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# Intimate Partner Violence, Perception of Safety, and Faith Among Female College Students Attending Faith-Based Institutions

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Intimate Partner Violence, Perception of Safety, and Faith Among Female College  
Students Attending Faith-Based Institutions

by

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Presented to the Faculty of the  
Graduate Department of Clinical Psychology

George Fox University

in partial fulfillment

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in Clinical Psychology

Newberg, Oregon

June 7, 2017

Intimate Partner Violence, Perception of Safety, and Faith Among Female College Students

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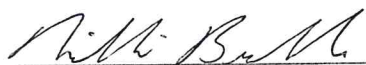
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**Abstract**

Many women experience intimate partner violence (IPV), and research shows this violence significantly impacts their mental health, physical health, and substance abuse. The experience of IPV may also impact other areas of life. This study aims to explore the relationship between the experiences of IPV, perception of safety, and perception of faith, among female college students attending Christian universities. Archival data from the National College Health Assessment (NCHA) was used to explore this relationship among female students who experienced physical, sexual, or psychological IPV in the past twelve months. Results indicate students who experienced IPV endorsed lower perceptions of safety than their counterparts who did not experience IPV. In addition, results failed to find that faith moderated the perception of safety among students who have experienced IPV.

*Keywords:* intimate partner violence, emotional abuse, physical abuse, sexual abuse, perception of safety, perception of faith

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## Chapter 1

### Introduction

Higher education institutions are typically viewed as safe environments, or ivory towers, and some research does indicate college campuses experience ten times less violent crime than the communities that surround them (Volkwein, Szelest, & Lizotte, 1995). However, college women are shown to be at greater risk for certain forms of criminal victimization, such as sexual victimization (Fisher, Cullen, & Turner, 2000). One particular form of sexual victimization common for women is risk for intrapersonal violence (Tsui & Santamaria, 2015).

Research has demonstrated that intimate partner violence (IPV) impacts the mental and physical health of the victims'. In addition, women who have experienced IPV have lower perceptions of safety than do their peers who did not experience IPV (Reid & Konrad, 2004) and may become more spiritually disengaged (Drumm, Popescu & Kersting, 2009). In this study, the relationship between all three factors; IPV, perception of spirituality, and perception of safety is examined. More specifically, this study seeks to explore if faith moderates the relationship between the perception of safety and the experience of IPV.

#### Effects and Impacts of IPV

The National Center for Injury Prevention and Control has defined Intimate Partner Violence (IPV) as physical, sexual, stalking, and psychological aggression (Intimate Partner Violence: Definitions, 2015). According to the National Intimate Partner and Sexual Violence Survey conducted in 2011, more than one in three women (35.6%) have experienced rape,



physical violence, and/or stalking in their lifetime in the United States (Black et al., 2011).

Rennison and Welchans (2000) reported rates of non-lethal intimate partner violence to be greatest among individuals aged 20-24, with the next highest being 16-19 age group, indicating college age individuals are at more risk than other age groups. Internationally, the prevalence of IPV among student bodies ranged from 17% to 45% while in an American sample of college students, IPV was noted to be as high as 43% among women (Straus, 2004).

### **Mental Health**

The effects of IPV are evident in various areas of the victim's life. Women who have experienced violence in an intimate relationship report higher levels of depression, anxiety, persistent or chronic physical manifestations of emotional problems (somatization) such as headaches or stomachaches, somatization-chronic/persistent physical symptoms with no identifiable origin (Singer, Anglin, Yu Song, & Lunghofer, 1995; Straight, Harper, & Arias, 2003), interpersonal sensitivity (low self-worth and/or feeling marginalized), and hostility (Amar & Gennaro, 2005, Christopher & Kisler, 2012; McGruder-Johnson, Davidson, Gleaves, Stock, & Finch, 2000; Messman-Moore, Long, & Siegfried, 2000). Christopher and Kisler (2012) surveyed 339 college women and found those who have experienced IPV are prone to feelings of inferiority and emotional vulnerability and may believe others dislike them or question their self-worth (Lloyd & Emery, 1999; Zweig, Crockett, Sayer, & Vicary, 1999).

Furthermore, women who have experienced high levels of IPV displayed increased depression (Amar & Gennaro, 2005; Carbone-Lopez, Kruttschnitt, & Macmillan, 2006; Golding, 1999), mental health disability (Carbone-Lopez et al., 2006), and greater frequencies of panic than women who experienced low or no IPV (Romito & Grassi, 2007). Specifically, women who

have experienced systematic abuse (extensive, multifaceted violence) are three times as likely to report serious depression and four times as likely to report a mental health disability (Carbone-Lopez et al., 2006). Glass et al. (2003), in their survey of adolescent females, found those who had been physically or sexually abused in a dating relationship were six to nine times more likely to have had suicidal ideation and/or actual attempts than were peers who reported no dating violence. Female victims of IPV also have a 64% mean prevalence of posttraumatic stress according to research conducted by Golding (1999). In support, Ehrensaft, Cohen, and Johnson (2006) concluded women in aggressive relationships had an increased likelihood of Post-Traumatic Stress Disorder at age of 26 when compared to peers not in aggressive relationships.

### **Physical Health**

Using data from the National Violence Against Women Survey, Carbone-López et al. (2006) concluded that females who have faced IPV were twice as likely to perceive their health as poor, have experienced an injury resulting in disability, and to have had a miscarriage. Straight and associates (2003) found the higher the level of partner psychological abuse, the more women experienced limitations on physical activities, cognitive impairment, and negative perceptions of health. Women who have experienced IPV reported more frequent headaches, respiratory/cardiovascular, and gastrointestinal concerns when compared with peers without IPV experiences (Porcerelli et al., 2003). And, adolescent females who experienced violence in a dating relationship were 4 to 6 times more likely to have ever been pregnant than their non-abused peers (Glass et al., 2003).

**Substance Abuse**

Experiences of IPV in women are associated with not only adverse mental and physical health outcomes, but also substance abuse issues (Glass et al., 2003). Female victims of IPV are twice as likely to report using alcohol daily when contrasted with peers who have not experienced IPV (Carbone-Lopez et al., 2006), and not surprisingly, the average prevalence of alcohol abuse among female victims of IPV was almost 20% in one study (Golding, 1999). Similarly, women experiencing systematic abuse were found to be more than twice as likely to report use of prescription pain pills, tranquilizers, sleeping pills, and/or sedatives, and three times as likely to use anti-depressants, when compared to females with no history of IPV (Carbone-Lopez et al., 2006; Straight et al., 2003). Aside from alcohol, women in aggressive relationship have an increased likelihood of marijuana dependence at age 26 when compared to age mates who have not been in aggressive relationships (Ehrensaft et al., 2006) and physical abuse and stalking victimization was related to increased use of drugs for women (Slashinski, Coker, & Davis, 2003).

**Spirituality and IPV**

Spirituality has been correlated with higher self-ratings in health, lower blood pressure, more positive outlook, and better quality of life (Ellison & Smith, 1991; Koenig, McCullough, & Larson, 2001). Anye, Gallien, Bian, and Moulton (2013) found a positive relationship between spiritual well-being and health related quality of life which included physical, mental and general health with college age students (Anye et al., 2013). Spirituality also serves as a protective factor by decreasing isolation, anxiety, lack of self-control, and substance abuse (Bryant-Davis & Wog,

2013; Stewart, 2001; Thoresen, 1999; Turner & Willis, 1979; Wang, Horne, Levitt, & Klesges, 2009;).

Despite the many benefits associated with higher spirituality, IPV among Christian women has been estimated by some researchers to be as high as 50% (Annis & Rice, 2002; Wang et al., 2009) which is over 60% higher than in other national findings of the general population (Tjaden & Thoennes, 2000). Koch and Ramirez (2010) found in their sample of 626 undergraduates, religious belief and practice had no impact on the likelihood of IPV. They also found Christian fundamentalism was positively related with approval of violence and use of violence in intimate partner relationships (Koch & Ramirez, 2010; Nason-Clark, 2000; Griffin & Maples, 1997). Nason-Clark (1995) refers to higher vulnerability for female victims of IPV in conservative religious communities perhaps in relation to themes of male domination over women and importance of marital reconciliation. Research suggests some of this increased vulnerability may be due to religious beliefs associated with women deciding to stay in an abusive relationship (Foss & Warnke, 2003; Griffin & Maples, 1997; Knickmeyer, Levitt, Horne, & Bayer, 2003; Nason-Clark, 2004; Wang, et al., 2009). However, some research indicates higher spirituality correlates with lower rates of IPV. For example, women who attend church services more regularly are less likely to be in violent/abusive relationships (Cunradi, Caetano, & Schafer, 2002; Ellison & Anderson, 2001; Wang, et al., 2009).

Research on faith as a coping technique for victims of IPV demonstrates positive ways in which religion and spirituality can support those who have suffered IPV. Through religious and spiritual coping, sufferers are able to derive support from a divine being, from other members of a religious congregation, and from making meaning of painful events, leading to increased

resilience, healing, and overall well-being (Van Dyke, Glenwick, Cecero & Kim, 2009).

However, negative religious coping, such as attributing violent incidents to the devil, seemed to increase psychological distress among Christian women who have experienced IPV (Ake & Horne, 2003; Pargament et al., 2001). In addition, IPV was correlated with spiritual disengagement, loss of faith community as a support group and mental health issues (Drumm et al., 2009).

### **Safety and IPV**

Factors such as gender, age, and history of prior victimization predict fear of crime and personal sense of safety (Fisher & Sloan, 2003; Reid & Konrad, 2004; Tulloch, 2000; Ziegler & Mitchell, 2003). Gender is clearly the strongest predictor for fear of victimization (Fisher & Sloan, 2003). Females are significantly more likely to fear crime than their male counterparts despite the fact that rates of victimization, except for rape, sexual assault, and stalking, are generally lower for women than men (Catalano, 2005; Tjaden & Thoennes, 2000). Despite women fearing a sexual assault from a stranger more than from an acquaintance, statistics indicate females are more likely to be sexually assaulted by an acquaintance (Tjaden & Thoennes, 2000).

Although not as consistent as gender, age is also a factor in safety perception with some studies showing younger people reporting greater levels of fear than other age groups (Tulloch, 2000; Ziegler & Mitchell, 2003). Similar to gender, prior history of victimization is an adequate predictor of perception of safety. Past history of sexual assault, as well as property crime, led to higher levels of fear for future victimization (Reid & Konrad, 2004). Furthermore, as the level of

severity of victimization experience increases, so does the level of fear of crime (Smith & Hill, 1991).

These three factors: gender, age, and past history of victimization pose a distinct risk to the sense of safety for female college students with a history of IPV. Although, research on victimization estimate there is a discrepancy between individuals' perceived likelihood of victimization and actual risk of victimization (Hughes, Marshall, & Sherrill, 2003), women report feeling they are at a higher risk for campus victimization than do men. Female college students were more fearful than male counterparts of physical violence, sexual assault, and stalking by strangers (Barberet, Fisher, & Taylor 2004) and daytime/nighttime did not mediate the fear (Fox, Nobles, & Piquero, 2009). Additional research found, fear of rape predicted women's fear of other types of crime, especially violent crime (Fisher & Sloan 2003; Lane, Gover, & Dahod, 2009). Victimization within the past 12 months was a more important predictor for fear than victimizations that occurred over a year ago (Fisher, Sloan, & Wilkins, 1995).

### **Faith as a Moderating Variable**

Faith has been shown to play a role in psychological well-being and potential increase in ability to adjust to stress, thus this study sought to explore faith's potential moderating effect on the perception of safety among female victims of IPV in the last 12 months. A moderating variable affects the relationship between two other variables, meaning the level of value placed on the moderating variable effects the degree of the impact of the predictor on the criterion variable (Baron & Kenny, 1986). Moderators are used to analyze different aspects of a formula and a moderator influences the strength of a relationship between the two other variables. We predicted that victims of all three forms of IPV (emotional, physical, sexual) would have

significantly lower perceptions of safety than those who had not experienced any form of IPV. In addition, we hypothesized that higher faith scores would moderate the negative impact of IPV on perception of safety, resulting in higher perceptions of safety among those having higher perceptions of faith.

## Chapter 2

### Methods

#### Instruments

**National College Health Assessment-II (NCHA-II).** The National College Health Assessment (NCHA) was developed by the American College Health Association (ACHA) and has been administered to thousands of students at colleges and universities across the United States and Canada for the last 16 years (<http://www.acha-ncha.org>, March 16, 2011). The assessment was first implemented in the spring of 2000 and has since been used by over 500 unique institutions. The most recent edition, the NCHA-II, is administered both electronically and in paper format and has been in use since 2008. The assessment surveys students on a wide range of health behaviors and perceptions, including: substance use, sexual practices, nutrition, exercise, violence, personal safety, and physical and mental health. The survey takes about 30 minutes to complete.

The purpose of the NCHA-II is to “adequately identify factors affecting academic performance, respond to questions and concerns about the health of the nation’s students, develop a means to address these concerns, and ultimately improve the health and welfare of those students” (<http://www.acha-ncha.org>, March 16, 2011). It should be noted that the NCHA is administered to self-selecting higher education institutions, and as such, the information is considered informational rather than generalizable. However, the participating institutions do correspond to a wide range of classifications (e.g., Carnegie classifications, public and private, 2-



year and 4-year, local and national, etc.) and affiliations (e.g., ACHA, religious affiliations, minority serving status). Of particular interest to this study are institutions that endorse a religious affiliation.

### **Procedure**

The ACHA was contacted and agreed to forward a letter of interest to the institutions that identified as “Protestant” or “Other Christian” and participated in the NCHA-II during the aforementioned time constraints. A similar letter of interest was distributed through an e-mail listserv of institutions that are members of the Council of Christian Colleges and Universities. The eligible institutions that displayed interest and willingness to participate were sent another letter containing the specifics of the study, a confidentiality agreement, and a request for their data to be released.

Two NCHA II questions relevant to this study were used. First, to determine whether a history of IPV was present, responses to question six were evaluated which asked students whether they’ve been in an intimate (coupled/partnered) relationship which was: emotionally abusive, physically abusive, and/or sexual abusive in the past twelve months. Students endorsed a “yes” or “no” to each type of IPV.

To assess the student’s perception of safety, responses to question seven were explored. This question asked students how safe they feel in a variety of settings including on their campus at daytime, on their campus at nighttime, in the community surrounding the school during daytime, and in the community surrounding the school during nighttime. The students were asked to rate their feelings of safety for each of the settings as very safe, somewhat safe, somewhat unsafe, and not safe at all. The responses for the safety question were compiled to

create a total safety score (1-16 with 1 reflecting low safety perception and 16 reflecting high safety perception).

Due to the fact no questions on this NCHA II assessed religion or spirituality, the four universities included in this study added an item or items, to assess this domain. Each university used a different item, or items and therefore Burrell (2016) developed a Protestant Christian Faith Variable based the items used by these universities. The construction and outline of the item is available in Appendix A.

### **Participants**

Students attending four Protestant faith-based universities completed the NCHA II between fall of 2009 and spring of 2012. A Protestant faith-based university is defined as one that publically endorses a Protestant religious affiliation, had a published statement regarding the institutions expected lifestyle behavior for students, endorsed religion as an active part of campus life and offered or required participation in activities that promoted spiritual development. These activities included regular religious meetings and required religious courses. In keeping with ACHA reference group standards, these institutions either surveyed all students or used a random sampling technique.

### Chapter 3

#### Results

Three data sets were created, one for each type of IPV. For each type of IPV, a corresponding random sample of equal number of students that endorsed no IPV over the past 12 months was selected for comparison. Descriptive statistics are presented in Tables 1, 2, 3 and 4

Table 1

*Descriptive Statistics – Population Ages*

Age	Emotional IPV		Physical IPV		Sexual IPV	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
18	61	(19.8%)	11	(15.4%)	12	(17.6 %)
19	57	(18.5%)	14	(20%)	13	(19.6%)
20	50	(16.3%)	10	(14.3%)	9	(13.2%)
21	45	(14.7%)	14	(20%)	13	(19.1%)
22	25	(8.1%)	4	(5.7%)	6	(8.8%)
23	16	(5.2%)	4	(5.7%)	5	(7.4%)
24	10	(3.3%)	2	(2.9%)	1	(1.5%)
25	9	(2.9%)	--	--	2	(2.9%)
26-66	33	(10.4%)	11	(15.7%)	6	(9%)
<i>Total n</i>	307		70		67	

Table 2

*Descriptive Statistics – Demographics*

Ethnicity	Emotional IPV		Physical IPV		Sexual IPV	
White, non-Hispanic	237	(76.9%)	52	(73.2%)	52	(76.5%)
Black, non-Hispanic	18	(5.8%)	5	(7%)	5	(7.4 %)
Hispanic or Latino/a	26	(8.4%)	9	(12.7%)	9	(13.2%)
Asian or Pacific Islander	21	(6.8%)	4	(5.6%)	3	(4.4%)
American Indian, Alaskan Native, or Native Hawaiian	7	(2.3%)	4	(5.6%)	3	(4.4%)
Biracial or Multiracial	17	(5.5%)	2	(2.8%)	2	(2.9%)
Other	8	(2.6%)	2	(2.8%)	2	(2.9%)

Table 3

*Descriptive Statistics – Year in School*

Year in School	Emotional IPV		Physical IPV		Sexual IPV	
1st year undergraduate	80	(26.1%)	12	(17.1%)	14	(18.9%)
2nd year undergraduates	59	(19.2%)	17	(24.3%)	12	(17.6%)
3rd year undergraduates	82	(26.7%)	20	(28.6%)	18	(26.5%)
4th year undergraduates	53	(17.3%)	15	(21.4%)	15	(22.1%)
5th year or more undergraduates	20	(6.5%)	3	(4.2%)	5	(7.4%)
Graduate/Professional students	8	(2.6%)	2	(2.8%)	2	(2.9%)
Non-Degree seeking students	1	(0.3%)	--	--	1	(1.5%)

Table 4

*Descriptive Statistics – Marital status*

Marital Status	Emotional IPV		Physical IPV		Sexual IPV	
Single	259	(84.4%)	55	(78.6%)	56	(82.4%)
Married/Partnered	33	(10.7%)	9	(12.9%)	8	(11.8%)
Separated	3	(1%)	1	(1.4%)	1	(1.5%)
Divorced	9	(2.9%)	4	(5.7%)	1	(1.5%)
Other	1	(0.3%)	1	(1.4%)	1	(1.5%)

**Emotional IPV (A)**

First, a t-test was used to evaluate whether there was a significant difference between those who have experienced emotional IPV and those who had not with regards to their personal sense of safety. There was a statistically significant difference in the experience of safety between female students who have and have not experienced emotional IPV,  $t(301) = 3.03, p = .05$ . The experience of safety was greater when no emotional IPV was reported. Cohen's  $d$  was calculated to measure the effect of emotional IPV on person's experience of safety and results indicate a small effect size ( $d = .35$ ). These means and standard deviations are presented in Table 5.

Next, an ANCOVA was used to examine the moderating effects of faith on the perception of safety when emotional IPV is experienced. In this situation, faith was not found to significantly moderate the relationship of emotional IPV and experience of safety,  $F(1,300) = .190, p = .66$ .

**Physical IPV (B)**

A t-test was used to evaluate whether there was a significant difference between those who experienced physical IPV and those who had not, with regards to their sense of personal safety. There was a significant difference between perception of safety among those female students who have and have not experienced physical IPV,  $t(64) = 2.5, p = .015$ . The experience of safety is greater in those who have not experienced physical IPV when compared to females who have experienced physical IPV. Cohen's  $d$  calculated for effect of physical IPV on a student's experience of safety results indicate medium effect size ( $d = .62$ ). These means and standard deviations are presented in Table 5.

Then, an ANCOVA was used to examine the moderating effects of faith on experience of safety when physical IPV is experienced. In this situation, faith was not found to significantly moderate the relationship of physical IPV and experience of safety,  $F(1,63) = 1.61, p = .21$ .

**Sexual IPV (C)**

The data was analyzed to evaluate whether there was a significance difference between those who experienced sexual IPV and those who had not with regards to their sense of personal safety. The experience of safety is significantly greater in those who have not experienced sexual IPV when compared to students who have experienced this form of IPV,  $t(71) = 2.29, p = .01$ . Cohen's  $d$  calculated for effect of sexual IPV on persons experience of safety indicated medium effect size ( $d = .54$ ). These means and standard deviations are presented in Table 5.

Then, an ANCOVA was used to examine the moderating effects of faith on experience of safety when sexual IPV is experienced. In this situation, faith was not found to significantly moderate the relationship of sexual IPV and experience of safety,  $F(1,70) = .05, p = .81$ .

Table 5

*Sample Means of Perception of Safety and Standard Deviations*

Variables	Denied IPV		Endorsed IPV	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Emotional IPV	13.74	1.67	13.07	2.11
Physical IPV	13.91	1.79	12.55	2.56
Sexual IPV	13.49	1.85	12.11	3.13

## Chapter 4

### Discussion

This study reviewed the impact of IPV on female college student's perceptions of safety and the role of faith as a moderating factor. Because of faith's moderating role in emotional wellbeing and physical health (Anye et al., 2013), this study sought to identify if faith had a significant impact on the perception of safety among female college students who have experienced various forms of IPV in the past 12 months. In general, we predicted victims of all three forms of IPV (emotional, physical, and sexual) would have significantly lower perceptions of safety than those who have not experienced any form of IPV. We also predicted that the higher a student's faith, the less impacted their perception of safety would be, despite the IPV experienced.

The results found that the perception of safety was significantly lower for victims of emotional, physical and sexual IPV when compared to students who have not experienced these forms of IPV in the past 12 months. These results are consistent with prior research indicating a prior history of victimization is one of the factors which lead to an increase in fear (Fisher & Sloan, 2003; Reid & Konrad, 2004; Tulloch, 2000; Ziegler & Mitchell, 2003). This relationship is reasonable because our perceptions of the future are impacted by experiences from our past. Dichter and Gelles (2012) also noted this trend and noted feeling unsafe is associated with experiencing particular forms of IPV, including battering and sexual violence. This is possibly



due to the severity in nature of the IPV. Sexual and physical IPV are more explicit and violent in nature and hence pose a threat to physical safety, while emotional IPV does not always do so.

In addition, we hypothesized that the higher a student's faith, the less impacted their perception of safety will be, despite the IPV experienced. However, results suggest that a student's level of faith did not moderate the relationship between the experience of emotional, physical, or sexual IPV and the female's experiences of safety. This means students who experienced a form of IPV, and held a high degree of faith, had an impacted perception of safety, which was comparable to their lower faith peers.

There are several possible explanations for this finding. First, it is possible that the perception of faith and perception of safety are not directly related. It may be possible for an individual to have low perceptions of safety while maintaining a high level of faith. Although a stronger faith is associated with greater physical health and a better quality of life, perhaps it is not associated with one's perception of safety because a victim's perception of safety might demonstrate a more accurate assessment of life on campus than before. It is possible the perception of safety victims of IPV expressed in the survey was an accurate appraisal of their reality. There is research that indicates factors such as personality characteristics and personal actions are not associated with lowered perceptions of safety as much as past experience of IPV (Dichter & Gelles, 2012) and, it may be that while faith has little impact on one's perception of safety, its benefits lay elsewhere (emotional and physical wellbeing).

Secondly, it is possible there is a relationship between the perception of safety and perception of faith, but we failed to detect it with the measures used in this study. To begin with, the faith measure used in this study was limited in range. It is possible it was not sensitive or

precise enough to allow a moderating effect to be detected. Also, is conceivable, that by assessing the severity of IPV, we could have detected at which point intensity of faith begins to moderate the perception of safety.

In addition, research has found associations between faith, physical health, emotional health, and better quality of life (Ellison & Smith, 1991; Koenig, et. al, 2001). Spiritual health has also been found to serve as a protective factor against maladjustment by decreasing social isolation, anxiety, and lack of self-control (Stewart, 2001; Turner & Willis, 1979; Wang et al., 2009). Faith, in some respects, serves as a vital coping skill by increasing social support and social engagement, among other things. Because of the shielding aspects of faith, we predicted a high degree of faith would also serve as a protective factor to the experience of IPV through moderating the effects of the violence and leading to a less impacted perception of safety. In this present study, we did not find evidence for this, which suggests that despite faith serving as a protective factor, the benefits of a high faith may lie outside of the perception of safety. Despite the lack of support, we still wonder if there is some relationship between the experience of faith and the experience of adverse effects of surviving IPV.

### **Implications**

Based on the results of this study, there are several considerations for providers working with students who endorse a history of IPV. First, it necessary to consider the ways a lower perception of safety may influence a victim's response to interventions and intervening personnel. For example, a lower perception of safety may contribute to more hesitation to seek out services, engage in services, and may require more patience from providers. Similarly, because faith does not appear to moderate the perception of safety following the experience of

IPV, it is important for universities to offer support and interventions which focus on factors other than faith. Alternative interventions may concentrate on safety planning, behavioral interventions, and other forms of therapy to focus on rehabilitating a sense of general safety. However, even though reinforcing faith related behaviors such as attending church services and participating in communal activities may strengthen the victim's sense of support and be helpful in healing, this research did not find that these interventions would improve the sense of safety.

### **Limitations**

The findings of this study should be considered in light of its limitations. First, the measure used to evaluate the level of faith had little range. Our measure of faith ranged from one (low faith) to four (high faith). Greater range in faith perception could likely be obtained by having a more expansive measure of faith, for example 1 to 100, with 100 being highest perception of faith. This would allow for smaller differences in faith to be detected, which could possibly detect a moderating impact of faith on perception of safety.

The faith measure used in this study also failed to differentiate between religious practices/behaviors and sense of spirituality, which is limiting in the inferences we are able to make. Prior research indicates engaging in religious practices (attending church services, bible studies, etc.) decreases isolation and increases a sense of community (Wang, et al., 2009). Engaging in religious practices however, cannot be confused with spirituality, as spirituality is an internalized experience. In this study, we assessed neither religiosity nor spirituality, but used a combined measure which assessed both. Hence, it is difficult to make conclusions on the outcomes of the study due to an unclear measure. It is possible the students used in this study were high in spirituality but low in religiosity, resulting in an individualized faith. The limitation

in the measure used to evaluate perception of faith in this study then did not provide differentiation between religiosity and spirituality which hinders the generalizability of the results. This is limiting because it is possible one of these (religiosity or spirituality) moderated the perception of both but not the two combined.

Similarly, the questions used to assess IPV did not differentiate frequency, intensity, and duration of the IPV experienced. Students were asked if in the past 12 months, they had been in an intimate relationship that was emotionally, physically, or sexually abusive. The frequency, duration, and intensity of the IPV were not identified. Hence, there is no distinction between an individual who endorsed a form of IPV and experienced it once over the past 12 months and a similar individual who experienced the IPV daily over the past 12 months. In the present study, students were divided into two groups, those who endorsed and those who denied a history of IPV. If students were divided into several groups, based on the severity of IPV experienced (i.e. severe, moderate, low severity), we could have been able to compare the means of perception of safety between these numerous groups. It is possible by having more sensitive and comprehensive questions examining IPV, we would have been able to detect greater variability in the perception of safety depending on the differences in severity of IPV type.

### **Areas for Further Study**

As a result of our findings, several questions remain. The results of the present study indicate students who have experienced IPV in the past 12 months have lower perceptions of safety when compared to their counterparts who did not experience IPV. Further research may evaluate safety perceptions prior to experience of IPV and following the experience of IPV. This is important because it is likely a person's sense of safety is altered after the experience of

emotional, physical, and/or sexual assault. This could be done by assessing college freshmen and following up with the same population at the end of their studies and evaluating whether they have experienced IPV and their altered perception of safety.

### **Summary**

In conclusion, the aim of this study was twofold: to examine whether perception of safety was different among college females who have experienced IPV and those who have not, and to assess whether perception of faith was a moderator of perception of safety among victims of IPV. As expected, the perception of safety was significantly lower among victims of IPV when compared to their counterparts who did not experience IPV. However, results failed to prove faith was a moderator of perception of safety among victims of IPV. As a result, interventions other than faith related interventions may be most appropriate when working with victims of IPV.

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## Appendix A

### Faith Variable Development

A faith variable was built by combining data received from four faith-based institutions asking a perceived importance of faith question in their ACHA survey.

The first institution ( $n = 574$ ) used a single item, question 75 “Check the box that most nearly expresses your level of Christian commitment.” This question was rated on a 4-point scale (1 = My relationship with Christ is a very important part of my life to 4 = My relationship with Christ is not a part of my life).

The second institution ( $n = 322$ ) built a faith variable from four items, including questions 76 “I feel like I belong to God,” 79 “I feel like God appreciates me as His servant,” 85 “I feel like I have worth in the eyes of God,” and 94 “I do not feel close to God.” Each item was rated on a 5-point Likert continuum from 1 = Strongly Disagree to 5 = Strongly Agree. Questions 76, 79, and 85 were reversed (5 = strongly agree). The 5-point scale used at this institution was converted to a 4-point scale by multiplying the mean item score by 0.8.

The third institution ( $n = 1,182$ ) built a faith variable from questions 67 “My relationship with Jesus Christ impacts my decisions related to what I do with my time, money, body, and relationships,” and 69 “I believe that making a commitment to Jesus Christ is one of the most important things a person can do with his or her life.” Question 67 had a reversed response (5 = always) as compared question 69 (5 = strongly disagree), therefore question 67 was reverse scored. They used a 5-point scale so convert these to a 4-point scale by multiplying the mean item score by 0.8.

The fourth institution ( $n = 520$ ) built a faith variable from questions 67 “How often do you attend religious services?”; 68 “How important or unimportant is religious faith in shaping how you live your daily life?”; and 69 “How often do you pray by yourself alone?” and all three were reverse scored. Questions 67 and 69 were combined and the average was multiplied by .5714 because they were on a 7-point scale. Question 68 was multiplied by 0.8 because it was on a 5-point scale. All three were combined and averaged to create a total faith scale for the fourth institution. A final faith scale was developed by combining all 4-point scales from the four faith-based institutions. Scores were reversed so that high scores represented high faith (Burrell 2016).

## Appendix B

### Curriculum Vitae

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#### EDUCATION

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PsyD Aug. 2013-[May 2018]	Degree Pursuing: Doctorate of Clinical Psychology George Fox University, Newberg, OR APA Accredited Grade Point Average: 3.8 on 4.0 scale
MA Aug. 2013- May 2015	Degree Awarded: Masters of Arts in Clinical Psychology George Fox University, Newberg, OR APA Accredited Grade Point Average: 3.8 on 4.0 scale
MA Certificate Aug. 2012-July 2013	Degree Pursued: Masters of Arts in Counseling with Addictions Boise State University, Boise, ID APA Accredited Grade Point Average: 4.0 on 4.0 scale
BS Psychology Sep. 2007-June 2012	Degree Awarded: Bachelors of Science in Applied Developmental Eastern Washington University, Cheney, WA Grade Point Average: 3.5 on 4.0 scale

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#### RELEVANT EXPERIENCE

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May 2015- Present	Supplemental Practicum - Cedar Hills Psychiatric Hospital, Portland, OR Masters Level Inpatient/Outpatient Assessment Counselor and Inpatient Therapist Perform assessment/clinical evaluation to determine level of symptom acuity, suicidality/homicide risk, and diagnostic criteria
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as part of admission process for inpatient and outpatient care under bi-weekly individual supervision.

- Population: Adults suffering from chemical dependency and/or severe persistent mental illness.
- As inpatient therapist, lead group therapy sessions each week, including Chemical Dependency, Psycho-educational, Pain Management groups, and provided individual psychotherapy from a Relational, Cognitive Behavioral, and Solution Focused framework.
- As assessment counselor, conduct intake interviews and suicide/homicide risk assessments/mental status exams to determine diagnostic criteria as part of admission for inpatient/outpatient programs. Coordinated care with patient's providers and local hospitals.
- Supervision: Jory Smith, Psy.D.

January 2017-May 2017

Pre-Internship Practicum – Willamette Family Medical Center, Salem, OR

Masters Level Behavioral Health Consultant, Therapist, and Assessment Clinician

- Population: predominately low SES, ages 10-65
- Within a behavioral health consultant role, provided Solution-Focused and Cognitive Behavioral interventions for psychological concerns such as depression, anxiety, grief, eating disorders, substance abuse, and medical concerns such as diabetes, multiple sclerosis, obesity, heart failure in a primary care medical setting.
- Within therapist role, provided Rogerian psychotherapy to children and teenagers struggling with depression, anxiety, and adjustment.
- Within assessment role, provided comprehensive assessment batteries for referrals of Learning Disability and ADHD to children.
- Supervision: Ross Bartlett, PsyD., Joshua English, LCSW

August 2016-Dec. 2016

Pre-Internship Practicum - Oregon State Hospital, Salem, OR  
Masters Level Clinician

- Population: forensic, ages 18-65
- Provided assessments to evaluate malingering, effort, motivation, intellectual functioning, and academic achievement, as necessary to identify barriers to competency restoration.
- Co-lead educational groups focusing on hypothetical reasoning, legal skills, and competency restoration.

- Supervision: Danielle Stafford, Psy.D., Jacob Helton, Ph.D.
- Aug. 2013- May 2017      Clinical Team- George Fox University Graduate Department of Clinical Psychology
- Participate in formal weekly group review of clinical casework with evaluated quarterly clinical presentations.
  - Supervision: Elizabeth Hamilton, Psy.D., Supervision: Erica Tan, Psy.D., Marie-Christine Goodworth, Psy.D.
- July 2015- July 2016      Practicum II - Santiam Memorial Hospital, Stayton, OR  
Masters Level Behaviorist, Therapist, and Assessment Clinician
- Population: Rural, primarily low SES patients ages 5-95
  - Provided Solution-Focused, Cognitive Behavioral, and Family System interventions for psychological concerns such as depression, anxiety, grief, eating disorders, substance abuse, and medical concerns such as diabetes, multiple sclerosis, obesity, heart failure in a primary care medical setting within a co-visit model.
  - Provided comprehensive assessment batteries for referrals of Learning Disability, ADHD, Anxiety, Depression, and Diagnostic Clarification.
  - Supervision: Jeni Felker, Psy.D., Tani Swisher, M.A.
- Sep. 2014- June 2015      Practicum I - North Clackamas School District, Milwaukie, OR  
Practicum Level Therapist and Assessment Clinician
- Population: Grade school age students
  - Provided counseling to high school students using Solution-Focused and Cognitive Behavioral Therapy for concerns such as depression, anxiety, interpersonal struggles, family discord, and academic struggles.
  - Provided comprehensive assessment batteries including for referrals of ADHD, Learning Disability, Intellectual Disability, and Anxiety disorders.
  - Supervision: Leslie Franklin, Psy.D., Fiorella Kassab, Ph.D.
- Feb. 2014- July 2016      Columbia Care Services, Portland, OR  
Qualified Mental Health Professional
- Population: Adults suffering severe/persistent mental illness in long term residential care.
  - Assisted clients in learning coping skills for symptom management and fostered acquisition life skills through individual interactions and group psycho-education.

- Engaged in therapeutic interventions, medication administration, and keeping accurate clinical documentations.
- Supervision: Sarah Tomlin, LCSW, M.A.
- Jan. 2014-June 2014      Pre-Practicum Student at George Fox University Graduate Department of Clinical Psychology, Newberg, OR
- Population: University Undergraduate Students
  - Weekly pseudo-therapy for two undergraduate students
  - Conducted intake interviews and treatment plans to inform Person Centered Therapy to clients struggling with anxiety, depression, and adjustment concerns
  - Supervision: Carlos Taloyo, Psy.D., Joel Simmons, M.A.
- Sept. 2012-Aug. 2013      About Balance Mental Health Counseling Clinic, Boise, ID  
Psychosocial Rehabilitation Specialist
- Population: Low SES patients on Medicaid/Medicare suffering from mental illness
  - Met with clients one-on-one in home and community settings to foster rehabilitation through teaching coping skills, social skills and communication skills among others.
  - Supervision: Marzena Zajda, M.A., Janet Guitierrez, M.S.
- Jan. 2012-Aug. 2012      New Horizon Care Centers Isabella House, Spokane, WA  
Support Staff
- Population: Low SES women dual diagnosed with substance abuse and severe/persistent mental illnesses
  - Met with treatment team of clinicians, dispensed daily routine medications, conducted intakes of new clients, adhered to treatment goals by teaching coping skills and sober living skills.
  - Unsupervised

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#### RELATED PROFESSIONAL EXPERIENCE

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- June 2016      Sklyarov, O., Rudneva, L. (2016)
- Family Adaptability and Cohesion Scale IV (FACES IV) translation from English to Russian
  - Accepted by publisher Life Innovations, Inc., in July 2016

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#### LANGUAGES SPOKEN

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English, Russian

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**RESEARCH INVOLVEMENT**


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- May 2017      Dissertation: Intimate Partner Violence, Perception of Safety, and Faith Among Female College Students Attending Faith-Based Institutions
- Dissertation Committee: William Buhrow, PsyD., Marie-Christine Goodworth, PsyD., Mark McMinn, PhD.
  - Preliminary defense- May 2016
- Feb. 2014-May 2017      Research Vertical Team Member, George Fox University
- Bi-weekly meetings focused on individual dissertation and as group research projects within a team model
  - Dissertation Chair: William Buhrow, Psy.D.
- May 2015      Exploring the influence of smartphone technology within the context of marriage: An intervention study  
Joshua Borrelli, Psy.D., Lauren Goins, M.A., Liliya Rudneva, M.A.  
Presented at: Oregon Psychological Association Conference in Eugene, OR
- Jun 2011- May 2012      Effects of a girl's relationship with her father in childhood on her choice of intimate partners in adult life.
- Mentor: Dorothy Munson, Ph.D.,
  - Presented at: Student Research and Creative Works Symposium at Eastern Washington University in Cheney, WA in May 2012
- Sep. 2010-June 2011      Research Assistant for Dorothy Munson Ph.D. at Eastern Washington University

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**TEACHING EXPERIENCE**


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- Spring 2016      Psychology of Human Diversity-Undergraduate Level Course  
Multnomah University, Portland, OR  
Supervisor: Elliott Lawless, Psy.D.
- Spring 2013      Intellectual Foundational Studies: Genius-Undergraduate Level Course  
Boise State University, Boise, ID  
Supervisor: J. Riley Caldwell-O'Keefe, Ph.D.
- Fall 2011      Risky Behavior-Undergraduate Level Course  
Eastern Washington University, Cheney, WA

Supervisor: Charalambos C. Cleanthous, Ph.D.

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PROFESSIONAL CONFERENCES AND TRAINING

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- March 2017                      Grand Rounds: Difficult Dialogue: Diversity
- Speakers: Kathleen Gathercoal, PhD, Winston Seegobin, PsyD
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- March 2017                      Clinical Colloquium: Domestic Violence: A Coordinated Community Response
- Speakers: Patricia Warford, PsyD and Sgt. Todd Baltzell
- February 2017                      Clinical Colloquium: Native Self Actualization: It's assessment and application in therapy, Newberg, OR
- Speaker: Sydney Brown, PsyD
- November 2016                      Grand Rounds: Children and Divorce, Newberg, OR
- Speaker: Wendy Bourg, Ph.D.
- October 2016                      Workshop: Dialectical Behavior Therapy Foundational Training, Salem, OR
- Speaker: Andrew Weitzman, Psy.D., Brian Chapman, M.A.
- October 2016                      Clinical Colloquium: Integration, Newberg, OR
- Speaker: Brooke Kuhnhausen, Psy.D.
- March 2016                      Grand Rounds: Working with Multicultural Clients with Acute Mental Illness, Newberg, OR
- Speaker: Sandra Jenkins, Ph.D.
- March 2016                      Conference: Christian Association for Psychological Studies: International Conference: The Healing Power of Relationship, Pasadena, CA
- Speakers: Stephen Simpson, Ph.D., Alexis Abernethy, Ph.D., Cynthia Eriksson, Ph.D., Ronald Welch, Psy.D., Brad Strawn, Ph.D., Terry Hargrave Ph.D., Marie Hoffman, Ph.D., Charlotte Rosenak, Ph.D..
- March 2016                      Workshop: Harnessing the Power of the Therapeutic Relationship Using Acceptance and Commitment Therapy and Functional Analytic Psychotherapy, Portland, OR
- Speaker: Joanne Steinwachs, LCSW

- February 2016 Clinical Colloquium: Neuropsychology: What Do We Know 15 Years After the Decade of the Brain? Newberg, OR
- Speakers: Trevor Hall, Psy.D., Darren Janzen, Psy.D.
- October 2015 Grand Rounds: Let's Talk about Sex: Sex and Sexuality With Clinical Applications, Newberg, OR
- Speaker: Joy Mauldin, Psy.D.
- September 2015 Clinical Colloquium: Relational Psychoanalysis and Christian Faith: A Heuristic Dialogue, Newberg, OR
- Speaker: Marie Hoffman, Ph.D.
- August 2015 Boot-camp: Workforce Development for Integrated Behavioral Healthcare, Newberg, OR
- Speakers: Mary Peterson, Ph.D., Jeri Turgesen, Psy.D., Juliette Cutts, Psy.D., Laura Fisk, Psy.D., Joy Mauldin, Psy.D., Julie Oyemaja, Psy.D.
- April 2015 Conference: Christian Association for Psychological Studies, Denver, CO
- Speaker: Bryce Hagedorn Ph.D., Sally Canning Ph.D., Steve Sweatman Ph.D., Jackie Halstead, Psy.D., Steve Stratton Ph.D., Jared Pingleton Ph.D., Scott Stanley, Ph.D.,
- March 2015 Workshop: Compassion Focused Therapy, Portland, OR
- Speaker: Russell Kolts Ph.D.
- March 2015 Workshop: Criminal Justice and Behavioral Health Issues, Portland, OR
- Speaker(s): Oregon Psychiatric Association
- March 2015 Clinical Colloquium: Spiritual Formation and Psychotherapy, Newberg, OR
- Speaker: Barret McRay, Psy.D.
- February 2015 Grand Rounds: Credentialing, Banking, the Internship Crisis, and other Challenges for Graduate Students in Psychology, Newberg, OR
- Speaker: Morgan Sammons, Ph.D.
- November 2014 Clinical Colloquium: "Face Time" in an Age of Technological Attachment, Newberg, OR
- Speaker: Doreen Dodgen-McGee, Psy.D.

- October 2014 Clinical Colloquium: Understanding and Treading ADHD and Learning Disabilities From a Neurological Perspective
- Speakers: Erika Doty, Psy.D., Tabitha Becker, Psy.D.
- July 2014 Workshop: Applied Suicide Intervention Skills Training through Center for Suicide Prevention, Portland, OR  
Speaker: Gary McConahay, Ph.D.
- March 2014 Clinical Colloquium: Evidence Based Treatments for PTSD in Veteran Populations: Clinical and Integrative Perspectives, Newberg, OR
- Speaker: David Beil-Adaskin, Psy.D.
- March 2014 Workshop: Healing Old Wounds: Skills-Focused Psychotherapy and Training, Portland, OR
- Speaker: Elisabeth Martindale, Psy.D.
- January 2014 Clinical Colloquium: DSM-V, Essential Changes in Form and Function, Newberg, OR
- Speaker: Jeri Turgesen, Psy.D.
- November 2013 Grand Rounds: African American History, Culture and Additions and Mental Health Treatment
- Speakers: Danette C. Haynes, LCSW and Marcus Sharpe, Psy.D.
- September 2013 Clinical Colloquium: Integrated Primary Care, Newberg, OR
- Speakers: Brian Sandoval, Psy.D., and Juliette Cutts, Psy.D.

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## COMMUNITY INVOLVEMENT

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- Aug. 2014-October 2015 Community Worship Planning Team, George Fox University, Newberg, OR
- March 2012-June 2012 Spokane Mental Health Crisis Hotline: First Call for Help, Spokane, WA  
Mental Health Worker/Crisis Response
- Sep. 2010-March 2012 John. R. Rogers High School, Spokane, WA  
Academic Achievement Volunteer
- Feb. 2011-Feb. 2012 Union Gospel Mission Crisis Shelter, Spokane, WA  
Support Staff

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**PROFESSIONAL MEMBERSHIPS**

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2014- Present	Christian Association for Psychological Studies, Student Member
2013-Present	Multicultural Committee at George Fox University, Student Member
2013-Present	Oregon Psychological Association, Student Member
2013-Present	American Psychological Association, Student Member