Spiritual and Religious Coping: Does It Impact Counseling Outcomes

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**ABSTRACT**

Current research indicates exponential growth in the occurrence of intimate partner violence (IPV), the increasing severity of harm inflicted, and the possibility of lifelong effects. The effects on victims who have left abusive relationships have produced no specific predictors as the studies indicate some individuals that experience IPV are better able to cope, overcome, and move on with their lives, then others. Those who have left an abusive relationship and are found to be having trouble with coping and overcoming, are often diagnosed with low levels of resilience and emotional distress such: as low self-esteem, low self-efficacy, depression, anxiety, and possible suicidal ideation. This study used data developed through an online survey presented to domestic violence survivors that have completed the counseling process to gain insight into the possible impacts of religion and spirituality on domestic abuse victims (DAV), in the counseling process.

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CHAPTER I

INTRODUCTION AND LITERATURE REVIEW

This study will seek an understanding of the possible impacts on, and the use of, religion and spirituality on spousal abuse (SA) victims, in the resiliency-building process. As a victim of SA, which occurs when one partner asserts power and control over another partner through means which can include physical, sexual, psychological, or economic coercion (Bureau of Justice Statistics, National Crime Victimization Survey, Concatenated File, 1992-2015, (U.S. Department of Justice), traumatic events (TE) can negatively impact an individual physically, emotionally and mentally (Sultan, Khawaja, & Kousir, 2016). The TE may have occurred in a millisecond, such as a car accident; or, slowly and consistently over an extended period, as is often the case with spousal abuse.

When adults experience trauma, the impact can be such that the individual has extreme difficulty with processing the occurrence (Perez, Moreira-Almeida, Naello, & Koenig, 2007). This phenomenon is a direct result of a traumatic experience so powerful that it disrupts the cognitive synthesis involved in emotional memories and long-term memories; thus, creating defects in the extinction of the response to fear (Perez et al., 2007). This condition also results in the disruption of an individual’s ability to relate to personal experience through the formation of terms and descriptions typically found in a communicable language.

A simple version of this type of disruption can be observed when a client experiences a thought loop interruption due to a sudden event or occurrence. Examples of this may include a near miss while driving or a surprise meeting of an old acquaintance thus leaving one speechless. The recovery from this type of interruption typically occurs within milliseconds (Perez et al., 2007). The disruption experienced from a traumatic event such as spousal abuse can require weeks, months, or years to recover if recovery at any level occurs at all.

While spousal abuse often occurs behind-closed-doors, in private (Reeves & O’Leary-Kelly, 2014), or is not considered wrong within cultural and societal standards, it has become a wide-spread, global epidemic (Cleaver, Maras, Oram, & McCallum, 2019). As victims develop the courage to speak out and victim advocacy grows, as indicated by the latest Bureau of Justice Statistics (Reaves, 2017) spanning from 2006-2015, an increase in reported occurrences indicate that 76% of “domestic assaults totaling 1,014,073 females were perpetrated by their intimate partner” (Reaves, 2017). As societies become more connected, behaviors often acceptable within a specific culture are being forced into the spotlight. Once these behaviors are highlighted, global pressure for societal change forces the judicial systems to make sweeping changes. The acceptance of the behaviors is now a legal issue; following suit in the realm of necessity is the need for proper treatment and support.

Abuse can take many forms, such as emotional, physical, sexual, financial exploitation, and controlling behaviors (Gray, Lewis, Mokany, & O’Neil, 2014). Recognizing that there is no gold-standard approach to treatment, these individuals, and the debate around the proper approach(es) to be utilized has become a source of much research. A 2014 study completed by Drumm, Popescu, Cooper, Trecartin, & Seifert indicates the earlier approach that removal of the abused spouse from the imminent threat as vital; yet, has not validated the value in continued interventions including spiritual, wellness, or any such self-efficacy and resiliency rebuilding approach. While removal of the spouse from the situation is effective in providing safety in the aftermath of the trauma, it also appears that providing an earlier intervention would be a productive application of efforts (Drumm, Popescu, Cooper, Trecartin, & Seifert, 2014). This study works to demonstrate that the previous logic of simply removing the abused victim from the situation was satisfactory- is flawed or missing a component; and that component is: continued intervention or use of some coping mechanism for resiliency rebuilding which is essential for the overall well-being of the abused victim.

**Statement of the Problem**

Previous and current studies do not appear to have discovered exactly how individuals that have experienced spousal abuse- which can often be complicated by behavioral or psychological conditions ranging in severity from low-efficacy, low self-worth, anxiety, depression, alcohol or substance abuse, sleep disorders, panic disorders and most often posttraumatic stress disorder (PTSD) (Centers for Disease Control and Prevention, 2008)- recover emotionally; therefore, much further research focusing beyond physical needs is required.

The multiple levels of encounters experienced as an SAV may include but are not limited to social workers, counselors and therapists, shelter workers and directors, as well as other support groups and resources- some of which, as indicated in Drumm, Popescu, Cooper, Trecartin, & Seifert’s 2014 study, often discount emotional needs and may not recognize or accept faith perspectives as a variable in the recovery process. This study focuses on the possibility that the acceptance of, and encouragement of, positive spirituality to promote improved self-worth- which is greatly needed by SAVs- and utilizing spirituality as a resilience-building tool, could be of value throughout the care and healing process.

**Purpose of the Study**

The significance of this study is to gain an understanding of the effect that religion and spirituality may or may not have on the SAV and recognizing the impact on their resilience and ability to move from victim to survivor. Statistics presented by the Bureau of Justice Statistics (BJS) report in the United States alone, between 2006 and 2015, 76% of domestic abuse, 1,014,073 females, was due to violence committed by their intimate partner (Reaves, 2017). It should be noted, males often do not report violence and abuse committed by a female intimate partner (Reaves, 2017). As indicated by Drumm, Popescu, Cooper, Trecartin, & Seifert (2014) by noting a lack of consideration for the victims emotional needs and the Bureau of Justice Statistics (BJS) depicting the significance of the occurrence of IPV and the long-term emotional effects associated indicate a gap may exist between the physical healing and emotional healing of an SAV.

Individuals, in general, utilize their sense of the sacred, whether it is connected to a specific religious practice or belief when faced with problems or adversity (Sahlein, 2002). Multiple factors, beginning with Freud’s debunking of religion, as well as the discomfort experienced by social workers with allowing spirituality to enter the discussion, result in the spiritual and faith aspects not given priority in the SAV’s care (Sahlein, 2002). The outcome of this study may demonstrate an impact of religion and/or spirituality in the resiliency-building and survivorship process.

**Literature Review: Research on Spousal Abuse Victims**

**Intimate Partner Violence**

Declared a *significant public health problem* in the United States by the American Psychological Association in 2008 (Elmore, 2009), due to the exponential rise in occurrence, has placed Intimate Partner Violence (IPV) into public focus. This level of attention has increased the public’s demand for violence reduction intervention. IPV has been defined by the APA as per Elmore (2009) as:

intentional actions of individuals towards others designed to intimidate and dominate through repeated patterns of coercive behaviors that include but are not limited to physical, sexual, emotional, psychological, and economical forms of abuse. Revealing some staggering statistics, the report states that fifty-two percent- over half- of women in the United States have experienced violence during their lifetime. Two-thirds of the violence experienced was at the hand of either a current or former intimate partner. Each year an average of five-million acts of intimate partner violence occurs among women ages 18 and older. One in every six women has been the victim of an attempted or completed rape(Elmore, 2009)*.*

**Historical Complexity of Intimate Partner Violence**

IPV has not always carried a negative connotation. During the 1700s the occurrence of violence between a husband and wife was acceptable and anticipated as an outspoken woman was not tolerated and there was a need to reprimand her if she did speak out (Pleck, 2004). The evolution of public opinion toward a more negative light can be observed in court records from the later part of the 1800s, which speak of men being charged with injury and murder of their wives (Hutson, 1996). The sentences were often lenient, including for the murder of their wives, as the blame was placed on the morality and actions of the women. Though occurring many years ago, the idea of the victim being responsible for the violence or somehow provoking or deserving the violence continues today. A review completed by Ernest Garcia and published by the World Health Organization in January of 2014, identified 23 studies in which authors examined participants from 61 countries that had participated in intimate partner violence committed against women. The studies included a mix of low, middle- and high-income countries. In a high percentage of the occurrence’s explanations were given which implied the woman was to blame. Some of the justifications given as the reason for the violence included but were not limited to; burning a meal or serving it late, neglecting a child, refusing to have sex, or talking back to the husband. Assessments of victim-blaming attitudes in high-income countries have included justifications such as infidelity or women “asking for it” (United States of America) and women’s provocative behavior (European countries) (Garcia, 2014).

That perception of responsibility carried into the 20th century as in most cases the female- though the male was incarcerated briefly- was given the responsibility of repairing any emotional or physical damage and moving on thus keeping the family intact (Pleck, 2004). In most instances, a reoccurrence of violence was considered due to the actions of the women; therefore, she must have deserved to be punished. It was also during the 20th century in which psychological text appeared that argued the females experienced sexual gratification from the violence (Dobash & Dobash, 1992). It was not until the 1970’s when the Battered Women’s Movement gave women a platform to refute certain perceptions and opinions of IPV, that they could speak out about the abuse (Pleck, 2004). As government officials, law enforcement, and social workers began supporting the movement, opinions shifted with Oregon being the first state to pass legislation mandating arrest in IPV cases.

Legislative changes occurring in the late 1970s and early 1980s increased the role of local and municipal law enforcement agencies. Community law enforcement services adopted a policy of accepting crime reporting from anonymous sources. For this reason, domestic violence or extremely loud interactions between partners may be reported by neighbors or acquaintances. Police departments during that period were the first responders to calls categorized as *Domestic Disturbances*. The records from that period, coupled with accounts from law enforcement officers, indicated that domestic calls were considered a low priority (Gooklasian, 1990). Officers believed and were trained to observe domestic disturbance calls as an area of unconcern and something best left for families to work out. This attitude often leads the officers to completely ignore the domestic disturbance calls or delay their response by several hours. Once on the scene, the officers would interview the male, remove the woman from *his* home if requested to do so, and in most instances, no arrest was made. There are reported instances in which a woman would report being attacked by a stranger to get law enforcement involvement only to be declared as being *not credible* and placed on a list. If a person were declared as *not credible*, they were also placed on a do not respond list (Zorza, 1990).

**Results of intimate partner violence**

Annually, nearly five-million injuries are experienced and reported due to IPV. The commonly experienced IPV physical injuries included: scratches, bruises, broken bones, internal bleeding, and head trauma (Rivas, Bonilla, & Vázquez, 2018). The commonly experienced IPV psychological injuries include depression, anxiety, posttraumatic stress disorder, diminished self-esteem, social isolation, and suicidal ideation (Elmore, 2009). Approximately fifteen-hundred deaths because of IPV have occurred, and the economic impact experienced due to IPV through medical care, mental healthcare, and lost productivity is estimated at 8.3 billion dollars (Elmore, 2009). Survivors of IPV have merely begun the pathway back to a normal existence. There will be long-term physical, psychological, and economic barriers experienced that must be considered and overcome.

Recognition of the significant number of IPV occurrences and reoccurrences, as well as the severity of those occurrences, prompted Congress to act. In 1994 the Violence Against Women Act (VAWA) was passed to create a conduit through which services devoted to curbing such violence could be developed and made available to the public through governmental and municipal channels (The United States Department of Justice, 2019). That conduit developed into The Office on Violence Against Women (OVW). The OVW has adopted the mission of providing leadership, financial, and technical resources to states, cities, towns, and communities that are actively developing policies, programs, and practices (The United States Department of Justice, 2019).

Intimate partner violence also referred to as *domestic violence* (DV) is defined by the

 OVW, as documented by The United States Department of Justice (2019), as:

 “A felony or misdemeanor crimes of violence committed by a current or former spouse or intimate partner of the victim, by a person with whom the victim shares a child in common, by a person who is cohabitating with or has cohabitated with the victim as a spouse or intimate partner, by a person similarly situated to a spouse of the victim under the domestic or family violence laws of the jurisdiction receiving grant monies, or by any other person against an adult or youth victim who is protected from that person’s acts under the domestic or family violence laws of the jurisdiction*”* (The United States Department of Justice, 2019)

 With the evolution of laws and policies, society’s perception, and legislation such as the VAWA (1994), the prosecution of perpetrators of DV has developed into a specialization within the court system. Federal, state, county, and most municipalities have adopted operational and procedural changes such as judicial oversight in which judges take the initiative to expedite the cases, implement protection orders, ensure the victim understands and has access to expanded services, and monitor defendants pretrial to ensure compliance with court orders (National Institute of Justice, 2018). Victims are assigned advocates to assist them with navigating the process and completing the required documentation. The result of these measures includes heightened safety for the victim and stiffer penalties for the perpetrators of DV. Despite all the positive steps toward the reduction of DV, follow-up treatments and monitoring are not in place to deter future violence and victim safety (Tuerkheimer, 2004).

            Coercive control (CV) has been described as *intimate terrorism* which Johnson (2008) describes as: “a behavioral pattern utilized by an individual to achieve complete dominance over another individual through intimidation, isolation, violence or the threat of violence, and in some cases physical restraint” (Johnson, 2008). The individual may be removed from public view or public interaction, isolated from friends and family, or anyone that may provide safety or a safe intervention. Other complexities interact with the conditions under which the individual exists that may hinder outside interventions or removal to a safe environment, such as poverty, racism, homophobia, xenophobia, and/or lack of law enforcement or safe shelter, can force a victim to comply with the demands of the dominant individual and accept violence as normal (Goodmark, 2008).

            The societal perception of the DV victim has been sensationalized and molded through certain media representations. That perception is mostly negative on the existence of, or the act of inflicting pain or suffering on one’s partner, there remains a certain perception of the victim somehow deserving to suffer, because they stayed in the relationship (Arriaga & Capezza, 2008). A form of victim-blaming, also labeled as weak for not having the strength to leave, frames the victim as responsible for the abuse they have suffered and continue to receive. A common question expressed in such situations is “why don’t they just leave?”.  Family members, friends, the general public, law enforcement, and social workers often do not have the training, or experience with DV and its effects to understand the victim’s reasoning for staying (Morgan & Thapar-Bjorkert, 2010).  Our cultural script dictates we not only can leave an unsafe environment but are directed and expected to do so therefore, a DV victim that continues to stay in a violent relationship is contributing to the violence (Morgan & Thapar-Bjorkert, 2010).

 **The impact of intimate partner violence**

The way a single individual experiences stress is not indicative of the experience another individual will have. Some individuals experiencing IPV exhibit high levels of resilience and will leave the relationship, cope, and start a new life. Other individuals experiencing similar conditions are faced with few resources, limited support structures, and less financial aid, will remain in the relationship until the proper resources come available; or, due to the severity of the injury sustained, will be provided resources through legal channels. The wide range of behavioral and cognitive outcomes exhibited by victims of IPV provides clarity of the complexity of diagnosis. Reported conditions experienced by IPV victims exhibit a high probability of psychological trauma associated with the physical trauma (Peres, Moreira-Almeida, Nasello, & Koenig, 2007). Reported conditions, according to National Center on Domestic Violence (2018), include Post-Traumatic Stress Disorder, Social Phobia, Somatoform Disorders, Dissociative Disorder, Eating Disorders, Self-Mutilation, Suicide Ideation, and Depression and Major Depression Episodes (National Center on Domestic Violence, 2018).

For the magnitude of the impact of IPV to be understood; resulting disorders must be clearly outlined. To begin, Post-Traumatic Stress Disorder results in the victim reliving their ordeal through flashbacks- and nightmares that can interfere with their ability to function normally daily (American Psychiatric Association, 2013).

Social phobia affects the victim’s everyday interactions, causes significant anxiety, fear, self-consciousness, and embarrassment. Victims fear being judged by others due to the occurrence of IPV, often leading to withdrawal from friends, family, and public outings. They may also re-enter the relationship with the perpetrator due to familiarity. Borderline personality disorder, a mental health disorder that impacts the way you view yourself, can impact normal functioning. There is often an association with high-risk behaviors such as repeated participation in unstable intense relationships, distorted self-image, extreme emotions, and impulsiveness (American Psychiatric Association, 2013).

Somatoform disorders are a group of psychological disorders in which a victim complains of, or reports, experiencing physical symptoms that cannot be fully explained by any underlying general medical or neurologic condition (American Psychiatric Association, 2013).

Dissociative disorder onset may be the victim’s survival response to the trauma of experiencing IPV to keep the memories controlled. Once onset is experienced, future stressful situations can worsen the symptoms; thus, negatively impacting activities of daily living may be observed by the victim’s involuntary escape from reality through disconnection between thoughts, identity, consciousness, and memory (American Psychiatric Association, 2013).

Eating disorders are often experienced by victims of IPV due to their perception of being completely powerless and having no control over their actions, decisions, or lives in general.  The victim may also experience feelings of inadequacy, low self-esteem, depression, anger, anxiety, and or loneliness (American Psychiatric Association, 2013).

Self-mutilation may be a victim’s response to IPV trauma to relieve stress as a coping skill. Individuals engaging in self-mutilation often report experiencing a release of the trauma pain by self-inflicting pain (American Psychiatric Association, 2013).

Suicide ideation is reported by IPV victims and may be intensified by low socioeconomic status, lack of education, unemployment, increasing age, being married, and not working outside of the home (American Psychiatric Association, 2013).

Depression and Major Depression episodes are often reported by IPV Victims. The reported symptoms range from: a loss of energy, change in appetite, change in sleeping habits, anxiety, difficulty concentrating, indecisiveness, restlessness, feelings of guilt or hopelessness, to thoughts of self-harm or suicide. (American Psychiatric Association, 2013).

**Spirituality and Religion as a Treatment Modality in Mental Health**

 **Religion Literary Review**

            An assessment of the current literature, it essential to differentiate between *spirituality*

and *religion.* While many practitioners utilize the term *spirituality* interchangeably with *religion*,

they carry very different meanings. Behere, Das, Yadav, & Behere (2013) document the

characteristic differences between spirituality and religion as follows:

Religion usually refers to socially based beliefs and traditions, often associated with ritual and ceremony, whereas spirituality generally refers to a deep-seated individual sense of connection through which each person's life is experienced as contributing to a valued and greater "whole," together with a sense of belonging and acceptance. Spirituality is expressed through art, poetry, and myth, as well as a religious practice. Both religion and spirituality typically emphasize the depth of meaning and purpose in life. One does not, of course, must be religious for life to be deeply meaningful, as atheists will avow. However, although some atheists might not consider themselves spiritual, many do. Spirituality is thus a more inclusive concept than religion” (Behere et al., 2013).

 Functional theology, as documented by Behere, P., Das, A., Yadav, R., & Behere, A. (2013), may promote improved mental health, which would aid individuals suffering from abuse or mental health disorders. Practitioners and medical care providers could utilize a client’s religious and spiritual beliefs to the benefit of the client, through treatment options once trained to do so.

            A recent randomized controlled study by Hegarty, O’Doherty, Taft, Chondos, Valpied, Astbury, Taket, Gold, Feder, and Gunn (2013) found that early screening for IPV in a primary care medical provider’s office, significantly reduced women’s depression, when compared to those not receiving counseling. This same study discusses the World Health Organization’s position that early IPV intervention should begin with a primary care medical provider, who is often the first professional to have contact with a victim of IPV (Hegarty, O’Doherty, et al, 2013).

            While victims of abuse may be experiencing different types of feelings, concerns, or strife, then that of an individual experiencing various types of mental health issues; medical providers and religious leaders have many options to cater to both. Medical providers and religious leaders utilize many constructs when evaluating the psychological health of an individual, including depression and self-reported life satisfaction (Wood, 2017).  Having a religious affiliation has been documented as a protective factor against depression and may increase overall well-being (Balbuena, Baetz, & Bowen, 2013). Three variables have been identified that affect religion's impact on mental health, which include the level of religious coping, the individual's social support, and the individual’s beliefs (Weber & Pargment, 2014).  Based on these identifiable factors, practitioners must recognize the spiritual needs of a patient can affect the outcome of their treatment (Behere et al., 2013). Majority of religions prohibit any behaviors that would harm health as noted by Behere et al. (2013): “The biblical teachings, 3000 years ago, about diet, ways to handle food, cleaning, and purity, circumcision, sexual behavior were important for preventing disease” (Behere et al., 2013). The writing of Behere (2013) further document that religion and spirituality as a treatment modality can be effective when explaining the success found by Thoresen et al. clinical research attempts to “modify Type A behavior in coronary patients through a program that included spiritual practices” (Behere et al., 2013).

            Concerning mental health, status within a church congregation may provide a “compensatory role” in the well-being of an individual dealing with mental health issues (McFarland, 2010); however, health practitioners oftentimes are uncomfortable with the integration of religion or spirituality into treatment and must ensure that they have adequate training and in-depth knowledge of cultural and religious environments in which they are working (Behere et al., 2013). While the debate of the treatment of mental health with religion has raged on for hundreds of years, the first form of psychiatric care throughout Europe and much of the United States, known as *moral treatment,* had a significantly large religious component (Koenig, David, & Larson, 2001). Research by Koenig et al. (2001) found that: “Of 100 studies identified in the systematic review, 79 (nearly 80%) found religious beliefs and practices consistently related to greater life satisfaction, happiness, positive affect, and higher morale” (Koenig et al., 2001);  and that led to the notion that: “If greater social support enhances mental health, and it can be shown that religious involvement enhances social support, then it would seem logical to suspect that religious involvement could similarly benefit mental health” (Koenig et al., 2001).

            The work of Koenig et al. (2001) indicates that the inclusion of increased

utilization of religion to improve the “resolution of emotional disorder” (p. 67-78) and to further enhance the overall quality of life, three concepts must be recognized: first, religious/spiritual beliefs provide a sense of direction and motivation for a client, which leads to optimistic feelings; second, religion promotes the need to care for our fellow man, which may lead to improved general wellness by distracting from an individual’s problems and dedicating positive energy towards the betterment of others; and, lastly, religious beliefs may open the door for increased social support through congregational affiliation (Koenig et al., 2001). A practitioner may aid a client in overcoming negative thoughts that are causing mental distress such as fear; by supporting positive, healthy beliefs, such as the belief in God’s love and forgiveness (Koenig et al., 2001).

**Religion as a coping strategy**

            Religion provides much-needed guidelines for individuals navigating the life and mental health struggles they may face and is documented as being psychologically necessary for mankind (Behere et al., 2013). While religion may aid individuals in overcoming the stress and strain that the fickleness of life may present, many outdated belief systems may hinder growth (Behere et al., 2013). For example, when compared to the overall population and those that they serve, mental health professionals are oftentimes considerably less religious, which can result in their clients' religious needs being overlooked or ignored (Heffernan, Neil, & Weatherhead, 2014, p. 221-236), which leads to what Behere et al. (2013) have termed the *religiosity gap*, that leads to biased care from the provider who simply may not understand nor appreciate the individual’s religious needs and beliefs (Behere et al., 2013).

An initial concern that practitioners may experience is an ethical “reservation” regarding the integration of religion into their function, coupled with discomfort due to a lack of knowledge of the use and misuse of prayer (Moss & Dobson, 2006, p. 284-299). Secondly, clinicians may worry that the use of prayer may blur the lines of a therapist and religious or spiritual leader, which would result in an inappropriate dual-relationship, that may lead to the therapist “jeopardizing the therapeutic relationship” with the client (Moss & Dobson, 2006, p. 284-299). Additional concerns take shape based upon the clinician's own religious or spiritual beliefs, as the clinician may not truly be able to be objective and unbiased when encountering a client with significantly opposing beliefs (Moss & Dobson, 2006, p. 284-299).

Psychologists must not disregard a client’s religious or spiritual beliefs; rather, he/she must properly, objectively assess these factors to accurately determine the impact that they may or may not have on the issue, or other issues within the client’s life (Moss & Dobson, 2006, p. 284-299). Some literature indicates that the therapists’ role, in regards to the use of religion and spirituality in counseling, is to merely listen to the client with an open mind, to avoid judgment, and to guide the patient in a direction that will allow them to safely fulfill those particular areas of their need (Moss & Dobson, 2006, p. 284-299). Despite ongoing research that indicates a health benefit to the use of spirituality, many providers avoid religion and spirituality integration for fear of offending the client or for creating a sense of personal intrusion for the client (Trieschmann, 2001, p. 26-32). Literature indicates that a practitioner's or clinician's spiritual and religious beliefs have been described as a valuable component of a client's use of such practices (Oxhandler, Polson, Moffatt, & Achenbaum, 2017).

Recent studies on religion demonstrated reductions in multiple areas of mental health including suicide, drug and alcohol abuse, anxiety, and depressive disorders; while indicating a positive correlation between religion and improved hope, optimism, and quality of life (Moss & Dobson, 2006, p. 284-299). Empirical psychological studies have found that religion and spirituality have a positive correlation to overall physical and mental wellbeing (Robbins & Hong, 2013).

**Negative Religious Coping**

 Religion may provide comfort to some individuals, but others experience added distress when negative forms of religious coping are utilized, such as viewing the adverse event as a punishment from God (Lee, Roberts, & Gibbons, 2013). Negative religious coping has been found to create additional stress for the client and had been linked to poorly adapted emotional mood states (Lee et al., 2013), a reduction in mental health, and reflect a spiritual tension that humans have with God (Mohammadzadeh & Najafi, 2018). Negative religious coping includes the belief that God has punished the client by creating the traumatic event; a sense that the Lord has abandoned them; an extreme confusion of their relationship with the Lord; and a belief that the devil has played a role in the outcome of the event (Lee et al., 2013).

 Negative religious coping methods have been linked to an immediate indication of psychological distress, and to long-term limitations in growth and well-being (Paragment, Feuille, & Burdzy, 2011). Further, clients experience spiritual doubt and questioning, internal religious dissatisfaction, poor overall functioning, and a reduction in the constructs of well-being, as a result of negative religious coping methods (Paragment et al., 2011). Spiritual stress can occur in negative coping and results in increased levels of depression and loneliness (Trevino, Paragament, Cotton, Leonard, Hahn, Caprini-Faigin, and Tsevat, 2010).

 In clinical, and non-clinical populations, negative religious coping is a major contributor to negative emotional reactions and is strongly correlated with maladaptive moods, including anxiety and depression (Lee et al., 2013). Trevino et al. (2010) found that negative religious/spiritual coping was associated with significant decreases is optimism, self-esteem, and medical adherence, in patients with HIV, and further noted a medically significant decline in patients experiencing negative religious coping/spiritual struggle, especially in patients with a belief that God is judgmental and their ailment was a result of punishment from the Lord (Trevino et al., 2010).

**Spirituality Literary Review**

Some may consider religion and spirituality to be interchangeable; however, the primary

difference between religion and spirituality is that spirituality is found internally and is not

governed by any specific guidelines (Narula, 2017). This is further demonstrated by middle-aged

individuals that choose spirituality over religion, as they are not under pressure from external

forces (Narula, 2012). This is not to conceptualize spirituality, nor to overlook its religious

implications and recognition that spiritual experiences can, and do, occur within the confines and

context of organized religion and religious institutions. Individuals can, and do, gain support

from other members of religious groups, as well as gain insight and meaning regarding their

personal experiences; thus, creating growth, understanding, and eventual healing (Van Dyke,

Glenwick, Cecero, & Kim, 2009).

 Spirituality in a broader sense can include experiences such as engaging in a formalized

ritual, doctrine, or specific practices to achieve or develop a sense of connection to a sacred source to develop meaning from personal experiences (Bowland, Edmond, and Fallot, 2012).

 In a more personal construct, researchers are beginning to consider spirituality as a private experience that facilitates growth (Good & Willoughby, 2008). In a singular sense, spirituality is founded on an individual’s system of beliefs that govern their emotions (Karr, Singh, Singh, 2012). One’s search for the sacred does not necessarily occur in a religious place or institution rather, it is more internal. It involves deep reflection into one’s experiences with an open mind to understanding and acceptance of the experience’s occurrence (Hill & Pargament, 2008). A more detailed description of personal spirituality may be the aspect of one’s psyche which refers to a need to find and feel meaning and purpose in the way we experience occurrences throughout our existence (Pulchaski, Ferrell, Virani, Otis-Green, 2009). One’s need to feel connected to the self, to others, to nature, and the significant (Pulchaski, Ferrell, Virani, Otis-Green, 2009) and as Narula (2012) noted that young adults and the middle-aged that practice faith or have a belief in a higher power, have enhanced happiness and overall well-being; and, that spirituality affects happiness (Narula, 2012).

**Spirituality as a coping strategy**

            Spirituality in a broad sense can include experiences such as engaging in a formalized

ritual, doctrine, or specific practices to achieve or develop a sense of connection to a sacred

source to develop meaning from personal experiences (Bowland, Edmond, and Fallot, 2012).

Recent research indicates that not all individuals will have a religious belief or affiliation, but

individuals that are seeking “ultimate meaning” will have spirituality (Moss & Dobson, 2006, p.

284-299).

 In a more personal construct, researchers are beginning to consider spirituality as a

private experience that facilitates growth (Good & Willoughby, 2008). In the individual sense,

the search for the sacred does not necessarily occur in a religious place or institution but is more

internal. It involves deep reflection into one’s experiences with an open mind to understanding

and acceptance of the experience’s occurrence (Hill & Pargament, 2008). This is not to

conceptualize spirituality, nor to overlook its religious implications and recognition that spiritual

experiences can, and do, occur within the confines and context of organized religion and

religious institutions. Individuals can, and do, gain support from other members of religious

groups, as well as gain insight and meaning regarding their personal experiences; thus, creating

growth, understanding, and eventual healing (Van Dyke, Glenwick, Cecero, & Kim, 2009).

            Research promotes the idea that a spiritual form of coping can lower stress, reveal

meaning, increase social engagement, and decrease occurrences of depression, which will result

in increased life satisfaction (Good & Willoughby, 2008). Karr et al. (2012) found that an

increase in spirituality can lead to improved emotional intelligence (Karr et al., 2012).  Trauma survivors with a heightened sense of hope, who can make sense of the

traumatic experience, often engage in religious or organized religious-based events to increase

the use of prayer, engage in pastoral support or care, or interact in hope-building events (Bryant-

Davis, Ellis, Burke-Maynard, Moon, Counts, & Anderson (2012). Thus, aspects of care may

require the integration of spirituality in terms of the interrelatedness of the mind, body, and spirit

(Moss & Dobson, 2006, p. 284-299).

 The integration of spirituality into counselor training would afford counselors and counselor educators the ability to value spirituality as a vital part of human functionality that is important for the client’s achievement of wellness (Myers & Williard, 2003). Counselors should be exposed to multiple types of religions and spirituality, so that they may recognize and understand the positive and negative effects that religion and spirituality may have on the client (Myers & Williard, 2003).

 Present-day, on-going research indicates that there is a positive correlation between a helping professionals’ integration of the clients use of spirituality and/or religion, and improved clinical objective responses (Oxhandler et al., 2017), and that client’s personal growth is highly related to spirituality as it guides an individual to a clearer understanding of their reality (Lombard, 2017). Literature describes a positive effect on the client's perceived level of support, comfort, and productive coping skills; in addition to lowering the level of stress that the client feels (Oxhandler et al., 2017). Based on the ethical duties, psychologists may choose to integrate client’s spirituality in their treatment, to recognize the client’s values, spiritual beliefs, and their overall needs, while treating the client as a "whole" person including psychological, spiritual, and physical needs (Reno & Nunes, 2019).

**Negative spiritual coping strategies**

The variance in the level of severity of effect and individual experiences due to a traumatic event is directly reflected in the ability to cope or process the experience which impacts the individual’s interpersonal relationships. Those experiencing or recovering from a traumatic event may question basic human relationships; thus, shattering the basic sense of trust and connectivity. This phenomenon may result in the inability to trust, including those who may wish to help, thus refusing to enter new relationships and completely withdrawing from existing trust-based relationships (Van Hook, 2016). Individuals experiencing an ongoing threat of abuse or violence often find it extremely difficult to maintain or develop positive beliefs. Developing a need for comfort and protection, heightened by the isolation they are experiencing, victims of IPV reach out to God or the sacred (Van Hook, 2006). When that protection is not received or they are not delivered from their plight, a negative spiritual coping strategy (NSCS) may occur. The NSCS may result in thoughts such as God is punishing them, God has forgotten them, or leave them questioning why this is happening to them (Van Hook, 2016). Experiencing a crisis of faith this deeply can lead to feelings of abandonment, feeling violated to their very core, and leave the individual questioning the meaning of life, as well as diminish the desire to continue living (Bryant-Davis, Ellis, Burke-Maynard, Moon, Counts, Anderson, 2012).

**The potential for trauma reduction**

            Research has not indicated a conceptual framework of understanding the specific

resource or resources utilized by IPV Victims to move beyond the violence and provide coping

strength (Hage, 2011). Research has documented that social support, coping styles, spirituality,

religious beliefs, and social and cultural factors, have a significant impact on their behavior

(Lehrer, 2004). Social support, friends, and family, has become accepted as having the most

impact in the active coping process for those victims of IPV (Hage, 2011) although many

reported high levels of positive impact from professional social support such as clergy, medical

personnel, and social workers (Sullivan, 2002). The negative side of professional social support

has surfaced as this support is often short-term and impersonal (Sullivan, 2002). The lack of

social support, whether from friends and family or professional social support from clergy,

medical personnel, and social workers, is an indicator of the level of self-blaming and the

probability of experiencing posttraumatic stress disorder (PTSD) (Hage, 2011).

            Though mentioned as a possible coping enhancement, spirituality has seldom been

measured to determine a possibility of significance and is most often disregarded in interaction

with medical personnel and social workers (Barnett, 2001). Religion and specific religious

beliefs are mentioned as a possible influencer, but mostly about the individual’s decision of

whether or not to continue the relationship with many stating that their region trapped them in

the relationship (Sullivan, 2002). The IPV victim’s cultural background has also been considered

concerning coping strategies. Traditional influences may dictate that the individual cannot

leave the relationship; thus, requiring the individual to adopt a passive coping strategy as a

survival technique (Yoshihama, 2002). Though most often observed in societies in which

females are considered as secondary citizens; this phenomenon can be observed in any society as

it may be enforced using intimidation, the threat of violence, or violence (Yoshihama, 2002). This survival technique can also be observed regarding the individual's perceived circumstances. Individuals that perceive themselves as helpless or lacking the resources necessary to change their circumstances, will often adapt the passive coping strategy to reduce or minimize the

possibility of emotional, physical, or financial injury. For instance, limited financial resources

may impact the victim’s decision-making process, influencing them to stay in an abusive

relationship when they would rather leave. Understanding the sense of self, affiliation, and

interdependence is often developed within the context of a relationship. When this condition

occurs in the context of an abusive or unhealthy relationship, the lack of intimacy indicts an

eventual failure in the sense of self (Hage, 2011).

            Traditionally, social workers focus on an ecological perspective, any intervention

implemented no matter where in the stage of the relationship the trauma will be lessened

(Johnson and Zlotnick 2009). Philosophically, the individual could have experienced a severe

traumatic event, present symptoms of stress disorder, and benefit from the intervention of

removal by the social worker. Social worker intervention also considers the perpetrator in the

equation of assistance, with referral to- and follow-up with therapy, counseling, and help groups

(Van Hook, 2016). The social worker, including clinical social workers, follows a list of local

resources that are typically first-come-first-serve. Many of those services include shelters

specific to IPV victims. The shelters have limited space and funding to offer more than a few

days of services to any single individual, which in many cases, forces the individual to rejoin the

relationship (National Center on Domestic Violence, 2018).

            Individuals under extreme stress are more likely to make decisions formulated as a

response to stress rather than completing the normal analytical thought cycle prescribed often

leading to a high-risk decision followed by a negative outcome (Nowacki, Heekeren, Deuter,

Joreiben, Schroder, Otte, & Wingenfeld, 2019). The intensity of the stressor and the complexity

of the decision can increase the risk of a negative result that may have long-term implications.

Individuals faced with a decision-making condition in which both possible outcomes are gains

typically apply less consideration to the probable risk, while individuals faced with the opposite

condition in which both possible outcomes are negative, tend to consider the probable risk with

the intent of opting for the outcome with the perceived lower risk (Nowacki, Heekeren, Deuter,

Joreiben, Schroder, Otte, & Wingenfeld, 2019).

Experiencing IPV is an extremely traumatic event in which the level of stress the victim endures consistently may impact the decision-making process as the desires of the perpetrator replace the consideration of risk (Nowacki, Heekeren, Deuter, Joreiben, Schroder, Otte, & Wingenfeld, 2019). These outcomes are expected or dictated thus removing the consideration of risk as the IPV victim accepts the possibility of risk is much higher for the decision the does not consider the desires of the perpetrator. If and when an IPV victim is faced with the decision to accept assistance and leave the relationship there is an exponential increase in stress and the risk consideration thus creating a conundrum which often inhibits the process thus the victim stays in or quickly returns to the relationship even though there is an expectation of punishment (Nowacki, Heekeren, Deuter, Joreiben, Schroder, Otte, & Wingenfeld, 2019).  Once removed from the relationship has been accepted, entering the confines of a shelter or safe house, and having few or no resources can be daunting. Typically, an individual in this situation has experienced limited exposure to friends and family, even if permitted to work outside of the home, they are not allowed to develop relationships nor keep their pay; therefore, they have no financial resources- thus, have become dependent on the abusive partner (Starcke, & Brand, 2016). During this period the victim is at the highest risk of uncertainty and reentering the decision-making process which is extremely stressful (Starcke, & Brand, 2016). The uncertainty and stress will increase the desire for guidance and a feeling of safety however the individual must be the decision-maker (Starcke, & Brand, 2016).

During this period an intervention of spiritual coping strategies may provide a stress- reducer and hope-building mechanism and may also serve to reduce the effects of the traumatic experience. Social workers competent in spiritual coping strategies may use this time to open the door for healing. IPV victims that have experienced a traumatic event have an immediate need to feel safe. The meaning of *safe* is not specific to being removed from the threat, at this point in the removal process a feeling of safety is associated with relationships and others (Barrett, 2008). By presenting the IPV victim with an offer of safety in the form of a caring and accepting, supportive relationship, and assisting with developing other safe environments, such as introduction into the shelter, and being interactive throughout the process- a sense of caring can develop (Barrett, 2008). When an individuals’ choice is respected, their opinion and concerns are considered and allowing them to control what services they receive, they are more apt to note that services are meeting their needs, and less likely to go back to their abuser (Zweig & Burt, 2007).

**Relation to client resiliency**

The subject of resilience has steadily been gaining momentum in psychology because it allows psychologists to be more efficient in their function and target factors of key importance regarding improving people's lives (Toland & Carrigan, 2011). Schwarz (2018) notes that the American Psychological Association considers resilience to be an adaptation process that individuals who have experienced adversity, a trauma, a tragic event, or other stressors (Schwarz, 2018) go through, with success. Resilience can be described as the ability to persevere over challenges (Rose & Steen, 2015). There are two primary defining characteristics of resiliency, which are: an experienced threat or significant adversity, and evidence of positive, forward movement, despite the interruption in the developmental process (Toland & Carrigan, 2011). For an individual to display resilience, they must have experienced a threat, with risk factors that could hinder development (Toland & Carrigan, 2011).  Resilience occurs when adults are exposed to an isolated and distressing event but can maintain healthy levels of physical and psychological functioning (Schwarz, 2018). Resilience indicates a significant transition in the wake of an adverse event (Buse & Burker, 2013); however, without support, a client’s level of resilience will degrade over time (Goodman & West-Olantunji, 2008).

 Resilience consists of various multidimensional attributes including the client’s level of

competence, the clients existing external support system, and the clients actual personal

structuring; possessing more of these attributes leads to an improved chance that the client will

better adapt to adversity or a significantly disruptive event (Lee, Nam, Kim, Kim, Lee, & Lee,

2013). Mental health providers can utilize resilience to focus on the strengths of an

individual, while encouraging improved functioning despite the encountered adversity

(Goodman & West-Olatunji, 2008). Increases in the level of client resilience have been linked to

improved adaptive behaviors, and, enhanced physiological and psychological growth (Lee et al.,

2013). Resilience does infer that there is an innate progression towards more productive and

proactive ways of functioning (Totland & Carrigan, 2011), and is a valuable contributing factor

in how some clients are better able to cope with trauma than others (Lee et al., 2013).

Due to the implications of an individual implementing either positive or negative spiritual

coping strategies, great care must be taken when approaching the subject and defining a course

of emotional treatment. If a client presents with a notable belief system, including religiously-

themed, rather than quickly labeling these beliefs, a clinician could utilize this belief system to

uncover ways that it has allowed the individual to persevere, fueled survival (Drumm et al.,

2014). Further, as noted by Drumm et al., (2014), a client presenting with a strong belief system

could be asked: “Do you have a spiritual or religious tradition that has been helpful to you?”

(Drumm et al., 2014).

            Literature demonstrates that there currently is a lack of connection between the religious

sector and domestic violence shelters (Nason-Clark, McMullin, Fahlberg, & Schaefer, 2010).

Results of this study that correlate with the proposed hypotheses could prompt social workers,

domestic violence shelter advocates and supervisors, and other counselors to begin creating

partnerships with religious leaders and domestic violence service persons.

            According to the U.S. Department of Health and Human Services’ (2001), spirituality is a

a valuable protective factor that aids in safeguarding an individual from mental health issues (U.S. Department of Health and Human Services, 2001). While programs for victims and offenders, and therapeutic interventions intending to aid in healing from a traumatic event (Johnson & Zlotnick, 2009; McNamara, Tamanini, & Pelletier-Walker, 2008) are helpful in the aftermath of a traumatic event, early intervention is required for a more proactive approach.

            Spirituality is gaining momentum in literature as a protective factor (Benavides, 2012),

and phenomenological qualitative studies have demonstrated that victims of abuse believe that

they have relied on their spirituality as a guide through the difficult times that they have

experienced (Benavides, 2012). Participants in a recent semi-structured interview study of

adolescents involved with domestic abuse indicated that their spirituality helped them to

recognize that all lived experiences are to be learned from, and they note that they transformed

their abuse experience into “insightful and beneficial experiences such as not taking unnecessary

risks when violence was occurring in their home” (Benavides, 2012). Additionally, Benavides

(2012) documents that this phenomenological qualitative study was geared towards developing

an understanding of how spirituality acts as a protective factor, and identified several themes

using:

phenomenological coding and the hermeneutical circle. Signiﬁcant themes of the study- learning from experience, self-expression, beliefs, and feelings—were addressed. These themes indicated that their spirituality did serve as a protective factor for most of the participants and highlighted the process by which it did so (Benavides, 2012).

            Participants in this study were interviewed regarding the result of utilizing their

spirituality in their coping strategy has indicated that they experienced a sense of happiness,

they were able to forgive, and they had a sense of confidence- all of which they attribute to their

belief in their spirituality (Benavides, 2012).

            Additional existing literature encourages the recognition of an individual’s spirituality as

an integral aspect of their existence that becomes a significant resource to draw from, also

to be a force of an organization. Pargament (2007) proposed a model to understand the spiritual

cultivation process which may be of use to counselors working with IPV survivors and other

trauma victims.

            Pargament’s model (2007) allows for additional interpretations of the abused individual's

spirituality concerning resiliency. In a study, the female participants explained that God was

the only consistent thing in their lives, that this constant became a lifeline which aided them in

their survival, and that they had turned to their inner spiritual faith in response to IPV

(Pargament, 2007). The women in this study attribute their spiritual values and belief in God to

their resilience. Having a belief that their faith in God alone, is what allowed them to find ways

to survive, was a common theme (Pargament, 2007). However, there was a point at which the

participant’s faith-based coping mechanisms induced a need to re-assess the spiritual

understanding and their religious beliefs (Pargament, 2007).

            Lastly, further research literature indicates that while ample literature exists regarding the

numerous ways that victims of abuse handle and cope with the abuse; there is very limited

research as to how spirituality and healing mechanisms may aid in the recovery from abusive

relationships.

Spirituality, in short, is about the “interior life” and the exercises of spirituality that “cultivate it” (Wilson, 2006), while Religion is a ritualized experience with specific norms that are associated with a “transcendent entity” (VanCappellen, Toth-Gauthier, Saroglou, & Fredrickson, 2016). The primary visible difference in spirituality and religion is that that spirituality often lacks the institutionalized structure of religion (VanCappellen et al., 2016). Studies have indicated that an individual’s educational background, age, gender, and their religious affiliation can all impact their spirituality (Wilson, 2006); while epidemiologic studies have found that, in general, religion and spirituality have a positive impact on an individual’s health (Kennedy, Abbott, & Rosenberg, 2002). Over the past twenty years, multiple studies have researched the impact of the combination of religion and spirituality, termed “R/S”, on an individual's psychological health (Hwang, Hammer, & Cragun, 2011). Research studies have found positive effects of the combination of religion and spirituality on individuals' psychological well-being when suffering from physical medical ailments such as blindness, spinal injuries, cancer, and HIV (Hwang et al., 2011). Based on, and in parallel to, the aforementioned research study findings, combining religion and spirituality into one determining factor of an individual’s coping abilities is the directive of this current study.

**Religious/Spiritual Interventions in SAV**

            Current literature demonstrates that victims of spousal abuse often utilize varying strategies to deal with the abuse, which include emotional-focused, including religion; and problem-focused, including support sought (Zakar, Zakar, & Krämer, 2012). A recent study conducted by Zakar et al. (2012), indicated that the majority of women utilized spiritual therapies to lessen the violent acts committed against them, and for psychosocial solstice (Zakar et al., 2012). One such nation where religion is heavily relied upon as a coping mechanism and intervention are Pakistan (Zakar et al., 2012). While the use of religion may have varying results across genders, the use of religious involvement aids individuals with social integration and sharing of feelings (McFarland, 2010). Religion is believed to allow the victim of abuse a sense of comfort from the unjust act; a way to call upon supernatural forces to allow an “escape” from the physical and mental control that the abuser has over the victim; and may empower the victim to leave confines of abusive situations (Zakar et al., 2012).

            Zakar et al. (2012) describe different religious coping strategies that were constructed by behavioral scientists Hill and Hood (1999) which include: “Beliefs, prayers, involvement in congregational activities, visits to holy places, sacrifices, seeking help from religious leaders, and so forth” (Zakar et al., 2012).

**SAV Experience with Religion/Spirituality**

            Victims of spousal abuse may turn to religion and their cultural spirituality to understand the acts committed against them. Many of these victims have long-held spiritual and/or religious beliefs that increase as a coping mechanism after abuse.Zakar et al., (2012) state that: “In addition to individual religious activities, involvement in collective and congregational religious activities was also used as a coping strategy against SV” (Zakar et al., 2012). Often, female victims feel that continued participation with their religious and/or spiritual congregation will afford them a reduction in fear and anxiety; provide them with patience; and also allows for them to have a connection with the world outside of their abuse (positive relationships, support networks, and the exposure to information) (Zakar et al., 2012).

            Cultural beliefs in religion and spirituality guide many victims of abuse to their coping mechanism; for example, Potter (2007) documents the findings of Short et al (2000) in his

 explanation that:

            “for battered Black women, in comparison to battered White women, religion and prayer (along with support from family and friends) are main sources of assistance with abusive relationships. Religious practices and houses of worship are important cultural components in the lives of many African Americans. Spirituality is also a source utilized by African Americans for healing” (Potter, 2007).

Further documented in Potter’s (2007) writing was that many Christian’s believed that the advice they sought from clergy, in regards to the abuse, was damaging and unhelpful (Potter, 2007); with many pastors advising the female victims to stay in the abusive relationship, pray to the Lord, and be a “good wife” (Potter, 2007).

**SAV Experience with Religion/Spirituality in Treatment**

            Potter (2007) notes that females who have a strong religious belief, often stay in an abusive marriage considerably longer than those that have a less religious foundation (Potter, 2007). Additionally, Potter (2007) documents that African American victims with significant levels of religious activities, often experienced “lower rates of violent victimization by their intimate partners” (Potter, 2007).

            Behere et al. (2013) documented that religion in the treatment of many health disorders has a positive correlation; they document research that found: Of physical health, religiousness was related to decreased smoking and alcohol consumption, as well as positively affecting heart disease and blood pressure” and “keeping a day of rest, the body as a sacred temple, monogamous sex, moderation on eating and drinking, peaceful relationships are doctrines that might be also helpful for contemporary health problems (related to stress, competition, individualism, narcissism, anger, shame, etc.)” (Behere et al., 2013).

McFarland (2010) notes that:

            “Religious involvement may increase social integration and consequently reduce suicide rates framework suggests that the religious context provides a unique avenue that encourages men to ask for help, share feelings and concerns, and engage in behaviors that in other social contexts would suggest to others that they are weak (McFarland, 2010).

**Rationale for the Study**

The literature review offered insight into the history and evolution from culturally and traditionally accepted, to a punishable crime. The research indicated the exponential growth of occurrences, the increasing severity of harm inflicted, and finally, the possible long-term effects. The long-term effects on victims who have left an abusive relationship, carry no specific predictors as the studies indicate some individuals that experience IPV are better able to cope, overcome, and move on with their lives, than others. Those who have left an abusive relationship and are found to be having trouble with coping and overcoming, are often diagnosed with low levels of resilience and emotional distress such: as low self-esteem, low self-efficacy, depression, anxiety, and possible suicidal ideation.

Though public opinion has evolved over the years to that of low tolerance, the literature indicates a negative view of those who stay in an abusive relationship or leave and then later return to an abusive relationship. These individuals are often seen as deserving of the abuse and often find assistance difficult to obtain, whether it is from law enforcement or social services.

The literature indicates studies have been completed and there is an appearance of a disruption in the IPV victim’s decision-making process- which may increase the occurrence of high-risk decisions. During the period of initially leaving the relationship and the perceived safety of that relationship, individuals are vulnerable and should not be required to make decisions without some guidance.

The research touches on multiple types and levels of intervention but does not include any uniform interventions accepted by clergy, social services, counselors, therapists, or shelter directors. The only services with a clearly defined process are social services. If specific criteria are met, social workers are to implement interventions focusing on immediate victim’s safety. The victim will receive medical services, protection, and referral or delivery to a shelter. There appears to be a lack of research that goes beyond the victim’s achievement of safety. This study seeks to understand the possible impact of religion and spirituality on counseling victims of domestic violence.

**CHAPTER II**

**METHODS AND PROCEDURES**

 This chapter defines specific terms to the problem and the population. Also included is the hypothesis, research questions, the intended research methodology, research design, target population, instrumentation, and data collection procedures.

**Definition of Terms**

Definitions for the following terms are intended to create a language and terminology bridge between the literature reviewed for this study and the present study:

**Intimate Partner Violence (IPV):** Violence or aggression occurring in a close relationship,

typically considered a relationship in which partners are consenting sexual partners (Centers for Disease Control & Prevention, 2008).

**Perpetrator:** An individual who carries out a harmful, illegal, or immoral act (Centers for Disease Control & Prevention, 2008).

**Shelter:** A secure area of safe domicile in which public access is denied and an individual’s presence is confidential (National Network to End Domestic Violence 2010).

**Spousal Abuse (SA):** Violence or aggression occurring in a close relationship, typically considered a relationship in which partners are consenting sexual partners (Centers for Disease Control & Prevention, 2008).

**Spousal Abuse Victim (SAV):** An individual within a close relationship with which acts of violence or aggression have been committed (Centers for Disease Control & Prevention, 2008).

**Survivor:** An individual no longer engaged in a close relationship with a perpetrator of violence or aggression that has returned to the desired lifestyle (Centers for Disease Control & Prevention, 2008).

**Traumatic Event (TE):** An occurrence of violence or aggression that is considered extreme (National Center on Domestic violence, 2018).

**Traumatic Impact (TI):** The lasting result of an occurrence of violence or aggression that is considered extreme (National Center on Domestic violence, 2018).

**Traumatic Impact Severity (TIS):** The level or depth of impact experienced by an occurrence of violence or aggression that is considered extreme (National Center on Domestic violence, 2018)

**Victim:** An individual within a close relationship with which acts of violence or aggression have been committed (Centers for Disease Control & Prevention, 2008).

**Research Question**

The primary research question for this study is: Does Spirituality/Religion as coping skills have an impact on counseling outcomes among domestic abuse victims?

**Hypothesis**

H0: Spirituality/Religion as coping skills have no significant impact on counseling outcomes for victims of domestic and intimate partner violence.

H1: Spirituality/Religion as coping skills have a significant impact on counseling outcomes for victims of domestic and intimate partner violence.

**Research Design**

 Quantitative research is best described as a systematic approach to the scientific

investigation of a phenomenon and its relationships (Mehrens & Lehmann, 1991). The

the objective of such an investigation is to utilize mathematical, models, theories, and hypotheses pertaining specifically to the phenomena of question. Central to quantitative research is the process by which statistical measurement provides an empirical observation. Within the social sciences, approaches to quantitative psychology research was originally modeled on Ernst Heinrich Weber's study of experimental psychology (Ross, 1995).

**Population and Sampling**

**Survivor Participants**

The participants will be recruited using a study recruitment letter provided to each of the services listed below, as well as to other counselors/therapists from a list developed from the Psychology Today “Find a Counselor Website”. The letter will be posted on their current events and community informational boards. Anyone desiring to respond will notify the facilities director. The inclusion and exclusion criteria for this study is the participating individual must:

* Be a minimum of 18 years old
* Have experienced domestic/intimate partner violence
* Have completed counseling/therapy
* Been provided the link to the study questions by a professional at the shelter director or counselor/therapist level

**Data Collection Procedure**

The data collection phase will begin by seeking the participation of forty individuals who will participate in the web-based survey. Utilizing SurveyMonkey to develop a survey, which will be open on the internet for sixty days, to allow participants to access and respond. The access will be limited to those participants chosen from a search of counselors, psychologists, therapists, clergy, or psychotherapists that list domestic violence and domestic abuse as a specialty within their practice. A letter will be mailed containing survey access information. An email will be sent to their general practice contact boxes, containing the same survey access information. The following entities have agreed to provide survey access to participants who meet the criteria for this study.

* Raleigh NC Chapter of the National Coalition Against Domestic Violence
* InterAct of Wake County
* Durham Crisis Response Center
* Family Violence Care Center, Community Intervention & Educational Services of Winston-Salem
* Eliza’s Helping Hands of Winston-Salem

**Data Collection Components**

**Demographic Survey**

 There will be three data gathering components in this study. The first is focused upon demographic information which typically includes: age, race, ethnicity, gender, marital status, income, education, and employment. Demographic information is data regarding the study participants. This is necessary to determine if the sample is representative of the target population which, for this study, are individuals that have been victims of domestic/intimate partner violence and have completed counseling and have achieved a level of healing to be considered a survivor.

**Counseling Feedback Form**

The second data gathering component is a Counseling Feedback Form (Mulhauser, 2011). The form has been modified to gather information from the participants regarding three components of the counseling experience:

1. Was counseling successful with their initial presenting concern?
2. Was the overall counseling experience successful?
3. Was lasting change achieved?

The three components are a definable counseling representation due to the specialty of the required counseling as well as the reparation of the damage caused by the experience of domestic or intimate partner violence. The remediation of the initial presenting concern and the overall experience may be observed as the ability to heal emotionally or not.

**Brief RCOPE**

 The final component of the study’s data gathering is a measure of religious/spiritual coping with major life stressors such as has been experienced by the study participants. To accomplish this, the Brief RCOPE will be utilized. It is a 14-item psychometric scale developed by Dr. Kenneth Pargament (2011) to include both positive and negative religious coping methods. Positive religious/spiritual coping methods reflect “a secure relationship with a

transcendent force, a sense of spiritual connectedness with others, and a benevolent world

view (Pargament, Feuille, & Burdzy, 2011)”.Negative religious/spiritual coping methods reflect “underlying spiritual tensions and struggles within oneself, with others, and with the divine (Pargament, Feuille, & Burdzy, 2011).”

 The Brief RCOPE, originating as RCOPE, is a tool that could be utilized by researchers to measure religious coping, which could enable mental health professionals to better integrate spiritual and religious aspects into their client’s treatment plans. Dr. Kenneth Pargament built the measure around five functions; “meaning, control, comfort, intimacy, life transition, and the search for the sacred or spirituality itself (Pargament, Koenig, & Perez, 2000)”. The psychometric properties of the RCOPE were evaluated by obtaining data from two sample groups of participants that were experiencing major life stressors. Group one consisted of 540 college students, while group two consisted of 551 middle-aged adults who were hospitalized with serious medical conditions. According to Pragament et al., (2000), validity is:

“The factor analysis provided evidence of high internal consistency and incremental validity. All but two of the RCOPE scales had alpha values of 0.80 or greater confirming generally high-reliability estimates. In this study and subsequent research studies, the RCOPE has performed well in predicting physical and psychological adjustment to life crises when compared to other measures of global religiosity and demographic variables (Pargament, Koenig, & Perez, 2000).”

The RCOPE, while a valuable tool, has not been widely utilized due to its extensive length therefore a need for a more condensed version leads to the development of the Brief RCOPE. The first use of the condensed RCOPE was utilized with a sample of participants residing in the vicinity of the Oklahoma City Bombing site during the incident. Pargament, Koenig, and Perez (2000) observed that the resulting information identified positive and negative coping. To validate these findings, Pargament, Koenig, and Perez (2000) conducted a confirmatory factor analysis of the Brief RCOPE by utilizing a sampling of elderly patients that were hospitalized and a sampling of college students. Their findings indicated the following:

“In both cases, the analyses indicated that the two-factor solution provided a reasonable fit for the data. Moreover, the positive and negative religious coping subscales were differentially related to measures of physical health and mental health. The findings indicated that the use of positive religious coping methods was linked to fewer psychosomatic symptoms and greater spiritual growth after dealing with a stressor (Pargament, Koenig, and Perez, 2000).”

 The utilization of the Brief RCOPE in this study is due to its ability to measure the religious struggle that often occurs during life’s more serious and traumatic situations. To ensure proper permissions were gained for use of the Brief RCOPE in this study, an email was sent to Dr. Kenneth Pargament at Bowling Green State University who promptly responded with permission for use (see Appendix A).

**Interpreting the Data**

Statistics is one of the most common methods of interpreting the resulting data. This process begins with data collection based on a theory or hypothesis then applying either descriptive or inferential methods (Ross, 1995). The relationships which are observed are then studied by manipulating factors thought to influence the phenomena (Ross, 1995). These empirical relationships are often studied using software capable of generating linear and non-linear models and completing factor analysis. One such software is the Statistical Package for the Social Sciences (SPSS) that was developed by IBM in the 1960s, to fill the need for a statistical analysis tool that could be performed by a computer to increase the efficiency of the data analysis process. The SPSS to be utilized in this study will be the recent 2017 edition.

The purpose of this quantitative study is to develop an understanding of the counselor’s placement of value on religion and spirituality when working with spousal abuse (SA) victims, in the resiliency-building process, and how that coping mechanism facilitated successful movement from victim to survivor.

**Role of the Researcher**

The responsibilities this researcher has for this study will include, but will not be limited to:

* Develop the study proposal for submission to the review committee.
* Complete the proper application and submit for HSR Committee review and approval.
* Ongoing communication with mentors and committee members.
* Determine the need for additional team members and recruit as needed and include mentors and committee members in the survey process. An example of this may be the possible need for additional support staff during the analysis of the completed surveys.
* Provide initial and ongoing ethical concerns discussions and reviews.
* Monitor and reduce possible biases.
* Develop competence in the chosen methodology by ensuring the topic of focus remains the focus. Also, reviewing the participant questions that will be utilized. Ensure recruitment follows the defined conditions that must be met for an individual to be approved for the study. Ensure ethical guidelines are followed including Confidentiality.
* Analysis of the data.
* Presentation of the findings.

**Ethical Considerations**

The highest priority will be given to anonymity and confidentiality. The data collected from the survey will contain demographic information and responses to a Brief RCOPE (Pargament, 2011) and a counseling feedback form (Mulhauser, 2011). At no point will identifying information be solicited or collected.

**Instrumentation**

The instrumentation and technology that will be utilized to complete this project will include a web-based survey from SurveyMonkey and an analysis of data utilizing SPSS. The SPSS software can generate linear and non-linear models and complete factor analysis.

**Dependent and Independent Variable**

The Dependent variable in this study is the resolution of the counseling client’s presenting problems, the achievement of lasting positive change, and overall satisfaction with the counseling experience that is a direct result of domestic and intimate partner violence.

The Independent variables in this study are the divine, intrapsychic, and interpersonal beliefs experienced by the victims of domestic and intimate partner violence who have completed counseling which was a direct result of the violence experienced.

**Statistical Analysis**

 The statistical analysis will be completed utilizing SPSS (IBM, 2017). Once the data collection has been completed the response from the survey will be categorized and manually input into an excel file utilizing the proper tabular forms. The excel file will then be imported into SPSS. The data will then be examined for accuracy of entry and missing values. Once the data has been cleaned up the analysis phase will begin. Linear regression will be used to determine if any relationship exists between the dependent variable and the independent variables. Once the regression model has been completed the data will be graphed utilizing a scatterplot to determine if the relationship is linear.

**Summary**

The common reactions to spousal abuse (SA) or domestic violence (DV) typically include: removing the victim from the situation; various legal remedies; assistance from social service agencies; and, relocation of the SAV to safe housing (Vinton, 1999; Zink, Regan, Jacobson, & Pabst, 2003), which upholds the belief that the immediacy of physical needs has historically dominated the thought process utilized by social workers and clinicians faced with a client that has been the victim of SA. The SAV is often placed in a safe location, whether it is a shelter or safe house, with little or no consideration of the trauma that has been experienced by the client nor the trauma the client is experiencing throughout the removal and life re-start process (Goodman, Smyth, Borges, & Singer, 2009). This quantitative study will focus on the impact of spirituality and religion in the counseling outcome among survivors of domestic/intimate partner violence.

**CHAPTER III**

**RESULTS**

**Research Question**

The primary research question for this study is: Does Spirituality/Religion as coping skills have an impact on counseling outcomes among domestic abuse victims?

**Sample Characteristics**

This research survey was distributed solely online via SurveyMonkey, due to the extenuating circumstances created by the Coronavirus pandemic. SurveyMonkey noted a total of 56 participants. The survey results from SurveyMonkey were exported into an SPSS format. Of the 56 surveys, 6 were incomplete, which resulted in exclusion from the data set.

**Descriptive Characteristics**

A total of fifty participant surveys were included in this study. The survey consisted of three sections with the first recording demographic information. The characteristics included in this section were: Age, Ethnicity, Marital Status, Education, and Combined Household Income.

Participant’s age range of 18-24 was 12% (n=6); age 25-34 was 28% (n=14); age 35-44 was 34% (n=17), age 45-54 was 12% (n=6), age 55-64 was 14% (n=7), and age range of 65+ was 0%. Participant ethnicity was: African American, 28% (*n* = 14), Asian American, 6% (*n* = 3), Native American, 0% (*n* = 0), Latin American, 8% (*n* = 4), Caucasian, 52% (*n* = 26), and Other, 6% (*n* = 3). Participant marital status included: Never Married, 32%, (n=16), Currently Married, 32% (n=16), Divorced, 16%, (n=8), Separated, 16%, (n=8), Widowed, 2%, (n=1), Other, 2%, (n=1). Participant's education level included: less than high school, 6%, (n=3); High School Graduate/GED, 34%, (n=17); Technical School Graduate or Certificate Holder, 18%, (n=9); and, Bachler’s degree or higher, 42%, (n=21). The combined household incomes ranged from Under $15,000 at 16%, (n=8); $15,000-$29,999 at 22%, (n=11); $30,000-$49,999 at 30%, (n=15); $50,000-$74,999 at 16%, (n=8); $75,000-$99,999 at 10%, (n=5); and greater than $100,000 at 6%, (n=3). See Table 1 below for a depiction of the participant’s demographic characteristics.

Table 1

*Demographic Characteristics of Participants (n = 50)*

|  |  |  |
| --- | --- | --- |
| Demographic | *F* | % |
| Age 18-24 25-34 45-54 55-64 65+ | 61417670 | 12283412140 |
| Ethnicity African American Asian American Native American Latin American Caucasian Other | 14304263 | 28608526 |
| Marital Status Never Married Currently Married Divorced Separated Widowed Other | 16168811 | 3232161622 |
| Education Less Than High School High School Grad/GED Technical/Trade Grad/Certificate Bachler’s Degree or Higher | 317921 | 6341842 |
| Combined Household Income Less than 15000 15000-29999 30000-49999 50000-74999 75000-99999 100000+ | 81115853 | 19.630.933.01.07.28.2 |
|  |  |
|  |  |  |

**Data Collection Characteristics**

The instrument for data collection was a survey developed in the online program SurveyMonkey. Once development of the collector link was complete and prepared for distribution, access links to the survey were emailed to the following:

* Tasha Sullivan, Senior Director of Domestic Violence Services at Interact of Wake County North Carolina
* Alma Davis, Director of Shelter Services at The Durham Crisis Response Center, located in Durham North Carolina
* Tenika Carson, Victim Services Director at Eliza’s Helping Hands located in Winston Salem North Carolina
* Kristin Brown, Chief Development Officer at The Women’s Center and Shelter of Greater Pittsburgh located in Pittsburgh Pennsylvania

These entities, along with many others were contacted in advance and solicited for participation in the study. These entities had responded positively.

Due to the low volume of participation created by external extenuating circumstances created by the COVID-19 virus pandemic which required the same resources that were assisting to shut down and temporarily close their doors. It was for that reason; a second collector was developed for sharing on social media.

With the widespread use of social media spanning nearly all age groups and populations, it has become a widely utilized platform for research studies (Hammer, 2017). Social media platforms such as Facebook and Twitter offer global access efficiently, to a large population for conducting research (Hunter, Gough, O’Kane, McKeown, Fitzpatrick, Walker, McKinley, Lee, & Kee, 2018). Hammer (2017) notes that approximately twenty-five percent of the world’s population utilizes social media, and nearly eighty percent of Americans use social media, which makes it a valuable platform for research origination. Hunter et al. (2018) explain that social media platforms are attractive venues for “identifying and contacting potential research participants”. Social media has enhanced the researcher’s ability to streamline data but must be approached with caution when seeking research participants, to ensure ethical standards are upheld (Hammer, 2017). Users of social media have already weighed the benefit-versus-risk of simply electing to use a social media platform, and accepted the assumed risk (Gelinas, Pierce, Winkler, Cohen, Lynch, & Bierer, 2017). The researcher's job is to evaluate the actual recruitment of research participants to ensure that the recruitment strategy itself, does not pose a risk (Gelinas et al., 2017).

A search was conducted in Facebook Groups for entities concerned with domestic violence. Several groups were listed, after messaging several group administrators and requesting permission to place a survey link on their group pages the following groups agreed.

* Domestic Violence & Emotional Abuse Friends Support Group
* Domestic Violence Support for Men
* Male Survivors & Supporters Against Domestic Abuse & Domestic Violence
* We are victims and survivors of domestic violence

The survey was open from 12:01 am on April 1, 2020, and closed at 11:59 pm on May 15, 2020. The data collected was saved and exported in an Excel file to be reviewed, cleaned, and prepared for import into SPSS (IBM, 2017). The exported document contained the respondent identification and IP address, which is a string of characters that identify each specific computer that is communicating over a network. To ensure no identifying information that could be traced back to a respondent, which could remotely compromise the security and confidentiality of the survey respondents, the identification code was replaced with a numerical order beginning with the number “1” and ending with the last respondent and the IP address was deleted completely.

**Hypothesis Testing**

H0: Spirituality/Religion as coping skills have no significant impact on counseling outcomes for victims of domestic and intimate partner violence.

H1: Spirituality/Religion as coping skills have a significant impact on counseling outcomes for victims of domestic and intimate partner violence.

**Cleaning the Data**

The survey report showed the survey had been accessed 61 times. 36 responses were registered to the original access link forwarded to the counseling and women’s centers and 25 responses were registered to the social media link. Five of the access attempts were closed without recording any responses. 56 respondents accessed the qualifying questions section. Respondents 10, 11, and 31 answered “no” to one of the qualifying questions and immediately exited the survey. After further review, respondents 30, 53, and 56 were found to have not answered the 14 Brief R-cope questions. Because responses to the Brief R-cope portion are valued, Respondents 10,11,30,31, 53, and 56 were removed from the data pool leaving 50 response sets to be analyzed or n-50.

**The Counseling Experience**

The second data gathering component of the survey were three specific questions taken from the Counseling Feedback Form (Mulhauser, 2011). The form has been modified to gather information from the participants regarding three components of their counseling experience:

1. Was the overall counseling experience successful?
2. Was counseling successful with their initial presenting concern?
3. Was lasting change achieved?

**The Dependent Variables**

Respondents were given the options:

**Overall Satisfaction**

Twenty-two respondents indicated feeling “Extremely satisfied” with counseling experience which carries a value of 1

Twenty Respondents indicated feeling “Satisfied” with their overall counseling experience which carries a value of 2

Two respondents indicated feeling “Extremely Dissatisfied” with their overall counseling experience which carries a value of 5.

**Presenting Concerns**

Twenty Respondents indicated “Complete positive change” which carried a value of 1.

Twenty-four Respondents indicated “Some positive change” which carries a value of 2

Two Respondents indicated counseling was a “Waste of time” which carries a value of 4

Four Respondents indicated feeling “Worse than before counseling” which carries a value of 5

**Lasting Change**

Twenty-two respondents indicated they “strongly agree” that lasting change was achieved which carries a value of 1

Twenty-six respondents indicated they “agree” that lasting change was achieved which carries a value of 2

One respondent indicated they “neither agree nor disagree” that lasting change was achieved which carries a value of 3.

Two respondents indicated they “strongly disagree” that lasting change was achieved which carries a value of 5.

**Data Prepared for SPSS Import**

 The responses for the Dependent Variables were imported into SPSS and given the values which coincided with the intended values from the survey.

Overall counseling experience:

1. = “Extremely Satisfied”
2. = “Satisfied”
3. = “Neither Satisfied nor Dissatisfied”
4. = Not Satisfied”
5. = “Extremely Dissatisfied”

Counseling impact on presenting concerns:

1. = “Complete Positive Change”
2. = “Some Positive Change”
3. = “No Impact”
4. = “No Change”
5. = “Less than before counseling”

Lasting change had been achieved:

Counseling impact on presenting concerns:

1.0= “Strongly agree”

2.0= “Agree”

3.0= “Neither agree nor disagree”

4.0= “Disagree”

5.0= “Strongly Disagree”

The measure for the variables was then defined as ordinal.

**The Independent Variables**

**Responses to the Brief R-cope**

 The data retrieved from the survey in this section, while on the excel spreadsheet, was then combined through the use of a “Summation” formula. The formula combined the responses across each respondent's numeric response, to each of the fourteen key religious functions measured. The data was then utilized to determine whether each respondent experienced positive religious coping skills or negative religious coping skills. To accomplish this the Respondent’s overall scores were transformed into a percentage. The overall achievable score on the combined 14 key functions was 70. To transform the score to a percentage, the overall score was divided by 70. The resulting percentage was utilized to determine Positive versus Negative by utilizing an “IF” formula. The formula, input as “=IF (C4<=51%, "Pos", IF(C4>51%, "Neg"))”, utilized as: “IF” the resulting respondent’s percentage is less than or equal to 51% they are deemed “Positive”. “IF” the resulting respondent’s percentage is greater than 51% they are deemed “Negative”. The data is then imported into SPSS (IBM, 2017). Once in SPSS (IBM, 2017) the values are given as 1.0 = “Positive”, 2.0 = “Negative” and the variables defined as ordinal.

 To determine the proper test to run in SPSS I reviewed methods with the focus on assessing the data for statistically significant differences on a continuous dependent variable by independent variables.  An ANOVA assumes the dependent variable is normally distributed and there is equal, or close to equal, variance on the scores across the group (Laerd Statistics, 2018). While performing the regression analysis it was determined the assumptions were not met thus indicating the means may be extreme and not representative of the center of the distribution. The following assumptions were utilized in determining whether a nonparametric test should be utilized:

1. Is the sample size large enough to represent the target population? The sample size is relatively small thus the answer to that assumption is no. The first indicator of a nonparametric test should be utilized.
2. Does the median better represent the center of distribution? Due to the use of a survey with an extreme question response range (fully positive to fully negative), the median better represents the distribution. The use of such extreme ranges also indicates these possible outliers cannot be removed.

In conjunction with the above-mentioned nonparametric assumptions, the nature of the nonnormal data, a mixed grouping of nominal and ordinal, indicates a nonparametric test should be utilized.

The Kruskal-Wallis test can be utilized for both continuous and ordinal dependent variables. The Kruskal-Wallis does not require the strict adherence of parametric assumptions utilized in the ANOVA (Laerd Statistics, 2018). It is accepted the Kruskal-Wallis may not be as powerful as the ANOVA however it can be utilized to determine statistically significant differences between two or more independent variables (Laerd Statistics, 2018). The utilization of the Post-Hoc feature in SPSS (IBM, 2017) also becomes positive for the use of this method.

**Hypothesis 1**

H0: Spirituality/Religion as coping skills have no statistically significant impact on the overall counseling experience being positive of victims of domestic and intimate partner violence.

H1: Spirituality/Religion as coping skills have a statistically significant impact on the overall counseling experience being positive of victims of domestic and intimate partner violence.

 A Kruskal-Wallis H test was performed to explore the overall counseling experience of domestic or intimate partner violence survivors and religious coping skills. There is a statistically significant difference in the overall counseling experience of domestic or intimate partner violence survivors and religious coping skills. The results of the Bonferroni post hoc test shows significance as the p-level of .004, which is less than the alpha level .05 and the distribution of Religious Coping is the same across categories of My overall satisfaction with my counseling experience was positive. Thus, the null hypothesis is rejected.

Table 2

*Hypothesis 1 Test Summary*

|  |  |  |  |
| --- | --- | --- | --- |
| Null Hypothesis | Test | Sig. | Decision |
| The distribution of Religious Coping is the same across categories of My overall satisfaction with my counseling experience was positive. | Independent Samples Kruskal-Wallis Test | .004 | Reject the null hypothesis. |
|  |  |  |  |

*Criteria: ALPHA=0.05 CONFIDENCE INTERVAL=95.*

**Hypothesis 2**

H0: Spirituality/Religion as coping skills have no statistically significant impact on the successful resolution of the initial presenting concern when counseling victims of domestic and intimate partner violence.

H1: Spirituality/Religion as coping skills have a statistically significant impact on the successful resolution of the initial presenting concern when counseling victims of domestic and intimate partner violence.

A Kruskal-Wallis H test was performed to explore the possible relationship between the religious coping skills of domestic or intimate partner violence survivors and the resolution of the survivors’ reason for seeking counseling. There is a statistically significant difference in the resolution of the reason domestic or intimate partner violence survivors seek counseling and their religious coping skills. The results of the Bonferroni post hoc test shows significance as the p-level of .040, which is less than the alpha level .05 and the distribution of Religious Coping is the same across categories of My counseling experience successfully addressed my reason for seeking counseling. Thus, the null hypothesis is rejected.

Table 3

*Hypothesis 2 Test Summary*

|  |  |  |  |
| --- | --- | --- | --- |
| Null Hypothesis | Test | Sig. | Decision |
| The distribution of Religious Coping is the same across categories of My counseling experience successfully addressed my reason for seeking counseling. | Independent Samples Kruskal-Wallis Test | .040 | Reject the null hypothesis. |
|  |  |  |  |

*Criteria: ALPHA=0.05 CONFIDENCE INTERVAL=95.*

**Hypothesis 3**

H0: Spirituality/Religion as coping skills have no statistically significant impact on the achievement of lasting change in counseling outcomes for victims of domestic and intimate partner violence.

H1: Spirituality/Religion as coping skills have a statistically significant impact on the achievement of lasting change in counseling outcomes for victims of domestic and intimate partner violence.

A Kruskal-Wallis H test was performed to explore the possible relationship between the religious coping skills of domestic or intimate partner violence survivors and the achievement of lasting change through attending and completing counseling. There is no statistically significant difference in the achievement of lasting change experienced by domestic or intimate partner violence survivors through counseling and their religious coping skills. The results of the Bonferroni post hoc test shows significance as the p-level of .572, which is well above the alpha level .05 and the distribution of Religious Coping is the same across categories of the achievement of lasting change achieved through counseling. Thus, the null hypothesis is retained.

Table 4

*Hypothesis 3 Test Summary*

|  |  |  |  |
| --- | --- | --- | --- |
| Null Hypothesis | Test | Sig. | Decision |
| The distribution of Religious Coping is the same across categories of lasting change occurred. | Independent Samples Kruskal-Wallis Test | .572 | Retain the null hypothesis. |
|  |  |  |  |

*Criteria: ALPHA=0.05 CONFIDENCE INTERVAL=95.*

**CHAPTER IV**

**Discussion**

This study investigated the relationship between religious/spiritual coping skills in the counseling experience of those seeking to resolve emotional scars. Based on the analysis of the current study, an SAV victim’s religious and spiritual faith has demonstrated to have a positive impact on their coping abilities and their ability to experience pronounced resilience. Previous studies reveal both an external and an internal component of religious/spiritual coping mechanisms. The first, social engagement, which occurs as one interacts with those who exhibit certain positive characteristics can provide the positive reinforcement and support that can enhance mental health, therefore involvement in religious activities and religion-based group interactions could similarly have a positive impact on the participants overall counseling experience. Thus, these interactions may result in “greater life satisfaction, happiness, positive affect, and higher morale” (Koenig et al., 2001). The second component, internal, is more personal. It is based on the individual’s faith in the divine, the sacred, or a higher power that can govern their emotions. This spirituality involves deep reflection into one’s experiences with an open mind to understanding and acceptance of the experience’s occurrence (Hill & Pargament, 2008). Either or both components may have contributed to the positive correlation with the SAV’s sense of success in the achievement of their counseling desires and outcomes.

**Hypothesis Testing**

Hypothesis 1 evaluated the relationship or lack thereof between the overall counseling experience and the existence of religious coping skills within the counseling process. The relationship was investigated by utilizing a Kruskal-Wallis H test. The variables were religious coping skills and the positive outcome of counseling. Analysis was performed to identify a statistically significant impact of religious coping skills on the overall counseling experience being positive. The data indicated a statistically significant impact. Based on the aforementioned results, the null hypothesis is rejected.

Hypothesis 2 evaluated the relationship or lack thereof between the resolution of the initial presenting concern (the reason counseling was sought) and the existence of religious coping skills within the counseling process. The relationship was investigated by utilizing a Kruskal-Wallis H test. The variables were religious coping skills and the resolution of the presenting concern. Analysis was performed to identify a statistically significant impact of religious coping skills on the resolution of the initial presenting concern. The data indicated a statistically significant impact. Based on the aforementioned results the null hypothesis is rejected.

Hypothesis 3 evaluated the relationship or lack thereof between the achievement of lasting change through the counseling process and the existence of religious coping skills within the counseling process. The relationship was investigated by utilizing a Kruskal-Wallis H test. The variables were religious coping skills and the resolution of the presenting concern. Analysis was performed to identify a statistically significant impact of religious coping skills on the resolution of the initial presenting concern. The data indicated no statistically significant impact. Based on the aforementioned results the null hypothesis is retained.

The hypothesis testing was performed to evaluate a possible relationship between the counseling experience and success of survivors of violence at the hand of an intimate partner who has attended counseling due to the violence experienced and the existence of their religious coping skills. Traumatic events often leave more than physical scares thus counseling is sought to assist the mental and emotional healing process.

 Though statistical significance exists supporting the positive impact religious/spiritual coping skills may have on counseling outcomes, the utilization of these skills appears to diminish over time as the individual moves to normalization, and the distance away from the counseling experience increases. This phenomenon is observed through the specific questions utilized from the Counseling Feedback Questionnaire (Mulhauser, 2011). There is an indicated space of time as interpreted from the milestones from which the participants were asked to draw from their experiences.

 Beginning with the shortest and possibly the most memorable counseling milestone, hypothesis one, or overall positive counseling experience, the statistical significance was a p-level of .004 using an ALPHA of .05. The p-level of the second hypothesis test, successful resolution of presenting concern, based upon an inferred period or test period that has passed to ensure the emotional triggers once experienced frequently are now occurring much less, was .040 using an ALPHA of .05. The results of hypothesis test 3, lasting change occurred, infers a longer time distance milestone has occurred, was a p-value of .572.

 The construct of the diminishing utilization of religious/spiritual coping skills may be supported by a previous study which indicates that the inclusion of increased utilization of religion to improve the “resolution of emotional disorder” (p. 67-78) and to further enhance the overall quality of life, three concepts must be recognized: first, religious/spiritual beliefs provide a sense of direction and motivation for a client, which leads to optimistic feelings; second, religion promotes the need to care for our fellow man, which may lead to improved general wellness by distracting from an individual’s problems and dedicating positive energy towards the betterment of others; and, lastly, religious beliefs may open the door for increased social support through congregational affiliation (Koenig et al., 2001).

 This construct may also be supported by the responses received regarding participant demographics. The participants of this study provided personal information about age, ethnicity, marital status, education, and household income. The highest percentage of participants reporting an overall positive counseling experience was in the age grouping of 45 – 54 years old which could indicate a longer period occurring since their counseling experience. The passage of time may have allowed ample time for reflection and to accept their SAV experience. An indicator of achieved life stability or as previous studies indicate a move from focusing on their problems to experiencing a desire to help their fellow man (Koenig et al., 2001) may be observed in the marital status and education level demographic responses. Those responses indicated a larger percentage had achieved life satisfaction as either not married or currently married and had completed a college-level education and received a minimum of a bachelor’s degree.

**Study Contribution**

Results of this study indicate the utilization of religious coping skills during the counseling process enhanced that process thus the participants of this study (n=50) experienced a positive impact on the overall counseling process as well as the complete resolution of the presenting concern and helping the individual understand what has occurred and how to move forward. The data analysis and interpretation also revealed a possible indicator/predictor that the utilization of religious/spiritual coping skills through the counseling experience can be a foundation of future religious/spiritual beliefs leading to greater life satisfaction.

**Research Limitations**

Beginning in early 2020, the world has been gripped by the devasting effect of the COVID-19 Pandemic. When assessing the limitations of the current study, the Federal, State, and local governmentally mandated closures, restrictions, and social distancing requirements, are of the largest and unavoidable significance.

Stemming from the COVID-19 pandemic, a trickle-down effect of limitations occurred including a notable decrease in the number of anticipated study participants. The limited number of available and accessible study participants was self-limiting and prompts a future recommendation of a larger-scale study. Further impacted by the COVID-19 was the physical access to study participants. Many of the study participants that were expected to participate, pre-COVID-19, no longer were accessible due to the mandated online nature of the pandemic, and their firm’s inability or unwillingness to convert to an online platform. Thus, the study had to resort to data collection through more than the preferred professional referral sources; social media was utilized to locate qualified study participants.

This study was limited in the time allotted, as it was not continuous, updated, nor monitored. Future recommendations for a more in-depth, non-time restricted study, will be made. Additionally, this study was strictly limited to the client’s perception of the therapy, future studies may focus on the practitioner’s perception.

**Suggestions for Future Research**

In consideration of the existing current and past literature, research, and the present study, there is a viable gap in scholarly research that may indicate a need for further research including studies that: utilize of an increased number of professional referrals, as opposed to a combination of professional referrals and online social media recruitment; a larger scale study, as opposed to the considerably less than one-hindered participants in the current study; a more in-depth, non-time restricted study, as opposed to the currently imposed constraints; a focus on the practitioner’s perception; as opposed to the clients perception; the conducting of a study during non-crisis, non-pandemic times; a study that focuses on the impact of religion on SAV counseling, independent of spirituality; a study that focuses on the impact of spirituality on SAV counseling, independent of religion; and, a study that studies varying religions and the impact that a variety of religions have on SAV counseling.

This research has indicated further study should be completed as there may be significant data indicating the practitioner’s encouragement of clients to utilize the coping method that best suits their personal beliefs. Furthermore, psychologists and practitioners who may find the use of religion and spirituality to be awkward, based on their lack of familiarity with the multitude of religious and spiritual beliefs that clients may subscribe to, educating themselves on the mainstream beliefs, may be of great benefit to the psychological well-being of their SAV clients.

The consideration of the religious coping skills transitioning to a deeper level of personal religious beliefs resulting in more religious social engagement and a higher concern for their fellow man is another research possibility. The understanding of such a transition and how it could occur as well as at what point in the transition can clinicians predict fewer experiences of emotional triggers.

The results offer further questions:

1. How do religious coping skills work to positively impact the overall counseling

experience?

1. How do religious coping skills work to help an individual overcome the reason they seek out counseling?
2. Is the answer to achieving lasting change through counseling enhanced by just completing the counseling process?
3. How can practitioners implement religious coping skills to increase the occurrences of positive overall counseling experiences?
4. How can practitioners implement religious coping skills to increase the occurrences of the resolution of the initial presenting concerns of clients?
5. What can religious coping skills tell us about the specific or specialized support a client may need that when supplied can enhance their ability to succeed in the counseling process and beyond.

**Conclusion**

 There is much to learn about the value of religious/spiritual coping skills in the counseling process of SAVs. Beginning with the inference form the statistical significance of the possible impact from the existence of religious/spiritual coping skills within the counseling process supporting an overall positive outcome. This phenomenon requires further research to understand the benefits of and how treatment interventions can utilize these coping skills at multiple levels. The implication that the use of these skills by SAV survivors appears to diminish over time is important as the results from this study may support Koenig’s (2001) conclusion that three concepts must be recognized: first, religious/spiritual beliefs provide a sense of direction and motivation for a client, which leads to optimistic feelings; second, religion promotes the need to care for our fellow man, which may lead to improved general wellness by distracting from an individual’s problems and dedicating positive energy towards the betterment of others; and, lastly, religious beliefs may open the door for increased social support through congregational affiliation to enhance one’s overall quality of life. The sample represented a small diverse group of spousal abuse victims whose responses proved a valuable contribution to research.

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**Appendix A**



MEMO

3/27/20

FROM: Amy Trout, Co-Chair HSRC for Counseling Ministries Program

TO: Alan Cassel, in CES/ MHPS student, and affiliate faculty Jim Sells, Ph.D. and Ingo Tophoven, Ph.D.

HSRC ID#: 031520

This submission was reviewed as an expedited review under the current rules for ethics review.

This HSRC is approved as of today, 3/27/20. You may collect data for one year

from this date in the manner described in your HSRC form, after which you would need to request an extension to continue to collect data. Please see the HSRC website for information on adverse events, continuance, or consult if needed for any ethical issues that may arise in your study.

Reviewer feedback: page 8 of the document; regarding the video-recording and online platforms being used. Generally, research doesn’t have to meet HIPAA-compliant standards, however, given that the students were attempting to store the recordings in that manner, recommend they utilize a platform that can reach that level of privacy **OR** they indicate clearly in the informed consent the difficulties with maintaining that level of encryption and subjects can still participate with that knowledge (and often will). An easy way to adjust is to not specify a specific platform but simply say a secure videoconferencing software program. The second recommendation is to specify Chickering’s information in the project description (in-text citation and reference). That was not specified.

Amy Trout, Psy.D.

Co-Chair of HSRC Committee

**Appendix B**



**Appendix C**

Survey Question and Response Possibilities from SurveyMonkey

ATTENTION: If your answer to questions 1 thru 3 is NO, please exit the survey.

Are you 18 years old or older?

YES/NO

Have you experienced domestic or intimate partner violence?

YES/NO

Did our receive counseling for your domestic or intimate partner violence experience?

YES/NO

Were you provided this link by a professional such as a shelter director, counselor, or therapist?

YES/NO

Page 2: This section will help us know a little about you. We will not ask your name or location.

I am....

* African American
* Asian American
* Latin American
* Caucasian
* Other

My age is.....

* 18-24
* 25-34
* 35-44
* 45-54
* 55-64
* 65+

My marital status is.....

* Never Married
* Currently Married
* Divorced/Separated
* Widowed
* Other

My level of education is...

* Less Than High School
* High School Grad/GED
* Technical School Grad/Certificate
* College Graduate

Last year my household income was...

* Under $15,000
* $15,000- $29,999
* $30,000-$49,999
* $50,000-$74,999
* $75,000-$99,999
* Above $100,000

I am currently.....

* Unemployed
* Employed Part-Time
* Employed Full-time
* Homemaker and do not work outside of the home

Tell us about the working relationship with your counselor.

My counselor listened to me effectively.

* Strongly Agree
* Agree
* Neither Agree nor Disagree
* Disagree
* Strongly Disagree

My counselor understood things from my point of view.

* Strongly Agree
* Agree
* Neither Agree nor Disagree
* Disagree
* Strongly Disagree

My counselor focused on what was important to me.

* Strongly Agree
* Agree
* Neither Agree nor Disagree
* Disagree
* Strongly Disagree

My counselor accepted what I said without judging me.

* Strongly Agree
* Agree
* Neither Agree nor Disagree
* Disagree
* Strongly Disagree

My counselor showed warmth towards me.

* Strongly Agree
* Agree
* Neither Agree nor Disagree
* Disagree
* Strongly Disagree

My counselor provided a safe and trusting environment.

* Strongly Agree
* Agree
* Neither Agree nor Disagree
* Disagree
* Strongly Disagree

My counselor followed my lead during our session.

* Strongly Agree
* Agree
* Neither Agree nor Disagree
* Disagree
* Strongly Disagree

My counselor challenged me during our sessions when and if it was appropriate.

* Strongly Agree
* Agree
* Neither Agree nor Disagree
* Disagree
* Strongly Disagree

The sessions with my counselor helped me with what originally led me to seek counseling.

* Strongly Agree
* Agree
* Neither Agree nor Disagree
* Disagree
* Strongly Disagree

Any changes which might have occurred as a result of my counseling have been positive and welcomed.

* Strongly Agree
* Agree
* Neither Agree nor Disagree
* Disagree
* Strongly Disagree

My overall satisfaction with my counseling experience was positive.

* Strongly Agree
* Agree
* Neither Agree nor Disagree
* Disagree
* Strongly Disagree

Religion or Spirituality

I looked for a stronger connection with God.

* Strongly Agree
* Agree
* Neither Agree nor Disagree
* Disagree
* Strongly Disagree

I sought God's love and care.

* Strongly Agree
* Agree
* Neither Agree nor Disagree
* Disagree
* Strongly Disagree

I sought help from God in letting go of my anger.

* Strongly Agree
* Agree
* Neither Agree nor Disagree
* Disagree
* Strongly Disagree

I tried to put my plans into action together with God.

* Strongly Agree
* Agree
* Neither Agree nor Disagree
* Disagree
* Strongly Disagree

I tried to see how God might be trying to strengthen me in this situation.

* Strongly Agree
* Agree
* Neither Agree nor Disagree
* Disagree
* Strongly Disagree

I asked forgiveness of my sins.

* Strongly Agree
* Agree
* Neither Agree nor Disagree
* Disagree
* Strongly Disagree

I focused on religion to stop worrying about my problems.

* Strongly Agree
* Agree
* Neither Agree nor Disagree
* Disagree
* Strongly Disagree

I wondered whether God had abandoned me.

* Strongly Agree
* Agree
* Neither Agree nor Disagree
* Disagree
* Strongly Disagree

I felt punished by God for my lack of devotion.

* Strongly Agree
* Agree
* Neither Agree nor Disagree
* Disagree
* Strongly Disagree

I wondered what I did for God to punish me.

* Strongly Agree
* Agree
* Neither Agree nor Disagree
* Disagree
* Strongly Disagree

I questioned God's love for me.

* Strongly Agree
* Agree
* Neither Agree nor Disagree
* Disagree
* Strongly Disagree

I wondered whether my church had abandoned me.

* Strongly Agree
* Agree
* Neither Agree nor Disagree
* Disagree
* Strongly Disagree

I decided the devil made this happen.

* Strongly Agree
* Agree
* Neither Agree nor Disagree
* Disagree
* Strongly Disagree

I questioned the power of God.

* Strongly Agree
* Agree
* Neither Agree nor Disagree
* Disagree
* Strongly Disagree

**Appendix D**

 Mulhauser, G. (2011)

**Appendix E**

**Brief RCOPE**



**Appendix F:**

**Email Correspondence:**

**From:** Alan Cassell [mailto:alancas@mail.regent.edu]
**Sent:** Saturday, April 4, 2020, 10:48 AM
**To:** Brown, Kristin <brownk@wcspittsburgh.org>
**Subject:** Dissertation Survey

Kristin,

   I know these are some tough and confusing times and I certainly appreciate how busy you must be. I only reach out to you out of a desire to help. My help may not be in the present but the long term.  As a doctoral student at Regent University’s School of Psychology and counseling, I am researching the overall counseling experiences of domestic/intimate partner violence victims. I hope to better understand the aspects of counseling that clients identify as helpful, as well as explore certain relational factors. To this end, I invite participants to respond to an online survey of domestic violence counseling.

      The survey asks questions regarding education, gender, age, the overall experience as well as one’s level of satisfaction after completion of counseling/therapy services. The questions are non-invasive and to ensure complete anonymity, as well as all responses to survey items, remain strictly anonymous, at no point will anyone be asked to input their name or other identifying information.  To further ensure both individual and institutional anonymity. All responses to this web-based survey are managed and maintained through SurveyMonkey. The anonymity of responses is insured through this program. Email addresses and Internet Protocol (IP) addresses are separated from the survey responses and therefore cannot be identified by the researcher. The responses, IP addresses, all backend logs and the survey questions themselves will be deleted after a set time or 13 months whichever comes first. If for any reason anyone decides to not participate in the study, even if they have begun the survey, simply log out and close the survey and no responses will be recorded.

      If you are willing to post the link to this survey, participants should allow approximately 15 minutes to take the counselor survey.  I believe that their’ participation will help produce valuable insights into domestic violence counseling and how it is helpful.

Thank you for your time and participation.

To begin the survey, click the link below.  If that does not work, please copy and paste it
into your browser.
<https://www.surveymonkey.com/r/FBYF28F>

Alan Cassell, MA, NCC, LCMHCA

Doctoral Candidate in Psychology and Counseling

Regent University

Virginia Beach, VA

(919) 389-1883

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|

|  |
| --- |
| **Carla A. <carlaa@wcspittsburgh.org>** |

 | Apr 6, 2020, 12:17 PM |  |  |
|

|  |
| --- |
| to me, Kristin, Paula |

 |

Hello Alan,

I will discuss the survey with our Clinical staff. We will share with the clients we currently serve.

Thank you!

Carla A.

Appendix G

Journal-Ready Manuscript

Spiritual and Religious Coping: Does It Impact Counseling Outcomes

Alan k. Cassell, James N. Sells, Ingo Tophoven

Regent University

Author Note

Correspondence concerning this article should be addressed to Alan Cassell

E-mail: a\_cassell@bellsouth.net

ABSTRACT

Current research indicates exponential growth in the occurrence of intimate partner violence (IPV), the increasing severity of harm inflicted, and the possibility of lifelong effects. The effects on victims who have left abusive relationships have produced no specific predictors as the studies indicate some individuals that experience IPV are better able to cope, overcome, and move on with their lives, then others. Those who have left an abusive relationship and are found to be having trouble with coping and overcoming, are often diagnosed with low levels of resilience and emotional distress such: as low self-esteem, low self-efficacy, depression, anxiety, and possible suicidal ideation. This study used data developed through an online survey presented to domestic violence survivors that have completed the counseling process to gain insight into the possible impacts of religion and spirituality on domestic abuse victims (DAV), in the counseling process.

*Keywords:* Spousal abuse victim, coping skills, counseling experience, lasting change

Spiritual and Religious Coping: Does It Impact Counseling Outcomes

When adults experience trauma, the impact can be such that the individual has extreme difficulty with processing the occurrence (Perez, Moreira-Almeida, Naello, & Koenig, 2007). A simple version of this type of disruption can be observed when a client experiences a thought loop interruption due to a sudden event or occurrence. Examples of this may include a near miss while driving or a surprise meeting of an old acquaintance thus leaving one speechless. The recovery from this type of interruption typically occurs within milliseconds (Perez et al., 2007). The disruption experienced from a traumatic event such as spousal abuse can require weeks, months, or years to recover if recovery at any level occurs at all.

Abuse can take many forms, such as emotional, physical, sexual, financial exploitation, and controlling behaviors (Gray, Lewis, Mokany, & O’Neil, 2014). Recognizing that there is no gold-standard approach to treatment, these individuals, and the debate around the proper approach(es) to be utilized has become a source of much research. A 2014 study completed by Drumm, Popescu, Cooper, Trecartin, & Seifert indicates the earlier approach that removal of the abused spouse from the imminent threat as vital; yet, has not validated the value in continued interventions including spiritual, wellness, or any such self-efficacy and resiliency rebuilding approach. While removal of the spouse from the situation is effective in providing safety in the aftermath of the trauma, it also appears that providing an earlier intervention would be a productive application of efforts (Drumm, Popescu, Cooper, Trecartin, & Seifert, 2014). This study works to demonstrate that the previous logic of simply removing the abused victim from the situation was satisfactory- is flawed or missing a component; and that component is: continued intervention or use of some coping mechanism for resiliency rebuilding which is essential for the overall well-being of the abused victim.

**Specialized Modalities Needed**

Previous and current studies do not appear to have discovered exactly how individuals that have experienced spousal abuse- which can often be complicated by behavioral or psychological conditions ranging in severity from low-efficacy, low self-worth, anxiety, depression, alcohol or substance abuse, sleep disorders, panic disorders and most often posttraumatic stress disorder (PTSD) (Centers for Disease Control and Prevention, 2008)- recover emotionally; therefore, much further research focusing beyond physical needs is required.

The multiple levels of encounters experienced as an SAV may include but are not limited to social workers, counselors and therapists, shelter workers and directors, as well as other support groups and resources- some of which, as indicated in Drumm, Popescu, Cooper, Trecartin, & Seifert’s 2014 study, often discount emotional needs and may not recognize or accept faith perspectives as a variable in the recovery process. This study focuses on the possibility that the acceptance of, and encouragement of, positive spirituality to promote improved self-worth- which is greatly needed by SAVs- and utilizing spirituality as a resilience-building tool, could be of value throughout the care and healing process.

**Approach to Bridging the Gap**

The significance of this study is to gain an understanding of the effect that religion and spirituality may or may not have on the SAV and recognizing the impact on their resilience and ability to move from victim to survivor. Statistics presented by the Bureau of Justice Statistics (BJS) report in the United States alone, between 2006 and 2015, 76% of domestic abuse, 1,014,073 females, was due to violence committed by their intimate partner (Reaves, 2017). It should be noted, males often do not report violence and abuse committed by a female intimate partner (Reaves, 2017). As indicated by Drumm, Popescu, Cooper, Trecartin, & Seifert (2014) by noting a lack of consideration for the victims emotional needs and the Bureau of Justice Statistics (BJS) depicting the significance of the occurrence of IPV and the long-term emotional effects associated indicate a gap may exist between the physical healing and emotional healing of an SAV.

Individuals, in general, utilize their sense of the sacred, whether it is connected to a specific religious practice or belief when faced with problems or adversity (Sahlein, 2002). Multiple factors, beginning with Freud’s debunking of religion, as well as the discomfort experienced by social workers with allowing spirituality to enter the discussion, result in the spiritual and faith aspects not given priority in the SAV’s care (Sahlein, 2002). The outcome of this study may demonstrate an impact of religion and/or spirituality in the resiliency-building and survivorship process.

**Methodology**

 Quantitative research is best described as a systematic approach to the scientific

investigation of a phenomenon and its relationships (Mehrens & Lehmann, 1991). The

the objective of such an investigation is to utilize mathematical, models, theories, and hypotheses pertaining specifically to the phenomena of question. Central to quantitative research is the process by which statistical measurement provides an empirical observation. Within the social sciences, approaches to quantitative psychology research was originally modeled on Ernst Heinrich Weber's study of experimental psychology (Ross, 1995).

**Research Question**

The primary research question for this study is: Does Spirituality/Religion as coping skills have an impact on counseling outcomes among domestic abuse victims?

**Participants**

The participants were recruited through two mediums. The first was a study recruitment letter containing a survey access link provided to entities that had responded favorably to pre-survey contact and agreed to the survey link to individuals that had completed counseling at their perspective facilities. The second was through social media in the form of a recruitment email provided to specific closed domestic violence forums’ administrators located on Facebook. All participants met the following criteria:

* Be a minimum of 18 years old
* Have experienced domestic/intimate partner violence
* Have completed counseling/therapy

**Data Collection Components**

**Demographic Survey**

 There were three data gathering components in this study. The first was demographic information which included: age, race, ethnicity, gender, marital status, income, education, and employment. Due to the online distribution of this survey, the demographic information regarding the study participants was necessary to determine if the sample is representative of the target population and to provide information that could provide insight into the profile of the participants.

**Counseling Feedback Form**

The second data gathering component was a Counseling Feedback Form (Mulhauser, 2011). The form has been modified to gather information from the participants regarding three components of the counseling experience:

1. Was counseling successful with their initial presenting concern?
2. Was the overall counseling experience successful?
3. Was lasting change achieved?

The three components are a definable counseling representation due to the specialty of the required counseling as well as the reparation of the damage caused by the experience of domestic or intimate partner violence. The remediation of the initial presenting concern and the overall experience may be observed as the ability to heal emotionally or not.

**Brief RCOPE**

 The final component of the study’s data gathering is a measure of religious/spiritual coping with major life stressors such as has been experienced by the study participants. To accomplish this, the Brief RCOPE will be utilized. It is a 14-item psychometric scale developed by Dr. Kenneth Pargament (2011) to include both positive and negative religious coping methods. Positive religious/spiritual coping methods reflect “a secure relationship with a

transcendent force, a sense of spiritual connectedness with others, and a benevolent world

view (Pargament, Feuille, & Burdzy, 2011)”.Negative religious/spiritual coping methods reflect “underlying spiritual tensions and struggles within oneself, with others, and with the divine (Pargament, Feuille, & Burdzy, 2011).”

**Ethical Considerations**

The highest priority was given to anonymity and confidentiality. The data collected from the survey, though it contained demographic information at no point were participants requested to divulge any information that could breach their identity. To further ensure confidentiality the participant’s computer IP addresses were deleted from the data import provided by SurveyMonkey.

**RESULTS**

**The Data**

The survey reported accessed 61 access attempts. 36 responses were registered to the original access link forwarded to the counseling and women’s centers and 25 responses were registered to the social media link. Five of the access attempts were closed without recording any responses. 56 respondents accessed the qualifying questions section. Respondents 10, 11, and 31 answered “no” to one of the qualifying questions and immediately exited the survey. After further review, respondents 30, 53, and 56 were found to have not answered the 14 Brief R-cope questions. Because responses to the Brief R-cope portion are valued, Respondents 10,11,30,31, 53, and 56 were removed from the data pool leaving 50 response sets to be analyzed or n-50.

**Descriptive Characteristics**

The survey was open from 12:01 am on April 1, 2020, and closed at 11:59 pm on May 15, 2020. The data collected was saved and exported in an Excel file to be reviewed, cleaned, and prepared for import into SPSS (IBM, 2017).

A total of fifty participant surveys were included in this study. The survey consisted of three sections with the first recording demographic information. The characteristics included in this section were: Age, Ethnicity, Marital Status, Education, and Combined Household Income. Participant’s age range of 18-24 was 12% (n=6); age 25-34 was 28% (n=14); age 35-44 was 34% (n=17), age 45-54 was 12% (n=6), age 55-64 was 14% (n=7), and age range of 65+ was 0%. Participant ethnicity was: African American, 28% (*n* = 14), Asian American, 6% (*n* = 3), Native American, 0% (*n* = 0), Latin American, 8% (*n* = 4), Caucasian, 52% (*n* = 26), and Other, 6% (*n* = 3). Participant marital status included: Never Married, 32%, (n=16), Currently Married, 32% (n=16), Divorced, 16%, (n=8), Separated, 16%, (n=8), Widowed, 2%, (n=1), Other, 2%, (n=1). Participant's education level included: less than high school, 6%, (n=3); High School Graduate/GED, 34%, (n=17); Technical School Graduate or Certificate Holder, 18%, (n=9); and, Bachler’s degree or higher, 42%, (n=21). The combined household incomes ranged from Under $15,000 at 16%, (n=8); $15,000-$29,999 at 22%, (n=11); $30,000-$49,999 at 30%, (n=15); $50,000-$74,999 at 16%, (n=8); $75,000-$99,999 at 10%, (n=5); and greater than $100,000 at 6%, (n=3). See Table 1 below for a depiction of the participant’s demographic characteristics.

**The Counseling Experience**

The second data gathering component of the survey were three specific questions taken from the Counseling Feedback Form (Mulhauser, 2011). The form has been modified to gather information from the participants regarding three components of their counseling experience:

1. Was the overall counseling experience successful?
2. Was counseling successful with their initial presenting concern?
3. Was lasting change achieved?

**The Dependent Variables**

Respondents were given the options:

**Overall Satisfaction**

Twenty-two respondents indicated feeling “Extremely satisfied” with counseling experience which carries a value of 1

Twenty Respondents indicated feeling “Satisfied” with their overall counseling experience which carries a value of 2

Two respondents indicated feeling “Extremely Dissatisfied” with their overall counseling experience which carries a value of 5.

**Presenting Concerns**

Twenty Respondents indicated “Complete positive change” which carried a value of 1.

Twenty-four Respondents indicated “Some positive change” which carries a value of 2

Two Respondents indicated counseling was a “Waste of time” which carries a value of 4

Four Respondents indicated feeling “Worse than before counseling” which carries a value of 5

**Lasting Change**

Twenty-two respondents indicated they “strongly agree” that lasting change was achieved which carries a value of 1

Twenty-six respondents indicated they “agree” that lasting change was achieved which carries a value of 2

One respondent indicated they “neither agree nor disagree” that lasting change was achieved which carries a value of 3.

Two respondents indicated they “strongly disagree” that lasting change was achieved which carries a value of 5.

**Data Prepared for SPSS Import**

 The responses for the Dependent Variables were imported into SPSS and given the values which coincided with the intended values from the survey.

Overall counseling experience:

1. = “Extremely Satisfied”
2. = “Satisfied”
3. = “Neither Satisfied nor Dissatisfied”
4. = Not Satisfied”
5. = “Extremely Dissatisfied”

Counseling impact on presenting concerns:

1. = “Complete Positive Change”
2. = “Some Positive Change”
3. = “No Impact”
4. = “No Change”
5. = “Less than before counseling”

Lasting change had been achieved:

Counseling impact on presenting concerns:

1.0= “Strongly agree”

2.0= “Agree”

3.0= “Neither agree nor disagree”

4.0= “Disagree”

5.0= “Strongly Disagree”

The measure for the variables was then defined as ordinal.

**The Independent Variables**

**Responses to the Brief R-cope**

 The data retrieved from the survey in this section, while on the excel spreadsheet, was then combined through the use of a “Summation” formula. The formula combined the responses across each respondent's numeric response, to each of the fourteen key religious functions measured. The data was then utilized to determine whether each respondent experienced positive religious coping skills or negative religious coping skills. To accomplish this the Respondent’s overall scores were transformed into a percentage. The overall achievable score on the combined 14 key functions was 70. To transform the score to a percentage, the overall score was divided by 70. The resulting percentage was utilized to determine Positive versus Negative by utilizing an “IF” formula. The formula, input as “=IF (C4<=51%, "Pos", IF(C4>51%, "Neg"))”, utilized as: “IF” the resulting respondent’s percentage is less than or equal to 51% they are deemed “Positive”. “IF” the resulting respondent’s percentage is greater than 51% they are deemed “Negative”. The data is then imported into SPSS (IBM, 2017). Once in SPSS (IBM, 2017) the values are given as 1.0 = “Positive”, 2.0 = “Negative” and the variables defined as ordinal.

 To determine the proper test to run in SPSS I reviewed methods with the focus on assessing the data for statistically significant differences on a continuous dependent variable by independent variables.  An ANOVA assumes the dependent variable is normally distributed and there is equal, or close to equal, variance on the scores across the group (Laerd Statistics, 2018). While performing the regression analysis it was determined the assumptions were not met thus indicating the means may be extreme and not representative of the center of the distribution. The following assumptions were utilized in determining whether a nonparametric test should be utilized:

1. Is the sample size large enough to represent the target population? The sample size is relatively small thus the answer to that assumption is no. The first indicator of a nonparametric test should be utilized.
2. Does the median better represent the center of distribution? Due to the use of a survey with an extreme question response range (fully positive to fully negative), the median better represents the distribution. The use of such extreme ranges also indicates these possible outliers cannot be removed.

In conjunction with the above-mentioned nonparametric assumptions, the nature of the nonnormal data, a mixed grouping of nominal and ordinal, indicates a nonparametric test should be utilized.

The Kruskal-Wallis test can be utilized for both continuous and ordinal dependent variables. The Kruskal-Wallis does not require the strict adherence of parametric assumptions utilized in the ANOVA (Laerd Statistics, 2018). It is accepted the Kruskal-Wallis may not be as powerful as the ANOVA however it can be utilized to determine statistically significant differences between two or more independent variables (Laerd Statistics, 2018). The utilization of the Post-Hoc feature in SPSS (IBM, 2017) also becomes positive for the use of this method.

**Hypothesis 1**

H0: Spirituality/Religion as coping skills have no statistically significant impact on the overall counseling experience being positive of victims of domestic and intimate partner violence.

H1: Spirituality/Religion as coping skills have a statistically significant impact on the overall counseling experience being positive of victims of domestic and intimate partner violence.

 A Kruskal-Wallis H test was performed to explore the overall counseling experience of domestic or intimate partner violence survivors and religious coping skills. There is a statistically significant difference in the overall counseling experience of domestic or intimate partner violence survivors and religious coping skills. The results of the Bonferroni post hoc test shows significance as the p-level of .004, which is less than the alpha level .05 and the distribution of Religious Coping is the same across categories of My overall satisfaction with my counseling experience was positive. Thus, the null hypothesis is rejected.

Table 2

*Hypothesis 1 Test Summary*

|  |  |  |  |
| --- | --- | --- | --- |
| Null Hypothesis | Test | Sig. | Decision |
| The distribution of Religious Coping is the same across categories of My overall satisfaction with my counseling experience was positive. | Independent Samples Kruskal-Wallis Test | .004 | Reject the null hypothesis. |
|  |  |  |  |

*Criteria: ALPHA=0.05 CONFIDENCE INTERVAL=95.*

**Hypothesis 2**

H0: Spirituality/Religion as coping skills have no statistically significant impact on the successful resolution of the initial presenting concern when counseling victims of domestic and intimate partner violence.

H1: Spirituality/Religion as coping skills have a statistically significant impact on the successful resolution of the initial presenting concern when counseling victims of domestic and intimate partner violence.

A Kruskal-Wallis H test was performed to explore the possible relationship between the religious coping skills of domestic or intimate partner violence survivors and the resolution of the survivors’ reason for seeking counseling. There is a statistically significant difference in the resolution of the reason domestic or intimate partner violence survivors seek counseling and their religious coping skills. The results of the Bonferroni post hoc test shows significance as the p-level of .040, which is less than the alpha level .05 and the distribution of Religious Coping is the same across categories of My counseling experience successfully addressed my reason for seeking counseling. Thus, the null hypothesis is rejected.

Table 3

*Hypothesis 2 Test Summary*

|  |  |  |  |
| --- | --- | --- | --- |
| Null Hypothesis | Test | Sig. | Decision |
| The distribution of Religious Coping is the same across categories of My counseling experience successfully addressed my reason for seeking counseling. | Independent Samples Kruskal-Wallis Test | .040 | Reject the null hypothesis. |
|  |  |  |  |

*Criteria: ALPHA=0.05 CONFIDENCE INTERVAL=95.*

**Hypothesis 3**

H0: Spirituality/Religion as coping skills have no statistically significant impact on the achievement of lasting change in counseling outcomes for victims of domestic and intimate partner violence.

H1: Spirituality/Religion as coping skills have no statistically significant impact on the achievement of lasting change in counseling outcomes for victims of domestic and intimate partner violence.

A Kruskal-Wallis H test was performed to explore the possible relationship between the religious coping skills of domestic or intimate partner violence survivors and the achievement of lasting change through attending and completing counseling. There is no statistically significant difference in the achievement of lasting change experienced by domestic or intimate partner violence survivors through counseling and their religious coping skills. The results of the Bonferroni post hoc test shows significance as the p-level of .572, which is well above the alpha level .05 and the distribution of Religious Coping is the same across categories of the achievement of lasting change achieved through counseling. Thus, the null hypothesis is retained.

Table 4

*Hypothesis 3 Test Summary*

|  |  |  |  |
| --- | --- | --- | --- |
| Null Hypothesis | Test | Sig. | Decision |
| The distribution of Religious Coping is the same across categories of lasting change occurred. | Independent Samples Kruskal-Wallis Test | .572 | Retain the null hypothesis. |
|  |  |  |  |

*Criteria: ALPHA=0.05 CONFIDENCE INTERVAL=95.*

**Discussion**

This study investigated the relationship between religious/spiritual coping skills in the counseling experience of those seeking to resolve emotional scars. Based on the analysis of the current study, an SAV victim’s religious and spiritual faith has demonstrated to have a positive impact on their coping abilities and their ability to experience pronounced resilience. Previous studies reveal both an external and an internal component of religious/spiritual coping mechanisms. The first, social engagement, which occurs as one interacts with those who exhibit certain positive characteristics can provide the positive reinforcement and support that can enhance mental health, therefore involvement in religious activities and religion-based group interactions could similarly have a positive impact on the participants overall counseling experience. Thus, these interactions may result in “greater life satisfaction, happiness, positive affect, and higher morale” (Koenig et al., 2001). The second component, internal, is more personal. It is based on the individual’s faith in the divine, the sacred, or a higher power that can govern their emotions. This spirituality involves deep reflection into one’s experiences with an open mind to understanding and acceptance of the experience’s occurrence (Hill & Pargament, 2008). Either or both components may have contributed to the positive correlation with the SAV’s sense of success in the achievement of their counseling desires and outcomes.

**Hypothesis Testing**

Hypothesis 1 evaluated the relationship or lack thereof between the overall counseling experience and the existence of religious coping skills within the counseling process. The relationship was investigated by utilizing a Kruskal-Wallis H test. The variables were religious coping skills and the positive outcome of counseling. Analysis was performed to identify a statistically significant impact of religious coping skills on the overall counseling experience being positive. The data indicated a statistically significant impact. Based on the aforementioned results, the null hypothesis is rejected.

Hypothesis 2 evaluated the relationship or lack thereof between the resolution of the initial presenting concern (the reason counseling was sought) and the existence of religious coping skills within the counseling process. The relationship was investigated by utilizing a Kruskal-Wallis H test. The variables were religious coping skills and the resolution of the presenting concern. Analysis was performed to identify a statistically significant impact of religious coping skills on the resolution of the initial presenting concern. The data indicated a statistically significant impact. Based on the aforementioned results the null hypothesis is rejected.

Hypothesis 3 evaluated the relationship or lack thereof between the achievement of lasting change through the counseling process and the existence of religious coping skills within the counseling process. The relationship was investigated by utilizing a Kruskal-Wallis H test. The variables were religious coping skills and the resolution of the presenting concern. Analysis was performed to identify a statistically significant impact of religious coping skills on the resolution of the initial presenting concern. The data indicated no statistically significant impact. Based on the aforementioned results the null hypothesis is retained.

The hypothesis testing was performed to evaluate a possible relationship between the counseling experience and success of survivors of violence at the hand of an intimate partner who has attended counseling due to the violence experienced and the existence of their religious coping skills. Traumatic events often leave more than physical scares thus counseling is sought to assist the mental and emotional healing process.

 Though statistical significance exists supporting the positive impact religious/spiritual coping skills may have on counseling outcomes, the utilization of these skills appears to diminish over time as the individual moves to normalization, and the distance away from the counseling experience increases. This phenomenon is observed through the specific questions utilized from the Counseling Feedback Questionnaire (Mulhauser, 2011). There is an indicated space of time as interpreted from the milestones from which the participants were asked to draw from their experiences.

 Beginning with the shortest and possibly the most memorable counseling milestone, hypothesis one, or overall positive counseling experience, the statistical significance was a p-level of .004 using an ALPHA of .05. The p-level of the second hypothesis test, successful resolution of presenting concern, based upon an inferred period or test period that has passed to ensure the emotional triggers once experienced frequently are now occurring much less, was .040 using an ALPHA of .05. The results of hypothesis test 3, lasting change occurred, infers a longer time distance milestone has occurred, was a p-value of .572.

 The construct of the diminishing utilization of religious/spiritual coping skills may be supported by a previous study which indicates that the inclusion of increased utilization of religion to improve the “resolution of emotional disorder” (p. 67-78) and to further enhance the overall quality of life, three concepts must be recognized: first, religious/spiritual beliefs provide a sense of direction and motivation for a client, which leads to optimistic feelings; second, religion promotes the need to care for our fellow man, which may lead to improved general wellness by distracting from an individual’s problems and dedicating positive energy towards the betterment of others; and, lastly, religious beliefs may open the door for increased social support through congregational affiliation (Koenig et al., 2001).

 This construct may also be supported by the responses received regarding participant demographics. The participants of this study provided personal information about age, ethnicity, marital status, education, and household income. The highest percentage of participants reporting an overall positive counseling experience was in the age grouping of 45 – 54 years old which could indicate a longer period occurring since their counseling experience. The passage of time may have allowed ample time for reflection and to accept their SAV experience. An indicator of achieved life stability or as previous studies indicate a move from focusing on their problems to experiencing a desire to help their fellow man (Koenig et al., 2001) may be observed in the marital status and education level demographic responses. Those responses indicated a larger percentage had achieved life satisfaction as either not married or currently married and had completed a college-level education and received a minimum of a bachelor’s degree.

**Research Limitations**

Beginning in early 2020, the world has been gripped by the devasting effect of the COVID-19 Pandemic. When assessing the limitations of the current study, the Federal, State, and local governmentally mandated closures, restrictions, and social distancing requirements, are of the largest and unavoidable significance.

Stemming from the COVID-19 pandemic, a trickle-down effect of limitations occurred including a notable decrease in the number of anticipated study participants. The limited number of available and accessible study participants was self-limiting and prompts a future recommendation of a larger-scale study. Further impacted by the COVID-19 was the physical access to study participants. Many of the study participants that were expected to participate, pre-COVID-19, no longer were accessible due to the mandated online nature of the pandemic, and their firm’s inability or unwillingness to convert to an online platform. Thus, the study had to resort to data collection through more than the preferred professional referral sources; social media was utilized to locate qualified study participants.

This study was limited in the time allotted, as it was not continuous, updated, nor monitored. Future recommendations for a more in-depth, non-time restricted study, will be made. Additionally, this study was strictly limited to the client’s perception of the therapy, future studies may focus on the practitioner’s perception.

**Contribution**

Results of this study indicate the utilization of religious coping skills during the counseling process enhanced that process thus the participants of this study (n=50) experienced a positive impact on the overall counseling process as well as the complete resolution of the presenting concern and helping the individual understand what has occurred and how to move forward. The data analysis and interpretation also revealed a possible indicator/predictor that the utilization of religious/spiritual coping skills through the counseling experience can be a foundation of future religious/spiritual beliefs leading to greater life satisfaction.

**Suggestions for Future Research**

In consideration of the existing current and past literature, research, and the present study, there is a viable gap in scholarly research that may indicate a need for further research including studies that: utilize of an increased number of professional referrals, as opposed to a combination of professional referrals and online social media recruitment; a larger scale study, as opposed to the considerably less than one-hindered participants in the current study; a more in-depth, non-time restricted study, as opposed to the currently imposed constraints; a focus on the practitioner’s perception; as opposed to the clients perception; the conducting of a study during non-crisis, non-pandemic times; a study that focuses on the impact of religion on SAV counseling, independent of spirituality; a study that focuses on the impact of spirituality on SAV counseling, independent of religion; and, a study that studies varying religions and the impact that a variety of religions have on SAV counseling.

This research has indicated further study should be completed as there may be significant data indicating the practitioner’s encouragement of clients to utilize the coping method that best suits their personal beliefs. Furthermore, psychologists and practitioners who may find the use of religion and spirituality to be awkward, based on their lack of familiarity with the multitude of religious and spiritual beliefs that clients may subscribe to, educating themselves on the mainstream beliefs, may be of great benefit to the psychological well-being of their SAV clients.

The consideration of the religious coping skills transitioning to a deeper level of personal religious beliefs resulting in more religious social engagement and a higher concern for their fellow man is another research possibility. The understanding of such a transition and how it could occur as well as at what point in the transition can clinicians predict fewer experiences of emotional triggers.

The results offer further questions:

1. How do religious coping skills work to positively impact the overall counseling

experience?

1. How do religious coping skills work to help an individual overcome the reason they seek out counseling?
2. Is the answer to achieving lasting change through counseling enhanced by just completing the counseling process?
3. How can practitioners implement religious coping skills to increase the occurrences of positive overall counseling experiences?
4. How can practitioners implement religious coping skills to increase the occurrences of the resolution of the initial presenting concerns of clients?
5. What can religious coping skills tell us about the specific or specialized support a client may need that when supplied can enhance their ability to succeed in the counseling process and beyond.

**Conclusion**

 There is much to learn about the value of religious/spiritual coping skills in the counseling process of SAVs. Beginning with the inference form the statistical significance of the possible impact from the existence of religious/spiritual coping skills within the counseling process supporting an overall positive outcome. This phenomenon requires further research to understand the benefits of and how treatment interventions can utilize these coping skills at multiple levels. The implication that the use of these skills by SAV survivors appears to diminish over time is important as the results from this study may support Koenig’s (2001) conclusion that three concepts must be recognized: first, religious/spiritual beliefs provide a sense of direction and motivation for a client, which leads to optimistic feelings; second, religion promotes the need to care for our fellow man, which may lead to improved general wellness by distracting from an individual’s problems and dedicating positive energy towards the betterment of others; and, lastly, religious beliefs may open the door for increased social support through congregational affiliation to enhance one’s overall quality of life. The sample represented a small diverse group of spousal abuse victims whose responses proved a valuable contribution to research.

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