practice of having IPV victims sign arrest complaints when the effectiveness of the domestic violence court became apparent. The creation of the victim-witness

program proved to be highly successful in helping state attorneys win prosecution. This program allowed attorneys to spend more time with the victims by helping them through the criminal justice system and getting medical doctors and therapists for themselves and their children (Walker, 2017).

According to Ritchie (2012), contrasts to this perspective begin with accounts of black women who have been the recipients of shocking violence at the hands of their partners, the local enforcers of public morality, and the state and its institutions. In each case, considerations of fairness and justice have reversed, and victims have become criminalized.

Little systematic information exists about how community-based prevention efforts at the state and local levels contribute to our knowledge of IPV prevention. The Center for Disease Control and Prevention's (CDC) Domestic Violence Prevention Enhancements and Leadership Through Alliances, Focusing on Outcomes for Communities United with States (DELTA FOCUS) program funds 10 state domestic violence coalitions to engage in IPV primary prevention through approaches addressing the outer layers of the social ecology. This paper explored how DELTA FOCUS recipients have contributed to a national-level dialogue on IPV prevention (Estefan, 2019).

All recipients sought to promote IPV prevention by communicating and sharing information and resources accumulated through practice-based prevention efforts with non-CDC-funded state coalitions, national partners, and other IPV stakeholders. A semi-structured coding scheme was applied: Creating Awareness, Catalyzing Action, Effecting Change, Disseminating Science, and Shaping the Future. Through implementing and disseminating their prevention work in many ways, DELTA FOCUS recipients are building practice-based evidence on community-based IPV prevention (Estefan, 2019).

Few studies have explicitly looked at the experiences and needs of Black women survivors of domestic violence. This study sought to discover (a) Black survivors' experience with various community entities and (b) how race may have affected these experiences. Results indicate much dissatisfaction with the services received as they try to escape or stay away from their abusive partners. This dissatisfaction was considerable due to a lack of cultural competence, which impacted service and presentation suggestions for community entities (Gillum, 2019).

Social Costs/Multiple Loss

The social costs of IPV are expressed in several ways. Societal resources are required to evaluate and treat the victims of violence; these resources include victim service organizations, child welfare agencies, mental health services, and medical facilities. The willingness of taxpayers and governments to fund resources is not commensurate with the need. Anyone who has ever worked in an agency involved with the treatment of victims of violence knows that the work is rewarding but challenging; the pay is low, and budget cuts are an ever-looming threat to continued services (Levers, 2012). The most damaging effect of IPV is its impact on succeeding generations of human relationships and its profound reduction of quality of life. The long-term effects of familial violence indicate the consequences for the participants' lives, giving one a glimpse of the pervasive impact of IPV (Levers, 2012).

Summary

This chapter presented various literature views and addressed the topic of intimate partner violence (IPV) in this society, affected by this traumatic experience, and how it affects not only individuals involved but how this traumatic behavior spills over into society at large in terms of the utilization of resources and services. Efforts to provide pastoral care leadership PCLs with current practical information will assist them in gaining knowledge and understanding regarding

the dynamics of abusive relationships. These efforts will also emphasize the need for information on IPV training programs, referral resources, and services and examine the attitudes, capacities, and motivations to proactively address the needs of IPV victims within their congregations and communities.

CHAPTER THREE: METHODS

Overview

This section addresses the correlational, non-experimental survey research methodology study used to examine whether intimate partner violence mediated the relationship between the attitudes towards IPV, IPV training, IPV resources and services awareness, and levels of assistance provisions for IPV victims amongst pastoral care leaders. The research design will also discuss the sampling method, procedures for data collection, and instrumentation, as well as its reliability, validity, internal procedures, and data analysis. The categorical variables and specific groups are described, followed by potential statistical methods and external validity, the degree to which the study results can be generalized to IPV issues considered in the real world. A review of the research questions and accompanying hypotheses for the study are also considered.

Research Design

The proposed dissertation study commenced once the Institutional Review Board (IRB) approval was obtained. The research incorporated in this study is nonexperimental, sometimes referred to as a correlational research design. This chosen study design has no distinctions between independent and dependent variables (based on implicit theories about possible causal connections). A Pearson correlation is much more frequently encountered in reports of nonexperimental data. In nonexperimental research situations, deciding which variable to treat as an independent variable may be arbitrary. Therefore, in some research situations, it may be preferable not to distinguish between independent and dependent variables. It was preferable to indicate that the two variables are correlated without identifying one as the predictor of the other (Warner, 2013).

The result of a nonexperimental study cannot be used to make a causal inference, and it is essential to avoid causal language when results are interpreted in a nonexperimental study. One of the most critical decisions in research is selecting a design whose strengths and weaknesses help the researcher to examine specific research questions and rule out as many plausible rival hypotheses or explanations as possible (Heppner et al., 2016). Therefore, this design examined the relationships between the categorical variables, attitudes towards IPV, IPV training, knowledge of IPV resources and services awareness, and the level of assistance provisions for IPV victims amongst pastoral care leaders. The variables are categorical, and the data is summarized in a contingency table that summarizes the scores in each variable group (Warner, 2013). The type of design chosen must be the one that best answers the relational research questions, which provides the direction to explore and the degree to which two or more constructs are related or vary together.

After the initial development of the relational research question or hypothesis, there is a conjecture about the relationship between or among constructs. All terms or constructs must be defined concretely so that the research idea can be empirically tested. Each construct must be operationally defined, specifying the activities or operations necessary to measure it in this project. It is not uncommon to revise the operation definitions or change the original research questions when research within a topic progresses, knowledge accumulates, measurement issues occur, or any events may lead the researcher to process more information in the study design. Given the existing knowledge base, the design and methodology are developed, and the hypotheses are more specific in stating the expected relationship between the constructs considered for investigation (Heppner et al., 2016). It is also essential that the design reduces as many alternative hypotheses or extraneous variables as possible in order to be able to conclude

with some degree of certainty. Multiple regression is a correlational design used to examine the relationship between two or more variables. It is a statistical method that examines the separate and collective contributions of one or more predictor variables in the variation of a dependent variable (Heppner et al., 2016). The tested hypotheses examined the influences of these relationships. The collected data was analyzed to satisfy anticipated conclusions correlated with a sample of a selected population group. The goal or expectations from this project satisfied the anticipated fulfillment of a desperate need to enable pastoral leaders with the capacity to assist IPV victims who seek assistance in the faith community.

The targeted population selected for this research is pastoral leaders from the Episcopal denomination. The sampling method for this study was nonprobability sampling, precisely a convenience type of sampling selection of pastoral leaders created by a participant pool identified as pastoral leaders who are representative of the Eastern and Western regions (rural, suburban, and urban areas) of the Episcopal Diocese of Kansas, as well as individuals who are members of the Union of Black Episcopalians (UBE) organization and other leaders of Episcopal ministries. This convenience selection provided more participant accessibility to the researcher and created an opportunity to observe as many of these populations as possible. The minimal expectation for each participant was that they are leaders attached to the Episcopal denomination in a leadership role capacity within the Kansas diocese, members of the UBE, or leaders of various Episcopal ministries who are adults at least 21 years of age, members of the Episcopal denomination, and completed the form of consent.

Research Questions

The study examined the relationship between attitudes towards intimate partner violence (IPV) and the relationship between IPV training, IPV resources, and service awareness used to

assess the level of assistance for IPV victims amongst pastoral care leaders. Therefore, this study examined the relationships and correlational strength between the categorical variables and how they influenced the outcomes for overall healing. The relational research questions ask about the relationship between the constructs that can be measured. Once a relationship was stated, the research question became a hypothesis (Heppner et al., 2016). The relational research questions and hypotheses are as follows:

RQ1: What is the relationship between the attitudes toward IPV and the level of assistance provisions for IPV victims among pastoral care leaders?

RQ2: What is the relationship between IPV training, knowledge of resources, service awareness, and the level of assistance provisions for IPV victims among pastoral care leaders?

Hypotheses

Faith can be an essential part of a victim's healing journey, but in some cases, it can also complicate their path to safety. Some victims may be faced with abusers who manipulate attitudes and religious teachings or pastoral care leaders who lack the knowledge to provide counsel, creating additional barriers to escaping the abuse (National Network to End Domestic Violence, 2018).

H_o: There is a significant relationship between attitudes towards intimate partner violence and the level of assistance provisions.

H_1: There is no significant relationship between attitudes towards intimate partner violence and the level of assistance provisions.

H_o: There is a significant relationship between IPV training, knowledge of resources, services awareness, and the level of assistance provisions.

H_2: There is no significant relationship between IPV training, knowledge of resources, service awareness, and the level of assistance provisions.

Participants and Setting

Selecting participants for a study typically involves selecting samples from a population of interest (Heppner et al., 2016). A convenience sampling of pastoral leaders drew participants for this study defined as those individuals who are ordained or non-ordained within the Episcopal denomination (i.e., the ordained: Bishops, priests, and deacons; non-ordained: Vestry, laypersons, and staff) or other leaders who represent the population pool of parishes in the Eastern and Western regions of the Episcopal Diocese of Kansas, members of the Union of Black Episcopal (UBE) organization, or leaders of various Episcopal ministries. These individuals can provide assistance or services to members or non-members of their congregation.

Recruitment

This research study received the participation of a diverse group of individuals who are members of the Episcopal denomination and represent different dimensions inclusive of those at least 21 years of age, gender preference, from other races or ethnically diverse education levels, and had various life experiences. Participants' service areas are located in rural, suburban, and urban communities in Kansas and other regions across the U.S. Participants were asked to specify their age, race/ethnicity, for example, A) Asian, B) Black/African, C) Caucasian, D) Hispanic/Latin X, E) Native American, F) Pacific Islander, G) Prefer not to answer, F) Some other race, ethnicity, or origin, as well as educational level.

The survey was conducted anonymously, and participation was completely voluntary. It did not affect participants' current or future relationships with the denomination affiliation. If participants decided not to answer a question, they could withdraw from the survey at any time

before submitting it. If a participant chose to withdraw from the survey, they were required to exit by closing their internet browser. Responses were not recorded or included in this study.

Inclusion and Exclusion Criteria

Each participant was asked to provide information on the screening/demographic form to determine if they met the inclusion criteria. The inclusion criteria to participate in the study required that individuals are preferably adults at least 21 years of age, a member of the Episcopal denomination, and currently serve in leadership roles within the Episcopal denomination (i.e., 3ordained Bishops, priests, and deacons; non-ordained: Vestry, laypersons, and staff). Participants were also required to complete the informed consent form. Participants who elected not to complete the informed consent form and did not meet the above-stated inclusion criteria were determined ineligible and were excluded from the study.

Data Collection

There are still segments of society that do not have ready internet access and many others that do not have the time to participate in online interviews. Still, for some projects, the Internet provides access to a nationwide sample (Heppner et al., 2016). Participants from underrepresented groups are often barraged with requests for participation in research studies such as master and doctoral counseling training programs seeking individuals of color, LGBTQ, or international backgrounds (Heppner et al., 2016). This researcher was aware and sensitive to the cultural contexts within the sample group. Therefore, an effort to collect information online was a customary means of disseminating information for receipt and responding or follow-up in the diocese. The survey research aimed to describe the sample population as individuals from the Eastern and Western Diocese of Kansas, members of the UBE organization, or leaders of various Episcopal ministries. The data was systematically collected through a self-report online

questionnaire. In self-report measures, the participant assesses the degree to which some characteristic is present, or some behavior has occurred. Self-reporting may be accomplished by responding to items in the questionnaire. The assumption is made that the report accurately reflects the actual state of affairs and that participants respond honestly and accurately (Heppner et al., 2016).

The primary advantage of such surveys is the ease of data collection, and a broad range of individuals in the target population from whatever location within the U.S. or beyond can complete the questionnaire. One of the most significant potential disadvantages is the difficulty of getting participants to respond and return the completed questionnaire; it is difficult to ascertain the representativeness of those participants who complete the online survey (Heppner et al., 2016). Response rates of online surveys are typically lower than paper surveys (Shih & Fan, 2008). Due to the everyday use of listservs to distribute recruitment emails, it is not easy to know who received the recruitment email and among those who opened and read it. Thus, it is almost impossible to estimate the participation rate in this case (Heppner et al., 2016). Social media has also become a common way to recruit research participants. Through snowballing methods, which is where participants recruit other participants, especially hard-to-find participants for the study, using social media, listservs, and word of mouth, researchers have very little control over who participates in response to the online survey (Heppner et al., 2016).

Instrumentation

Demographic Information Questionnaire

The demographic questionnaire used 13 questions to collect the necessary data for this study. This questionnaire captured sociodemographic information such as age, ethnicity/race, gender, educational level, position, area of service (church or office location), and church size.

The first three questions served as the screening criteria to determine inclusion eligibility (Appendix A).

Domestic and Gender-Based Violence: Pastors' Attitudes and Actions, Survey of Protestant Pastors (LifeWay, 2014; 2018)

The Survey of Protestant Pastors (SPP) questionnaire was used for the study. This survey questionnaire is on the Likert scale, which consists of a 5-point degree agreement rating scale. A Likert scale item for an attitude scale consists of a "stem" statement representing either a positive or negative attitude about the survey object (Warner, 2013). Item responses consisted of strongly agree to strongly disagree and some binary (yes or no) and multiple-choice questions. There are 30 questions. This format accommodated Cronbach's alpha to determine the internal consistency or reliability of the Likert scale format.

There may be times when researchers generalize the results of studies; they must assume there are no systematic differences in the variables of interest between two groups, an assumption that is often tenuous at best. The protection against this possibility is expressed as Cronbach's alpha level, the probability of falsely rejecting the null hypothesis. When the alpha level (type I error) is set at 0.05, the probability that a null hypothesis is rejected when it is true is less than 0.05. The probability that significant results are due to unrepresentative samples is small. The central point: Rejection of a null hypothesis does not mean that the null hypothesis is false; it means that the obtained results would be very unusual if the null had been confirmed, and thus, the decision is made to reject the null. However, there is still a tiny possibility that the null is accurate, and that sampling error was responsible for the obtained results (Heppner et al., 2016). A study by Vedral and Esworthy in 2014, first measured the respondent's understanding of and response to sexual and domestic violence. Sojourners and Interchurch Medical Assistance

(IMA) World Health (on behalf of WeWillSpeakOut.US) commissioned a survey of Protestant pastors' views on sexual and domestic violence (Vedral & Esworthy, 2014).

The survey, perhaps the first of its kind in the U.S., revealed an unrealized potential within churches for the prevention of and response to sexual and domestic violence. It began with awareness: an overwhelming majority of the faith leaders surveyed (74%) underestimate the level of sexual and domestic violence experienced within their congregations, leading to infrequent discussions of the issue from the pulpit as well as a lack of appropriate support for victims. Additionally, only 56% of pastors were adequately familiar with local resources that specifically address sexual and domestic violence, creating missed opportunities for victims to access services. The survey also found that even pastors who have handled incidents of violence may not be offering appropriate advice to those who are suffering, potentially doing more harm than good (Vedral & Esworthy, 2014).

Though this survey showed that churches are currently falling short of their potential, there was encouragement: 81% of pastors said they would take appropriate action to reduce sexual and domestic violence if they had the training and resources to do so - revealing an opportunity to turn this uncertain and unprepared group into powerful advocates for prevention, intervention, and healing (Vedral & Esworthy, 2014).

Interchurch Medical Assistance (IMA) World Health and Sojourners subsequently set out to explore how perceptions of gender-based violence have evolved among Protestant pastors in the U.S. On behalf of the We Will Speak Out coalition and campaign, this 2018 study built upon the research previously conducted in 2014. The first study revealed that Protestant pastors were surveyed about their perceptions and responses to domestic and sexual violence in their communities. This 2018 update showed that more pastors than ever before, 95% have reported

they are familiar with resources locally available to which they can refer a parishioner struggling with abusive situations; it considers how and even if those perceptions have evolved in light of the #MeToo movement where it was determined that there is much room for growth; Most pastors, 81% report being confronted with some abusive situation requiring their attention: a staff member, a parishioner, a community member or others. However, 50% of pastors surveyed report receiving little or no formal training to be able to respond to abuse effectively. The study also considered the perceptions and pervasiveness of the #ChurchToo movement, which aimed to reveal that Protestant church communities are not immune to harassment, sexual, physical, and other kinds of abuse (LifeWay, 2018).

The SPP questionnaire measured how perceptions of domestic and IPV have evolved among Episcopal faith leaders in the U.S. The questionnaire consisted of a minimum of 30 questions covering five domains, which included participant demographics; the awareness among Episcopal faith leaders that abuse and harassment are problems within their communities; outside resources and intervention; how churches respond to sexual, domestic, and IPV; and #MeToo and #ChurchToo context (LifeWay, 2018). The measure of awareness of someone who has experienced domestic or sexual violence required a *yes*, *no*, or *do not know* response; measuring how familiar they are with local resources and services that can help survivors required a Likert scale consisting of a 5-point scale that ranged from (1) Not at all familiar, (2) Somewhat familiar, (3) Familiar, (4) Very familiar, (5) Do not know.

Validity and Reliability

There are two considerations recognized with any measurement: Validity and reliability. Validity concerns the measuring instrument's soundness and effectiveness (Leedy, 1993). The Survey of Protestant Pastors on Sexual and Domestic Violence was administered in both 2014

and 2018. This recognizes differences in several consistent areas, indicating the relevant validity and reliability in the statistical conclusions of the relationship between pastors' attitudes and actions toward IPV (LifeWay, 2018). Faith leaders surveyed in 2014 indicated that 74% underestimated the level of sexual and domestic violence experienced within their congregation compared to 81% shown in the survey of 2018. Faith leaders indicated that 81% would take appropriate action to reduce sexual and domestic violence if they had the training and resources to do so, compared to 83% in 2018. There was an increase from 40% in 2014 to 45% in 2018, in which seminary training provided sufficient resources to address domestic violence (LifeWay, 2018). Face validity relies on the researcher's subjective judgment. It asks two questions the researcher must finally answer following their best judgment: (1) Is the instrument measuring what it is supposed to measure? (2) Is the sample being measured adequate to represent the behavior or trait? The degree to which inferences reflect how things are is called validity. However, it is essential to keep in mind that no study will be able to rule out every threat to the validity of the conclusion reached. The study is not guaranteed to produce valid conclusions because unexpected events occur despite the researcher’s best efforts (Heppner et al., 2016). This instrument appears to be valid upon its face value. The decision to make IPV provisions for victims of IPV has been influenced by faith leaders speaking out and connecting to community resources and services. Still, few report the lack of training received to safely and appropriately support those enduring sexual and domestic violence (LifeWay, 2018).

Reliability focuses on the instrument's accuracy and yielding consistent results (Warner, 2013). Does it ask how accurate the instrument used in making the measurement is? With what accuracy does this questionnaire measure what is intended to measure? To assess reliability, at least two sets of measurements must be assessed. A low reliability implies that the scores contain

a great deal of measurement error. Other factors being equal, variables with low reliability tend to have low correlations with other variables (Warner, 2013). This questionnaire indicated the heightened awareness of faith leaders that there is a genuine need for IPV response to assist parishioners in need. Even though it witnessed or has witnessed what many call the rapid secularization of American culture, some 70% of Americans still identify as Christian (LifeWay, 2018). Churches are places where Americans turn in times of national or personal crisis. Churches continue to be lifted as a frequent community resource where those experiencing sexual violence, abuse, or harassment might turn for support, resources, and even emergency shelters (LifeWay, 2018). This study revealed a significant need for growth in pastor training. At the same time, nine out of 10 pastors surveyed here reported being called on to address a situation of abuse or harassment, and only around half reported being formally trained for such a response. Faith leaders are left in the untenable position of being expected to respond with little experience to channel when needed (LifeWay, 2018). Cronbach's alpha will be used to measure or determine the internal consistency or reliability of the multiple Likert scales created by the survey questionnaire. When levels of alpha of 0.6-0.7 are indicated, then levels of acceptability are considered reliable (Heppner, 2016).

Procedures

Initially, meetings were held between the Bishop of the Episcopal Diocese of Kansas, her staff, and me to introduce the study and gain permission to access potential participants willing to respond to a self-report questionnaire instrument online voluntarily. Permission was granted in October 2021.

It was agreed upon that this dissertation research study, after securing Institutional Review Board (IRB) approval, would be announced within a bi-weekly diocese newsletter

inviting participants to engage in the official survey accompanied by a brief introduction of the researcher and the purpose and content of the study. Contact was made with the administration and regional leadership of the Union of Black Episcopalians, Inc. (UBE). This organization was organized in 1968 as the Union of Black Clergy and Laity but changed to its current name in 1971. This organization consists of more than 55 chapters and interest groups within six regions across the U.S. and the Caribbean. There are also members in Canada, Africa, and Latin America. This effort was made to increase the study sample size and to get the perspective of predominant members of color within the denomination. Information regarding the study was distributed throughout the organization. Additionally, contact was made with leaders of various Episcopal ministries within the Episcopal faith. The researcher spoke with department heads of different ministries within the organization to help establish a means to distribute the survey questionnaire. The Qualtrics survey link was distributed within the organization's membership, limiting voluntary participation to the denomination leadership. Based on the sample size calculator, the estimated population size is 200, yielding a sample size of N=132.

The IRB is a panel that reviews research proposals and weighs potential risks and benefits for all research, certifies that projects comply with the regulations and policies set forth by the Department of Health and Human Services (DHHS) regarding the health, welfare, safety, rights, and privileges of human participants (Heppner et al., 2016). To preserve the participant's dignity and welfare in their potential voluntary participation, they were provided with a fair, transparent, and explicit agreement about the study and informed consent (Appendix B). Consent allows participants to decide whether to participate in this research study (Heppner et al., 2016). The researcher was ethically bound to obtain informed consent from participants responsibly to establish a transparent and fair agreement that clarified obligations, risks, and responsibilities

before the study (Heppner et al., 2016). According to Turnbull (1977), consent is a special relationship comprising three key elements: Capacity, information, and voluntariness. Capacity refers to a participant's ability to process information and involves the issues of legal age, qualification, and ability. Potential participants' information about the study must be relevant to the study to make an informed decision about the merits and liabilities of participating (Kitchener & Anderson, 2011; Turnbull, 1977). Voluntariness refers to assent that must be given without explicit or implicit coercion, pressure, or undue enticement (Heppner et al., 2016).

The Consent Form, Demographic Questionnaire, and Survey of Protestant Pastors (SPP) questionnaire were uploaded into the Qualtrics survey system. The survey link was sent to the denomination offices' technical staff for dissemination through the organization's portal to avoid any improprieties in sharing participant information. Participant responses were captured, input into the system, and exported to a spreadsheet for data analyses. Responses to data collection were reported directly to the researcher and carried out at an appropriate time after IRB approval.

Before taking the online survey, participants were advised to find a quiet place to delegate the required time to complete it. Upon receiving the survey link and clicking on it, participants were requested to click on a separate link in the survey link section that directed them to the informed consent form. Participants were then asked to read the consent form before participating in the survey.

Participants were advised that participation in the survey was voluntary and completely anonymous; no personal identifying information was collected, and the survey took approximately 30 to 40 minutes to complete. No follow-ups were necessary after the completion of the study. If participants did not wish to participate, the survey was concluded. Those who consented to participate in the survey were required to affirm that they met the inclusion criteria.

Participants were asked to provide certain demographic/screening information about age, Episcopal member affiliation, and service in a leadership role within the Episcopal denomination to achieve this.

Participants were provided a form of consent to participate in the study; they were advised that they could end the questionnaire's completion at any point and that they were not obligated to complete it if they wished not to.

Data Analysis

This section provided information relative to the methodology used in the data analysis process for this study. Included were facets of the study's correlational variable constructs related to the research questions and hypothesis presented for examination of this research. Demographic information questionnaire responses and instrumental items were made through the Qualtrics Survey. The data was downloaded from the Qualtrics survey. The statistical analysis used was multiple regression. This test is a simple statistical technique to determine if there is a significant association or relationship between the categorical X variables, attitudes, training, resources knowledge, and services awareness, and Y dependent variable, the response in assisting victims of IPV (Warner, 2013). A multiple regression described the significant association between the independent X and dependent Y variables. Researchers frequently refer to the comparison between the observed frequency in each category of the cross-tabulation and the frequencies expected under the null hypothesis.

Categorical Variables

This study examined the strength of the categorical variables (provisions of assistance) and (attitudes, training, resources knowledge, and services awareness). One of the variables used for this study was the provision of assistance. Questions from the research survey examined each

participant's willingness to provide IPV assistance, such as offering safety provisions, shelter relocation assistance, medical and legal referrals, and counseling or referring to non-secular counseling services for victims of IPV.

Other variables used for comparison for this study consisted of attitudes such as individualism/core values, which are the guiding principles clergy might use to regulate their behavior when providing a favorable or non-favorable response to assist a victim of IPV in need. It was measured by incorporating a Likert scale indicating (1) Strongly agree, (2) Moderately agree, (3) Neither, (4) Moderately disagree, and (5) Strongly disagree. Teachings from the Episcopal faith are those tenets or doctrines that a member of the Episcopal faith believes and adheres to the true Word of God and serves as a source of strength through their religious practices and advocates for promoting greater psychological well-being for IPV victims. It was measured by using the Likert scale, which indicated (1) Strongly agree, (2) Moderately agree, (3) Neither, (4) Moderately disagree, and (5) Strongly disagree. Intimate partner violence training, IPV resources, and service awareness consist of steps to understand the dynamics of IPV, how to respond appropriately upon domestic violence disclosure, and referral to counseling, medical, legal, and shelter services. This area was measured as to how much IPV training the faith leader has received and the level of IPV resources knowledge and services awareness they have. A yes measured this or no answer relative to the type of IPV training received, and a Likert scale indicating (1) Extremely useful, (2) Moderately beneficial, (3) Practical, and (4) Not helpful. Intimate partner violence resources and services awareness was measured by a Likert scale that indicated: (1) Strongly favor, (2) Moderately favor, (3) Neither (4) Moderately oppose, and (5) Strongly oppose.

Data Screening and Cleaning

Data cleaning is qualitatively checking quantitative data to ensure a data set contains accurate information. Data cleaning involves several practical approaches to dealing with data, such as checking data coding, inputting, examining data distributions, and identifying issues such as extreme values (Huxley, 2020). Data cleaning is essential to reduce the impact of any errors made during data collection and imputation. Data cleaning processes and techniques supported accurate and reliable data analysis. This included screening data, extreme values, and missing or incomplete data and distributions (Huxley, 2020).

Summary

This chapter presented the methods used to capture the information needed to examine the relationship between the attitudes of pastoral leadership in the Episcopal church and their provision of assistance levels to victims of IPV. It described the sampling method to select representatives from the Eastern and Western regions of the Episcopal Diocese of Kansas, members of the Union of Black Episcopalians, or leaders of various Episcopal ministries who were located within rural, suburban, and urban regions throughout the U.S. The factors discussed were the research design, the rationale, and why the design was most appropriate for the study. The relational research questions derived from the problem, purpose statements, and corresponding hypotheses gave an overview to participants drawn from samples of the Episcopal denomination. The participants were selected from leaders whose parishes or work areas are in Kansas, members of the UBE, or leaders of various Episcopal ministries located in rural, suburban, and urban areas throughout the U.S. The instrumentation format was a questionnaire, and the procedures provided a detailed description of its composition. This researcher analyzed the data utilizing a multiple regression test as the statistical test for the presented hypotheses.

CHAPTER FOUR: FINDINGS

Overview

This study examined the attitudes and behaviors of pastoral care leaders of the Episcopal denomination (i.e., the ordained bishops, priests, and deacons; non-ordained vestry, laypersons, and staff) toward IPV. Efforts identified their respective deficiencies and examined their IPV training needs, IPV knowledge of resources and services awareness, and how they influence the level of assistance provided to congregant members or individuals victimized by intimate partner violence.

The instrument used to collect the data for this study was Domestic and Gender-Based Violence: Pastors' Attitudes and Actions (LifeWay, 2018), an online survey that elicits participants' responses. The survey was distributed randomly among the Episcopal Diocese of Kansas, members of the Union of Black Episcopalians (UBE), and various Episcopal churches throughout the United States.

The statistical analysis used for this quantitative research study was multiple regression analysis, which incorporated the Statistical Package for the Social Sciences (SPSS). The SPSS served as a data management device to examine the responses provided by study participants and determine the relationship between the independent X and dependent Y variables investigated in the various research questions and associated hypotheses. This chapter presents the findings for the research questions and hypotheses, the study's results indicated what influences the level of IPV assistance provided to victims, and descriptive statistics (demographics). Several questions did not apply to all participants and were not answered using the survey instrument.

Research Questions

RQ 1: What is the relationship between the attitudes toward IPV and the level of assistance provisions for IPV victims among pastoral care leaders?

Research Question One

The first research question sought to examine whether there was a relationship between pastoral care leaders' awareness of IPV in their congregation and their IPV training capacity and knowledge of resources and services awareness.

In the SPSS analysis, responders sampled several variations of questions to examine the strength of the relationship between the categorical variables. This SPSS analysis utilized a multi-regression analysis that indicated if there is a significant relationship between the pastoral leader having specific training capacity and resource awareness that would stimulate them to take action to reduce domestic and sexual violence and recognizing that domestic or sexual violence (including physical violence, sexual assault, rape, or child sexual abuse) occurs in the lives of people in their congregations. The Figure 2 model summary depicts the information regarding a pastor's level of seminary training where the R^2 indicates the coefficient of determination .094. Figures 3 and 4 indicate the coefficients and residual statistics. The strength of the relationship was not significant.

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.306[a]	.094	.039	1.454	.094	1.707	2	33	.197

a. Predictors: (Constant), As a pastor, my seminary training provided me with sufficient resources to address situations of domestic violence., If I had training and resources, I would take action to reduce domestic and sexual violence.

b. Dependent Variable: Domestic or sexual violence (including physical violence, sexual assault, rape, and child sexual abuse) occurs in the lives of people in our congregation.

Figure 2. Model Summary

Coefficients[a]

Model		Unstandardized Coefficients B	Unstandardized Coefficients Std. Error	Standardized Coefficients Beta	t	Sig.
1	(Constant)	.705	.968		.728	.472
	If I had training and resources, I would take action to reduce domestic and sexual violence.	-.055	.248	-.037	-.221	.827
	As a pastor, my seminary training provided me with sufficient resources to address situations of domestic violence.	.411	.224	.304	1.835	.076

a. Dependent Variable: Domestic or sexual violence (including physical violence, sexual assault, rape, and child sexual abuse) occurs in the lives of people in our congregation.

Figure 3. Coefficients[a]

Residuals Statistics[a]

	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	1.06	2.70	2.17	.454	36
Residual	-1.704	3.528	.000	1.412	36
Std. Predicted Value	-2.435	1.182	.000	1.000	36
Std. Residual	-1.172	2.426	.000	.971	36

a. Dependent Variable: Domestic or sexual violence (including physical violence, sexual assault, rape, and child sexual abuse) occurs in the lives of people in our congregation.

Figure 4. Residual Statistics

RQ 2: What is the relationship between IPV training, knowledge of resources, service awareness, and the level of assistance provisions for IPV victims among pastoral care leaders?

Research Question Two

The second research question examined the relationship between pastoral care leaders' IPV training, knowledge of resources and services awareness, in addition to the relationship, ties to how prepared the pastoral leaders were in knowing what to say and not say to someone experiencing domestic or sexual violence, and whether it would encourage them to take actions or provide the level of assistance provisions to reduce domestic and sexual violence. The R^2 depicted a rate of .089 in the model summary, figure 5. Figures 6 and 7 also represent the coefficients of B = .301 if one had training and resources to assist in reducing domestic and

sexual violence, along with the residual statistics as indicated below. Question 2 is also represented by Figure 8, a model summary where $R^2 = .179$, and Figure 9 coefficient represents B = .285 if one had training and resources to assist in reducing domestic and sexual violence if they were prepared with training in what to say to victims of IPV indicated in figure 10, residual statistics.

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.298[a]	.089	.030	1.108	.089	1.505	2	31	.238

a. Predictors: (Constant), As a pastor, my seminary training provided me with sufficient resources to address situations of domestic violence., If I had training and resources, I would take action to reduce domestic and sexual violence.

b. Dependent Variable: How often do you speak to your church in sermons or large group messages about domestic or sexual violence?

Figure 5. Model Summary

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	3.668	.754		4.865	<.001
	If I had training and resources, I would take action to reduce domestic and sexual violence.	.301	.192	.269	1.571	.126
	As a pastor, my seminary training provided me with sufficient resources to address situations of domestic violence.	.126	.175	.123	.720	.477

a. Dependent Variable: How often do you speak to your church in sermons or large group messages about domestic or sexual violence?

Figure 6. Coefficients[a]

Residuals Statistics[a]

	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	4.10	5.80	4.65	.335	34
Residual	-1.648	1.779	.000	1.074	34
Std. Predicted Value	-1.649	3.453	.000	1.000	34
Std. Residual	-1.487	1.605	.000	.969	34

a. Dependent Variable: How often do you speak to your church in sermons or large group messages about domestic or sexual violence?

Figure 7. Residual Statistics[a]

Model Summary[b]

					Change Statistics				
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	R Square Change	F Change	df1	df2	Sig. F Change
1	.423[a]	.179	.129	.745	.179	3.594	2	33	.039

a. Predictors: (Constant), As a pastor, my seminary training provided me with sufficient resources to address situations of domestic violence., If I had training and resources, I would take action to reduce domestic and sexual violence.

b. Dependent Variable: How prepared are you to know what to say and not to say to someone experiencing domestic or sexual violence?

Figure 8. Model Summary[b]

Coefficients[a]

		Unstandardized Coefficients		Standardized Coefficients		
Model		B	Std. Error	Beta	t	Sig.
1	(Constant)	1.038	.496		2.093	.044
	If I had training and resources, I would take action to reduce domestic and sexual violence.	.285	.127	.354	2.243	.032
	As a pastor, my seminary training provided me with sufficient resources to address situations of domestic violence.	.168	.115	.231	1.462	.153

a. Dependent Variable: How prepared are you to know what to say and not to say to someone experiencing domestic or sexual violence?

Figure 9. Coefficients[a]

Residuals Statistics[a]

	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	1.49	3.30	2.14	.338	36
Residual	-1.967	1.553	.000	.723	36
Std. Predicted Value	-1.919	3.447	.000	1.000	36
Std. Residual	-2.641	2.085	.000	.971	36

a. Dependent Variable: How prepared are you to know what to say and not to say to someone experiencing domestic or sexual violence?

Figure 10. Residual Statistics[a]

Hypotheses

H_0: There is a significant relationship between domestic or sexual violence (including physical violence, sexual assault, rape, and child sexual abuse) occurring in the lives of people in their congregation, and if they had training and resources, they would take action to reduce domestic and sexual violence.

H_0: There is a significant relationship between how prepared they are to know what to say and not to say to someone experiencing domestic or sexual violence, and if they had training and resources, they would take action to reduce domestic and sexual violence.

H_0: There is a significant relationship between how prepared they are to know what to say and not to say to someone experiencing domestic or sexual violence and how familiar they are with their local resources that address domestic and sexual violence.

Descriptive Statistics

The following section will provide an overview of this study's descriptive statistical findings (demographics).

Participants

The participants in this sample consisted of N=42 pastoral care leaders aged 21 years and above. The selection was anonymous, voluntary, and non-clinical. The eligibility criteria for all participants included individuals 21 years and above who were members of the Episcopal

denomination and served in a leadership capacity. In describing the population sampled, 97.67% of participants were over 21, 34.88% were over 60 and represented the largest age group. Those who are members of the Episcopal denomination represented 96.15%. Those serving in a leadership role represented 45.24% were mainly priests. About half (53.66%) of the respondent's length of service was one to five years. Of the total participants sampled, 66.67% were females,30.95% were males, and 2.38% represented as non-binary. The areas of service indicated 58.54% urban, 21.95% suburban, and 19.51% rural. The congregation or constituent size served 100 or less made up 30 %; congregation size of 101-250 represented 47.50%; 251-499 represented 12.5% and 10% represented congregation size greater than 500. The educational levels indicated for all participants were 14.29% completed some college, 9.52% completed college, 14.29% completed some graduate school, 57.14% completed graduate school, and 4.76% other. Marital status indicated 14.29% never married, 2.38% separated, 23.81% divorced, 9.52% widowed, and 50.00% married. The racial or ethnicity groups represented 4.76% Asian, 21.43% Black/African, 61.90% Caucasian, 4.76% Hispanic/Latin X, 2.38% Native Indian, 2.38% other, and 2.38% preferred not to say. I was unable to obtain responses from the Pacific Island community due to the destruction of communication infrastructure caused by a devastating fire, on August 8, 2023, that affected many Hawaiian Islands. Table 1 (see below) depicts the participant demographic variables, percentages, mean, standard deviation, and frequency occurrences.

Table 1.

Means, standard deviations, and frequencies among variables of interests.

	Min.	Max.	Means	Std. Dev.	Var.	%	N Totals
	1.0	6.0	4.70	1.27	1.61		43
Age Years/Group)							
<21						2.33	1
21-29						2.33	1
30-39						13.95	6
40-49						20.93	9
50-59						25.58	11
>60						34.88	15
	1.0	2.0	1.04	0.19	0.04		52
Are you a ember of the Episcopal denomination?							
Yes						96.15	50
No						3.85	2
	2.0	7.0	3.24	1.41	1.99		42
What is your leadership role within the Episcopal denomination (Ordained/Non-Ordained)?							
Bishop						0.00	0
Priest						45.24	19
Deacon						19.05	8
Vestry						11.90	5
Layperson						16.67	7
Administrative Staff						4.76	2
Other						2.38	1
							41
Length of Service							
<12 months						4.88	2
1-5 years						53.66	22
6-10 years						14.63	6
11-15 years						17.07	7
16-20 years						7.32	3
≥21 years						2.44	1
							41
Area of denomination service (Church/Office)							
Rural (countryside)						19.51	8
Suburban (outside city limits)						21.95	9
Urban (city limits)						58.54	24
	1.0	5.0	2.88	1.12	1.26		40
Congregation/Constituency Size							
<50						15.00	6
51-100						15.00	6
101-250						47.50	19
251-499						12.50	5
≥500						10.00	4
	2.0	6.0	4.29	1.16	1.35		42
Highest level of education completed.							
Completed high school						0.00	0
Some college						14.29	6

	Min.	Max.	Means	Std. Dev.	Var.	%	N Totals
Completed college						9.52	4
Some graduate school						14.29	6
Completed graduate school						57.14	24
Other						4.76	
	1.0	5.0	3.79	1.44	2.07		42
Marital Status							
Never Married						14.29	6
Separated						2.38	1
Divorced						23.81	10
Widowed						9.52	4
Married						50.00	21
	1.0	3.0	1.71	0.50	0.25		42
Gender							
Male							
Female							
Non-binary/third gender							
	1.0	8.0	3.0	1.23	1.52		42
Racial/Ethnicity (Check all that apply)							
Asian						4.76	2
Black/African						21.43	9
Caucasian						61.90	26
Hispanic/Latin X						4.76	2
Native Indian						2.38	1
Pacific Islander						0.00	0
Other						2.38	1
I prefer not to say						2.38	1

Hypotheses

H_o: There is no significant relationship between domestic or sexual violence (including physical violence, sexual assault, rape, and child sexual abuse) occurring in the lives of people in their congregation, and if they had training and resources, they would take action to reduce domestic and sexual violence. Evidence indicates null is accepted.

H_o: There is no significant relationship between how prepared they are to know what to say and not to say to someone experiencing domestic or sexual violence and if they had training and resources, would they take action to reduce domestic and sexual violence. Evidence indicates null is accepted.

H_0: There is no significant relationship between how prepared they are to know what to say and not to say to someone experiencing domestic and how familiar they are with their local resources that address domestic and sexual violence. Evidence indicates null is accepted.

Conclusion

This study examined pastoral care leaders' attitudes and behaviors, their IPV training and knowledge level, and their awareness of IPV resources and services. Previous studies in 2014 and 2018 addressed similar issues. This study utilized a Qualtrics survey program shared with participants who met the eligibility criteria. Multiple regression analysis examined the hypothesis of the first research question that examined whether there is a significant relationship between pastoral care leaders' attitudes and behaviors, their awareness of IPV in their congregation, and their IPV training capacity and awareness of resources and services. Findings indicated there is not a significant relationship between pastoral leader's level of awareness of members of their congregation and the leaders' level of training and resources awareness. Those leaders who indicated that they did not know if members of their congregation were victims also indicated limited IPV training and awareness of IPV resources.

The examination hypothesis of the second research question sought to examine the significant relationship between pastoral care leaders' IPV training, knowledge of resources and services awareness, and the level of assistance provisions they were willing to give IPV victims. Findings indicated that no significant relationship existed. The results exposed in this study revealed that there was no significant relationship in terms of pastoral care leaders' inherent display of compassion and willingness to assist those individuals who are victims of intimate partner violence. There seemed to be a willingness to enhance their knowledge and develop collaborative relationships with other professionals who assist the victims of intimate partner

violence. Domestic or sexual violence is prevalent among all races and ethnic groups regardless of their status. There is no immunity among any group, including those within religious communities. It is a compelling conclusion that pastoral care leaders should increase and avail themselves of the necessary education and training regarding IPV and enhance their knowledge and awareness regarding resources and services to extend to their congregants and community members who may present as IPV victims.

CHAPTER FIVE: CONCLUSION

Overview

This study examined whether pastoral care leaders' attitudes toward IPV and their level of IPV training, knowledge of IPV resources, and service awareness would influence their behaviors, or the level of assistance provided to congregant members or individuals victimized by IPV within the community.

Discussion

Examining the first research question and hypothesis revealed findings that did not result in a significant relationship between pastoral care leaders who have had training and are aware of various IPV resources and services. Recognition of IPV symptoms would encourage them to reduce domestic and sexual violence. Domestic and sexual violence includes physical violence, sexual assault, rape, or child sexual abuse that occurs in the lives of individuals in their congregation (LifeWay, 2018). According to the LifeWay study (2018), “findings within this study indicated a significant relationship in terms of 31% to 50% of adults and children in the U.S. population having been victims of domestic or sexual violence.” According to the research, church leaders selected outside intervention rather than within the family to resolve IPV issues. There are more than 10 million adults who experience domestic violence annually in the United States (NCADV, 2020). According to findings found in the National Coalition Against Domestic Violence, 2020 report, “statistics indicate that one in four women experience sexual violence and physical violence by an intimate partner.” In 43% of domestic violence incidents with female victims, children are residents of the household where domestic violence incidents have occurred (U.S. Department of Justice, 2006). According to the NCADV, 2015 report, “the number of children exposed to intimate partner violence in 2010 was one in 15.”

This relates to my study in terms of domestic violence because children are inclusive in terms of the victimization of IPV. Children who are often exposed to a violent and hostile environment created by domestic violence, are affected both physically and emotionally (NCADV, 2015). The impact of domestic violence, inclusive of child abuse within the home, as indicated by 97.30% of pastoral care leaders within this study, that resolution to such occurrences primarily be resolved through outside intervention. This study also indicated that 45.95% of pastoral care leaders strongly agreed that domestic and sexual violence, inclusive of children, occurs in the lives of people within their congregation. It was also indicated by the LifeWay, 2018 study report, that 72.97% strongly agreed that domestic and sexual violence is recognized as a big problem not only in the U.S. but within other countries in the world, and 56.76% strongly agreed that they would take action to reduce domestic and sexual violence if they had the necessary training and available resources.

The findings of the second research question and hypothesis did not indicate significant relationships between one's preparation to know what to say or not say to someone experiencing domestic or sexual violence and how familiar they are with local resources that address domestic and sexual violence and have sufficient training that would encourage action to reduce domestic and sexual violence (LifeWay, 2018). According to Choi, 2015a, “victims suffering at the hands of an intimate partner often need and seek help from an array of professionals and organizations” as reflected in the literature review. Victims and survivors of IPV regularly turn to faith communities and local churches for help (Postmus et al., 2014). Victims and survivors of IPV who have reached out for assistance from pastoral care leaders indicated mixed experiences of effective interactions and outcomes and did not always perceive such experiences and outcomes as positive (Postmus et al., 2014).

The findings of this study did not indicate a significant relationship between several indicators that addressed the relational research questions and hypotheses. As shown in the research, a resolution for domestic or sexual violence occurs within a home through outside intervention 97.30% rather than within the family (LifeWay, 2018). This finding is consistent with past research (Lifeway, 2014, 2018), which indicated 80% and 83% in 2014 and 2018, respectively. The percentage selected in this current study showed a choice of 31% to 50% of adults and children in the U.S. population that have been victims of domestic or sexual violence rather than 21% to 30% in past research, (Lifeway, 2014, 2018).

Implications

This study examined the attitudes and actions of a pastoral care leader who minimally expressed concern about IPV. The most significant number of respondents who participated were married Caucasian females over 60 who had attained a graduate degree and lived and served as priests in an urban setting. As revealed in the literature review, victims highlighted a need and desire for clergy-specific training. However, data analyses also showed that fellow clergy members' perpetration of Religious Spiritual abuse was a barrier to addressing the IPV problem (Davis & Johnson, 2020). Religious leaders expressed tension between their leadership role and responding to IPV. Furthermore, religious leaders acknowledged their need for more excellent training and connections with service providers. They also reported not being connected to other IPV resources or organizations within the community (Houston-Kolnik et al., 2019).

Several pastoral leaders indicated that they could assist individuals with developing a safety risk assessment but would rely on making IPV referrals rather than taking on the responsibility of service provisions. Over 85% of responders indicated that they were aware of or know a victim of IPV. Of those who indicated, 92% were aware of the #MeToo movement, and

57% revealed they had not suffered IPV. The research indicated that in the LifeWay, 2018 report, leaders' awareness of the # MeToo movement and of those who have succumbed to the awareness of their members who have experienced IPV, are inclined to preach about domestic or sexual violence 41%. However, 57% say they will remain the same when discussing IPV. Results also in the LifeWay, 2018 report indicated, “28% of the congregation is more aware of how common sexual and domestic violence is, 28% of those have more empathy toward those experiencing sexual and domestic violence, and 20% of the congregation is more confused about this issue.” These results indicate a need for more research regarding the congregation's reaction to what pastoral care leaders can do to improve their overall behaviors towards IPV and how a comprehensive IPV program can be developed to assist with prevention and assisting IPV victims.

Limitations

The major limitation of this study was the utilization of the survey method and the reliability of the convenience/snowball selection method within the Episcopal denomination. Snowball sampling is a nonprobability procedure to identify responders in a specific network (Heppner et al., 2016). This method was inexpensive and was initially the most favorable option, especially to attain those pastoral care leaders who served in predominantly rural areas. The target sample size for this study was 132 individuals; however, only 69 individuals completed the survey through Qualtrics. Based on the statistical reliability, varied numbers of cases represented this study's viable sample size. Although this study was anonymous and voluntary, there was constant surmise that respondents needed help connecting this topic with their personal views and relative interpretation of the denominational doctrines and, therefore, may have been challenged to share their respective responses.

Additionally, due to the challenges the researcher experienced in securing participation, this topic appeared low priority in the goals and objectives within the denomination. The study was free from the bias of the researcher's adherence to the data presented without forming a conclusive view. The effort was to examine the strength of the leaders' attitudes and behavior towards IPV victims if they had IPV training and were aware of IPV resources and services. Once measured, the general conclusion of the current data indicated an external validity in that results presented from previous studies (LifeWay 2014, 2018) stated a relationship between the leaders' response to assisting IPV victims when they attained IPV training and became aware of IPV resources.

A final limitation this researcher experienced was that the survey distribution became subjected to predatory behavior and was disallowed. Several steps of program usage required an unnecessary and time-consuming verification process.

Recommendations for Future Research

This study emphasized the limited correlational strength between the attitudes and behaviors that pastoral care leaders would extend when confronted with the issue of intimate partner violence and the level of IPV training, knowledge of IPV resources, and service awareness. Future research that would benefit pastoral care leaders would be to create a specific IPV training and guidance manual that augments information on accessible IPV resources and services. The current study indicates the reliance on various referral services and the support of domestic violence experts in the community. The collaboration of several community organizations, including secular establishments and educational programs, would serve as a comprehensive network addressing the needs of those individuals exposed to the victimization of IPV.

Conclusion

The gap this researcher identified as a need was the prevalence of Intimate Partner Violence (IPV) as a behavior that has no boundaries regardless of religious or spiritual orientation, age, racial or ethnic, or sexual preference (Davis & Johnson, 2020) that occurred in several actual or threatened forms: physical, sexual, psychological, or emotional abuse by a current or former partner.

Victims of IPV often rely on their respective religion or spirituality as a source of support and healing. Pastoral leaders are viewed as a means of spiritual or moral counsel, and many victims seek their advice or confidential guidance to assist with their decision process for their ultimate survival.

Pastoral leaders recognize there is a need for their advocacy for ending domestic violence of all forms and securing the pertinent resources and support within their respective communities or society at large. Repeatedly, there was a theme expressed by faith leaders about their hesitancy in providing domestic violence assistance due to their lack of training and assurance of how they could support or provide resources to those victimized by IPV without intentionally revictimizing them.

While the researcher initially anticipated a high number of participants for the project, the response rate fell short of expectations. The reactions revealed a clear need for pastoral leaders to acquire specialized training in intimate partner violence, collaborate with other organizations to foster community support, advocate for change through public messaging, develop policies and procedures, implement a prevention program, and establish safe spaces for victims.

The biblical connection recognized from this degree program is that some patriarchal viewpoints have become discriminately obsolete. As a result of this study, the researcher has

become a powerful advocate for those who are often overlooked, particularly by serving as a bridge between their educational experiences and their community service in this field of study. The researcher's project on intimate partner violence project addresses only a portion of the needs in pastoral care. The study was inspired by the researcher's commission to provide a positive path toward a kingdom that represents their spirituality of compassion, encouragement, and service.

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APPENDICES

Appendix A: IRB Exemption Letter

LIBERTY UNIVERSITY

INSTITUTIONAL REVIEW BOARD

March 20, 2023
Francine Young
Elisa Niles

Re: IRB Exemption - IRB-FY21-22-1251 Pastoral Care for Intimate Partner Violence: An Examination of Attitudes and Behaviors

Dear Francine Young, Elisa Niles,

The Liberty University Institutional Review Board (IRB) has reviewed your application by 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. 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 a human participant's research is exempt from the policy outlined 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 investigator records the information obtained in a manner that does not readily allow the identity of the human subjects to 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 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 B: Consent Form

CONSENT

Title of the Project: Pastoral Care for Intimate Partner Violence: An Examination of Attitudes and Behaviors
Principal Investigator: Francine Powell Young, Doctoral Candidate, Liberty University

Invitation to be part of a Research Study

You are invited to participate in a research study. To participate, you must be 21 years of age or older, be a pastoral leader, be a member of the Episcopal denomination, and serve in a leadership role within the Episcopal denomination (i.e., the ordained Bishops, priests, and deacons or non-ordained: vestry, lay-persons, and staff). Taking part in this research project is voluntary.

Please read this entire form and ask questions before deciding whether to participate in this research.

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

The purpose of the study is to examine participants' attitudes and behaviors toward intimate partner violence. It is also a means to determine if leaders have a level of intimate partner violence training in, knowledge of, and awareness of resources and services used in assisting individuals subjected to intimate partner violence.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following:

1. Complete an anonymous online survey. The survey will take approximately 30 – 40 minutes to complete.

How could you or others benefit from this study?

Participants should not expect a direct benefit from participating in this study.

Benefits to society include study findings from the collected data that can be useful for developing future training modules to assist leaders in creating pastoral care programs for their denominational members and the community. Findings may provide further insight to assist pastoral care leaders, as well as other mental health professionals, with the creation of specific policies and programs regarding the aspects of domestic or sexual violence and various public movements.

What risks might you experience from being in this study?

The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

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 and the researcher's faculty sponsor will have access to the records.

- Participant responses will be anonymous.
- Data will be stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted.

Is study participation voluntary?

Participation in this study is voluntary. Your participation will not affect your current or future relations with Liberty University. If you decide to participate, you are free not to answer any questions or withdraw before submitting the survey without affecting those relationships.

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

If you choose to withdraw from the study, please exit the survey and close your internet browser. Your responses will not be recorded or included in the study.

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

Francine Powell Young is the researcher conducting this study. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at fpyoung@liberty.edu. You may also contact the researcher's faculty sponsor, Dr. Elisa Niles, at eniles@liberty.edu.

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, in that case, **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) ensures that human subjects research is conducted ethically, 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 Liberty University's official policies or positions.

Your Consent

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

Appendix C: Demographics

Pastoral Care for Intimate Partner Violence Participant Demographics Survey

1. Please read each question in its entirety carefully.
2. Complete the demographic/screening section of the following survey.
3. Thirteen questions include four screening questions to determine participant eligibility.
4. After completing the demographic/screening section, move to the survey's Domestic and Gender-Based Violence: Pastors' Attitudes and Actions section.
5. There are 30 multiple-choice questions. Each question requires a single response answer unless multiple responses are requested.
6. Please press the submit button once the questionnaire is complete.

Thank you for your participation!

1. **Are you 21 years of age or older?**

Yes
No

2. **Are you a pastoral leader?**

Yes
No

3. **Are you a member of the Episcopal denomination?**

Yes
No

4. **Do they serve in a professional leadership role within the Episcopal denomination (i.e., the ordained bishops, priests, and deacons; non-ordained vestry, laypersons, and staff)?**

Yes
No

5. **What is your leadership role within the Episcopal denomination (Ordained/Non-Ordained)?**

Bishop
Priest
Deacon
Vestry
Layperson
Administrative Staff
Other _____
None of the Above

6. **Age (Years/Group)**

< 21
21 - 29
30 – 39
40 – 49
50 – 59
≥60

7. **Length of service**

< 12 months
1 – 5 years
6 – 10 years
11 – 15 years
16 – 20 years
≥21 years

8. **Area of denomination service (Church/Office)**

Rural (Countryside)
Suburban (Outside city limits)
Urban (City limits)

9. **Congregation/Constituency Size**

<50
51 – 100
101 – 250
251 – 499
≥500

10. **Highest level of education completed.**

Completed high school
Some college
Completed college
Some graduate school
Completed graduate school
Other _____

11. **Marital Status**

Never Married
Separated
Divorced
Widowed
Married

12. **Gender**

Male
Female
Non-binary/third gender
I prefer not to say

13. Racial/Ethnicity (Check all that apply)

Asian
Black/African
Caucasian
Hispanic/Latinx
Native Indian
Pacific Islander
Other _____
I prefer not to say

Appendix D: Permission

July 1, 2022

Dear Rev. Karen,

I am Francine Powell Young, a graduate student in the Department of Community Care and Counseling at Liberty University. I am conducting research as part of the requirements for a Doctorate of Education degree. The title of my research project is Pastoral Care for Intimate Partner Violence: Examining Attitudes and Behaviors. The purpose of this cross-sectional correlational design is to examine the relationships between pastoral care leaders' attitudes and behaviors towards intimate partner violence (IPV) and their level of IPV training, knowledge, and awareness of resources and services to assist individuals subjected to intimate partner violence.

I am writing to request your permission and solicit your assistance in recruiting participants and members of your staff/church/organization who may be willing to volunteer for this study. Participants are required to be at least 21 years of age, a member of the Episcopal denomination, and serve in a leadership role within the Episcopal denomination (i.e., the ordained Bishops, priests, deacons, non-ordained Vestry, laypersons, and staff. Recruitment information may be distributed by any method you deem appropriate (i.e., e-mail or newsletter).

Participants will be presented with informed consent information before participating in this study. Participation is entirely voluntary, and participants can discontinue participation at any time.

1. Participants will be asked to complete an anonymous online survey that asks about their demographic information, awareness, outside resources, and intervention, sermons on domestic or sexual violence, taking action against domestic or sexual violence, preparation and training, and the # Me Too and # Church Too Movements. The survey will take approximately 20 – 30 minutes to complete.

Recruitment will begin once the Liberty University Institutional Review Board approves the study. Thank you in advance for considering my request.

Sincerely,

Francine Powell Young
Doctoral Candidate
Department of Community Care and Counseling at Liberty University

Patrick Funston
To:
Karen Schlabach
+2 others
Mon 7/11/2022 12:18 PM

Francine,

Congratulations on your doctoral and research pursuits. We would be happy to invite leadership to participate in the survey. We have various methods of getting information to leaders, but the primary ways would be through our email lists and our clergy-only Facebook group. Once you have approved your research, would it be possible for you to write up what you would like us to include in such spaces and the link to the survey? You can send it to Mother Karen and me, and we can determine our best distribution methods!

=Canon Patrick

The Rev. A. Patrick K. Funston
he/him/his (why pronouns matter)
Canon to the Ordinary
The Episcopal Diocese of Kansas
835 SW Polk Street
Topeka, KS 66612-1688
785-706-1223 mobile/text

If you need to get in contact with me urgently, please call or text me at 785.706.1223.