Received: 3 May 2023 | Revised: 22 September 2023 | Accepted: 8 October 2023

DOI: 10.1002/ajs4.298

ORIGINAL ARTICLE

WILEY

A "Dark Side" of religion? Associations between religious involvement, identity and domestic violence determinants in Australia

Naomi Priest[1,2] | **Marian Esler**[1] | **Yusuf Ransome**[3] | **David R. Williams**[4] | **Ryan Perry**[1,2]

[1]Centre for Social Research and Methods, Research School of Social Sciences, College of Arts and Social Sciences, Australian National University, Canberra, Australian Capital Territory, Australia

[2]Population Health, Murdoch Children's Research Institute, Melbourne, Victoria, Australia

[3]Yale School of Public Health, Yale University, New Haven, Connecticut, USA

[4]Harvard T. H. Chan School of Public Health, Harvard University, Boston, Massachusetts, USA

Correspondence
Naomi Priest, Centre for Social Research and Methods, Research School of Social Science, Australian National University, RSSS Building, Ellery Crescent, Acton, ACT 2601, Australia.
Email: naomi.priest@anu.edu.au

Funding information
Department of Social Services, Australian Government

Abstract

This study investigates associations between religious involvement and identity and attitudes related to domestic violence using nationally representative cross-sectional data from $n=1287$ Australian adults in the 2018 Australian Survey of Social Attitudes (AuSSA). Linear regression models were used to analyse the association between religious involvement (frequency of service attendance and prayer) and identity (religious, spiritual or both) with attitudes related to domestic violence (patriarchal beliefs, failure to acknowledge domestic violence as an issue and trust in faith leaders' responses to domestic violence). Results showed that religious service attendance, frequency of prayer and spiritual/religious identity were associated with more patriarchal beliefs about gender roles. There was no evidence that religious involvement or identity was associated with failure to acknowledge domestic violence as a national issue. In contrast, frequent (but not infrequent) religious involvement and religious identity were associated with failure to acknowledge domestic violence in participants' own faith communities. Addressing patriarchal beliefs and acknowledgement of domestic violence within faith communities among those who regularly attend services, pray and identify as religious are key targets for action to address domestic violence and improve population health.

KEYWORDS
Australia, domestic violence, gender, religion

1 | INTRODUCTION

Religion is a social determinant of health, and religious communities have an important role in improving population health and health equity (Idler, 2014; Kawachi, 2020; Milstein et al., 2020; Oman & Neuhauser, 2018; Ransome, 2020). Despite increasing secularisation, many high-income western countries, including Australia, still have high levels of religious affiliation and participation (Bouma & Halafoff, 2017). Religion, faith and faith-based communities remain core to the lives of many and provide moral, spiritual, and social guidance and support (IMA World Health, and Sojourners, 2018; Milstein et al., 2020; Our Watch, Australia's National Research Organisation for Women's Safety [ANROWS], and Vichealth, 2015). In this study, we examined the extent to which religious involvement and identity are associated with domestic violence endorsement. Specifically, more frequent service attendance and prayer, along with identifying as religious compared with nonreligious should be associated with failing to acknowledge domestic violence as a serious issue. The following paragraphs outline why this association is expected.

1.1 | Religion and health

Religious involvement and practices, religious beliefs and religious institutions are related, but distinct aspects of religion that can have differing relationships with health and health behaviours. Within religion and health research, there is also now recognition of the need for a greater consideration of multiple dimensions of religious involvement in relation to health and health determinants, including distinguishing public forms of religious practice, such as service attendance, from more privates form of practice, such as prayer (Musick et al., 2004; VanderWeele, 2017). Furthermore, with the increasing adoption of spirituality that is independent of specific religious affiliation, there is also a need to account for differences in identity alongside practice (Ransome, 2020). Applying such multidimensional conceptualisations of religious involvement and spiritual identity to research on religion and health, including determinants of health, is an outstanding research priority.

Individual-level religious and spiritual practices, including religious service attendance and prayer, have been longitudinally associated with a wide range of positive health outcomes including reduced all-cause mortality (Chen & VanderWeele, 2018; VanderWeele et al., 2017; Wallace et al., 2019). However, some individual-level indicators of religious participation have also been associated with poorer health outcomes (Bernardelli et al., 2020; Pargament et al., 2001). Further, some studies report null associations (Ferraro & Kim, 2014). Some of the individual-level religious involvement factors that have been associated with negative health effects include negative social encounters in religious settings, high spiritual and religious struggles, defined as "tension, strain, and conflict about sacred matters with the supernatural, with other people, and within oneself" (Abu-Raiya et al., 2015; Ellison & Lee, 2010; Pargament et al., 2001) and high levels of shame, guilt and unforgiveness (Moreira-Almeida, 2013; Pargament & Lomax, 2013; Weber & Pargament, 2014).

Religious beliefs and interpretations of sacred texts and religious institutions and systems each may also have various effects on health that are partly dependent on characteristics of such beliefs and institutions, such as doctrine, gender norms and level of social sanctioning for sins, which may be heightened if those characteristics are enforced by religious leaders

(Kawachi, 2020). For example, a recent cross-sectional US study found women who attended religious institutions with structural sexism, that is, institutions that structurally exclude women from power and leadership, experienced poorer self-rated health than those who attended more inclusive congregations and that only women who attended inclusive religious institutions had higher self-rated health than those who were nonreligious (Homan & Burdette, 2021). Greater attention to the ways in which various aspects of religious practices, beliefs and institutions may be negatively associated with health among individuals and at the societal level (i.e., the "dark side of religion") has recently been recognised as a critical evidence gap requiring attention (Kawachi, 2020).

1.2 | Religion and domestic violence

The ways in which religion may be associated with domestic violence and violence against women are one such potential "dark side" of religion that is receiving growing attention globally, both within the empirical literature and within public policy, community settings and the media (IMA World Health and Sojourners, 2018; Our Watch, Australia's National Research Organisation for Women's Safety [ANROWS], and Vichealth, 2015; Priest, 2018; Vaughan et al., 2020). Domestic violence is a major public health issue and contributor to population burden of disease globally. Globally, 30 per cent of women experience physical and/or sexual violence from their partners at least once in their lifetime (World Health Organization, 2013). Domestic violence has profound short-term and long-term effects for individuals who persist long after violence has ceased, including acute and serious injuries, long-term health problems and chronic pain, sexual and reproductive health conditions, depression, anxiety, self-harm and suicidality, alcohol and substance misuse and even death (World Health Organization, 2013). Gender equity beliefs and practices at both individual and systemic levels are major drivers of domestic violence, with norms and attitudes that privilege men over women and that reinforce hierarchical gender roles considered key determinants (Broady et al., 2014; Davis & Greenstein, 2009; Flood, 2020; Golden et al., 2013; Heise & Kotsadam, 2015). A recent systematic review also identified that greater gender equality has a positive effect on male and female health outcomes more broadly (King et al., 2020). Promoting gender equality is therefore key to the prevention of domestic violence and associated health harms, as well as to achieving wider population health equity.

Religious institutions and faith-based communities are powerful sources of social norms and behaviours, including those related to gender. Attitudes and practices regarding gender roles are often deeply held and seen as core religious and faith beliefs by individuals as well as by leaders and at institutional levels. Existing studies on domestic violence and religious communities within western contexts provide rich qualitative insights from community members, often women who are victim-survivors, and identify beliefs and practices related to hierarchical gender roles and submission of women to men as critical drivers of domestic violence in these contexts across both individual and institutional levels (Nason-Clark et al., 2018; Ringel & Park, 2008; Westenberg, 2017). Population-representative large-scale empirical studies in this area still remain scant, even more so outside the United States and using contemporary population-representative data. High-quality prevalence data on domestic violence and individual- and institutional-level determinants within faith communities remain a major research gap internationally (Priest, 2018; Vaughan et al., 2020). One recent multicountry study found no evidence to suggest that domestic violence was any less prevalent in faith communities than in the wider population (Institute for Family Studies and Wheatley Institution, 2019).

The vital role played by faith communities in dealing with family violence and the authority and influence faith leaders have over attitudes within their communities was highlighted in

Australia by the 2016 Victorian Royal Commission into Family Violence. It identified that women experiencing family and domestic violence (FDV) in faith-based communities may face barriers seeking help as a result of attitudes and practices within their faith-based communities among individuals and at a community and institutional level, inadequate or ill-informed responses by faith leaders and a lack of cultural understanding and sensitivity by mainstream FDV services (State of Victoria, 2016). Religious institutions and faith communities often promote gender roles and relationship norms founded on love and commitment but can also potentially drive or condone violence through norms that subordinate women in the church, in the home and in wider society (IMA World Health and Sojourners, 2018; Our Watch, Australia's National Research Organisation for Women's Safety [ANROWS], and Vichealth, 2015; Priest, 2018; Vaughan et al., 2020).

Denial and lack of acknowledgement of domestic violence by faith community members and leaders has also been identified as a major issue across affiliations, although awareness is slowly increasing in Australia (Truong et al., 2020) and other high-income western countries (Aune & Barnes, 2018; le Roux et al., 2016). Trust in religious leaders' responses to domestic violence, both within and outside faith communities, is also mixed. While leaders can be vital sources of support and care, inappropriate, at times, harmful responses have also been identified as common. These include defensiveness, victim blaming and an overemphasis on reconciliation and forgiveness at the expense of personal safety (IMA World Health and Sojourners, 2018; Truong et al., 2020; Vaughan et al., 2020). Explanations for such denial identified within qualitative studies include the following: a focus on domestic violence as individual sin and a rare aberration of faith rather than a systemic issue with structural and cultural drivers; viewing domestic violence and family relationships as private and not public issues; a fear of stigmatisation of religion by secular society; and a lack of knowledge of domestic violence beyond direct physical abuse (IMA World Health and Sojourners, 2018; Truong et al., 2020; Vaughan et al., 2020).

Exploring how dimensions of religious involvement and identity relate to attitudes toward domestic violence will fill key knowledge gaps required to inform action to address domestic violence. Specifically, in this study, we examined the extent to which religious service attendance, frequency of prayer and spiritual/religious identity are associated with domestic violence acknowledgment within a nationally representative Australian sample. We hypothesised that more frequent service attendance and prayer, along with identifying as religious, will be associated with lower levels of acknowledging domestic violence as a serious issue.

1.3 | Study setting

Australia is religiously diverse, close to a third of the population identify no religion, followed by Catholic (23%), Anglican (13%), Pentecostal (3.7%), Uniting Church (3.7%), Muslim (2.6%), Buddhist (2.4%), Presbyterian (2.3%), Eastern Orthodox (2.1%), Hindu (1.9%), Baptist (1.5%), Lutherans (0.7%) and Jewish (0.4%), along with other smaller groups (Bouma & Halafoff, 2017). In 2016, the State of Victoria, one of Australia's most populous states (26% of the national population), conducted a Royal Commission into family violence. The report clearly stated that, alongside other factors, "there is no doubt that violence against women and children is deeply rooted in power imbalances that are reinforced by gender norms and stereotypes" (State of Victoria, 2016, p. 2). It highlighted faith communities as one of three main social contexts (alongside workplaces and sports clubs) that need to be supported to address family violence. It also noted that faith leaders risk exposing followers to domestic abuse through their "attitudes and practices, and inadequate or ill-informed responses," and that "women experiencing family violence can face barriers to seeking help in their faith community because

of particular religious beliefs" (State of Victoria, 2016, p. 35). Examples included religious leaders and community members not knowing how to respond to intimate partner violence, counselling women to stay in unsafe relationships due to beliefs about divorce, victim blaming or providing inappropriate advice.

2 | METHODS

2.1 | Data source

We used cross-sectional and nationally representative data from the 2018 Australian Survey of Social Attitudes (AuSSA), the Australian component of the annual International Social Survey Project (ISSP). The AuSSA research team contacted 5000 individuals who were randomly selected from the Australian Electoral Roll, with names and contact details provided by the Australian Electoral Commission. A total of 1287 individuals completed and returned the written survey, and a further 289 were deemed ineligible (giving a response rate of 27.30% that was slightly higher than expected). Full details are provided elsewhere (Evans et al., 2018). The ISSP is administered internationally, with some content variation across countries, and each year focusses on a special topic. In 2018, this topic was religion (which was also the focal topic in 2008, 1998, and 1991). Survey content regarding patriarchy beliefs and domestic violence was included in AuSSA using measures developed by the Australian National University (ANU) and The Australian Government Department of Social Services (DSS) and funded by DSS. Poststratification weights were provided by AuSSA (applied herein) to adjust the sample by gender, education and age to be representative of the Australian 2016 Census of Population and Housing (Evans et al., 2018).

2.2 | Measures

2.2.1 | Outcomes (domestic violence attitudes)

Patriarchal beliefs

Patriarchal beliefs were measured using six items adapted from the National Community Attitudes Towards Violence Against Women Survey (NCAS; Webster et al., 2018). For example, "When there are not enough jobs for everyone, men should get jobs and not women", and "A woman has to have children to be fulfilled." Response options ranged from strongly disagree to strongly agree on a 5-point Likert scale. Patriarchal belief scores were created by averaging responses across all six items ($\alpha = .83$).

Failure to acknowledge domestic violence as a National Issue

Attitudes about domestic violence as a national issue were measured with two items developed specifically for this survey as noted above: "Domestic violence is a serious issue in Australia," and "Domestic violence is common in Australia." Response options ranged from strongly agree to strongly disagree on a 5-point scale, and the mean of both items was averaged for the analysis ($\alpha = .75$). Items were reverse-coded for analysis and for consistency of interpretation across measures.

Failure to acknowledge domestic violence as an issue for faith communities

Attitudes about domestic violence as an issue specifically for faith communities were assessed with a single item developed specifically for this survey: "Domestic violence is a serious issue for faith communities." Response options ranged from strongly agree to strongly disagree on

a 5-point scale. Items were reverse-coded for analysis and for consistency of interpretation across measures.

Failure to acknowledge domestic violence in own faith community

Participants reported whether they agreed that domestic violence was common in their own faith community using an item developed specifically for this survey: "Domestic violence is common in my faith community." Response options ranged from strongly agree to strongly disagree on a 5-point scale. Items were reverse-coded for analysis and for consistency of interpretation across measures.

Trust in faith leaders' responses to domestic violence

Across six items, participants also reported whether they trusted leaders in their faith community to respond appropriately and support them if they or someone they know experienced domestic violence using items developed specifically for this survey. For example, "If I (or someone I know) experienced domestic violence, I trust leaders in my faith community would put my safety as the number one priority." Response options ranged from strongly disagree to strongly agree on a 5-point Likert scale. A scale score was created by averaging responses across all six items ($\alpha = .83$). Items were reverse-coded for analysis and for consistency of interpretation across measures.

2.2.2 | Religious exposures

Two dimensions of religious involvement examined the frequency of religious service attendance (a form of public participation) and frequency of prayer (a form of private participation). A third exposure examined whether participants identified as religious and/or spiritual (ISSP Research Group, 2020; ISSP Research Group et al., 2020).

Religious service attendance

Frequency of religious service attendance was assessed by asking, "Apart from such special occasions as weddings, funerals, etc., how often do you attend religious services?" Responses were categorised into four options: never; infrequent (less than once a year, about once or twice a year and several times a year); frequent (about once a month, 2–3 times a month and nearly every week); and very frequent (every week, several times a week) (ISSP Research Group, 2020; ISSP Research Group et al., 2020).

Frequency of prayer

Prayer frequency was assessed by asking, "About how often do you pray?" Responses were categorised into four options: never; infrequent (less than once a year, about once or twice a year and several times a year, about once a month); frequent (2–3 times a month, nearly every week, every week and several times a week); and very frequent (once a day and several times a day) (ISSP Research Group, 2020; ISSP Research Group et al., 2020).

Religious/spiritual identity

Participants reported their religious/spiritual identity by selecting one of four response categories: both religious and spiritual ("I follow a religion and consider myself to be a spiritual person interested in the sacred or the supernatural"); religious ("I follow a religion, but don't consider myself to be a spiritual person interested in the sacred or the supernatural"); spiritual ("I don't follow a religion, but consider myself to be a spiritual person interested in the sacred or the supernatural"); or neither spiritual nor religious ("I don't follow a religion and don't consider myself to be a spiritual person interested in the sacred or the supernatural") (ISSP Research Group, 2020; ISSP Research Group et al., 2020).

2.2.3 | Covariates

Sociodemographic characteristics

Sociodemographic characteristics included participant age (in years), sex (female or male), highest level of education (no postschool qualifications, certificate qualification, university degree and graduate degree), marital status (married, separated/divorced/widowed and never married) and self-rated health (poor/fair/good and very good/excellent). Participants also reported whether they were currently, not currently or never in paid work, which was categorised as their employment status (employed and not employed). Participants provided their average monthly household incomes, which were standardised and categorised into quartiles for analysis (outliers with $z > 2.576$ were removed before categorising income). This represents a monthly household income of AUD 100 K, which was considered implausible and that the respondents had read the question as annual income. Eight responses were removed as outliers.

Self-reported race or ethnicity is not routinely collected in Australia, other than Indigenous status. Instead, indicators such as country of birth are often used as proxies. Following previous approaches (O'Connor et al., 2019; Priest et al., 2016), we derived an Indigenous status and ethnicity variable drawing on Indigenous status, country of birth ("What country were you born in?") and ancestry ("What is your ancestry?") responses. Categories for this derived variable were as follows: Indigenous (Aboriginal and/or Torres Strait Islander); Australian-born (and not reporting an ethnic minority ancestry); Anglo/European (according to both reported country and ancestry); and Ethnic minority (defined as non-Indigenous and non-Anglo/European ancestry or country of birth). Ethnic minority birth countries and reported ancestries were classified consistent with previous approaches (O'Connor et al., 2019; Statistics Canada, 2015).

Frequency of attendance in childhood was measured with the question, "…when you were around 11 or 12, how often did you attend religious services then?" Consistent with the service attendance exposure, responses were categorised into four options: never; infrequent (less than once a year, about once or twice a year and several times a year); frequent (about once a month, 2–3 times a month and nearly every week); and very frequent (every week and several times a week).

2.3 | Statistical analyses

Distributions of key study variables were estimated for the overall sample and at each exposure level. Proportions were calculated for each of the categorical variables and are reported as percentages in Table 1. Mean scores for the continuous age variable are also reported in Table 1. To examine associations between each of the exposures (religious service attendance, frequency of prayer and religious/spiritual identity) with patriarchal beliefs, failure to acknowledge domestic violence and trust in faith leaders, a series of regression models were fitted for each outcome. Unadjusted models examined the crude association with each outcome. Models were then adjusted for key covariates (gender, education, childhood religious service attendance, marital status, employment, self-rated health and income) in the next step. We examined the robustness of the regression models in the previous step by adjusting for all covariates in one step.

Missing data among covariates were around 5% or less, including 2.41% missing for gender, 5.66% for education, 4.58% for childhood service attendance, 4.04% for marital status, 2.95% for employment status and 1.55% for self-rated health. Household income was missing data on nearly 40% of cases. There were minimal missing data on religious involvement exposures (1.6% religious service attendance and 3.2% prayer frequency) with a greater amount of missing data for religious/spiritual identity responses (10.7%). Missing data on outcomes were

TABLE 1 Weighted distributions of participant characteristics by religious involvement and identity ($N = 1287$).

	Religious service attendance				Prayer				Spiritual/religious identity				Full sample
	Never	Infrequent	Frequent	Very frequent	Never	Infrequent	Frequent	Very frequent	Neither	Spiritual	Religious	Both	
	%	%	%	%	%	%	%	%	%	%	%	%	%
Covariates[a]													
Age, reported as Mean	48.8	54.7	55.0	55.1	48.0	51.6	55.5	59.0	50.1	49.6	56.4	51.9	51.3
Gender													
Male	49.5	42.7	49.8	50.7	55.1	41.4	33.7	44.0	60.7	33.6	43.6	43.5	47.7
Female	50.5	52.3	50.2	49.3	44.9	58.6	66.3	56.0	39.3	66.4	56.4	56.5	52.3
Education													
School	41.7	39.2	40.0	25.7	41.0	37.6	42.5	36.4	41.0	35.9	47.1	36.4	39.8
Certificate	23.7	14.1	17.1	18.3	23.3	19.8	10.5	18.9	21.4	23.0	19.9	14.6	20.3
Degree	28.1	36.2	32.8	41.7	28.8	34.0	36.8	33.3	29.6	32.7	28.1	37.2	31.6
Postgrad	6.4	10.5	10.1	14.2	6.9	8.6	10.2	11.5	8.0	8.4	4.9	11.8	8.4
Ethnicity (country of birth, ancestry and Indigenous status)													
Australia	68.9	59.1	69.4	50.0	70.2	65.3	55.6	53.2	70.9	63.7	59.4	58.6	64.9
Anglo/European	9.3	11.4	3.8	7.0	9.5	7.6	13.1	8.6	9.8	9.7	6.2	10.8	9.4
Visible minority	18.0	26.3	26.3	42.0	18.1	20.4	28.3	36.8	16.1	22.5	30.3	29.5	22.5
Indigenous	3.8	3.2	0.4	1.1	2.2	6.7	3.0	1.4	3.2	4.2	4.1	1.2	3.2
Attendance (childhood)													
Never	46.8	10.2	6.8	4.2	48.9	17.2	11.5	6.7	46.0	36.9	7.5	12.1	31.1
Infrequent	19.6	36.6	10.8	8.7	21.2	35.8	14.5	16.5	22.4	24.5	30.9	15.8	23.0
Frequent	17.6	32.7	57.2	18.6	15.7	29.4	38.9	33.7	17.6	18.8	38.1	33.9	24.3
Very frequent	16.0	20.6	25.0	68.5	14.1	17.6	35.1	43.1	13.9	19.8	23.5	38.3	21.6

(Continues)

TABLE 1 (Continued)

	Religious service attendance				Prayer				Spiritual/religious identity				Full sample
	Never	In frequent	Frequent	Very frequent	Never	In frequent	Frequent	Very frequent	Neither	Spiritual	Religious	Both	
	%	%	%	%	%	%	%	%	%	%	%	%	%
Self-rated health													
Poor/fair/good	43.7	46.5	47.5	47.7	41.9	51.2	41.3	49.6	42.6	45.1	51.3	44.6	45.0
Very good/ excellent	56.3	53.5	52.5	52.3	58.1	48.8	58.7	50.4	57.4	54.9	48.7	55.4	55.0
Marital status													
Married	48.5	60.3	55.6	70.3	45.9	59.5	63.5	64.1	52.3	41.8	70.5	58.9	53.8
Separated/ divorce/ widow	13.7	17.9	16.9	11.3	14.9	12.9	15.7	17.3	13.6	17.9	16.0	12.7	14.9
Never-married	37.8	21.8	27.5	18.4	39.2	27.6	20.9	18.6	34.1	40.3	13.5	28.4	31.3
Employment status													
Employed	65.9	61.1	47.4	54.5	67.8	65.2	55.0	46.8	66.1	66.5	58.0	54.1	62.6
Not employed	34.1	38.9	52.6	45.5	32.2	34.8	45.0	53.2	33.9	33.5	42.0	45.9	37.4
Income (quartile)													
Q1	25.7	26.6	46.1	32.5	24.9	25.4	31.2	38.1	27.1	25.1	27.0	32.8	27.7
Q2	26.8	28.1	23.7	26.5	26.3	28.8	24.2	28.8	25.8	29.3	30.5	23.3	27.0
Q3	27.1	22.9	23.5	20.7	26.5	24.1	29.6	18.5	25.3	23.8	25.1	27.1	25.2
Q4	20.5	22.3	6.7	20.3	22.2	21.8	14.9	14.6	21.8	21.8	17.4	16.7	20.1
Observations, *N* (%)	707 (54.9)	367 (28.5)	85 (6.6)	114 (8.9)	607 (47.2)	287 (22.3)	171 (13.2)	203 (15.8)	493 (38.3)	316 (24.6)	187 (14.5)	252 (19.6)	1287 (100)

[a]Adjusted for all covariates (age, gender, education, income, ethnicity, marital status, employment status, self-rated health and childhood attendance frequency).

minimal (0.9% for patriarchal beliefs, 3.2% for failure to acknowledge domestic violence as an issue for the nation and 4% for failure to acknowledge domestic violence as an issue for faith communities). Males were more likely than females to have missing data on domestic violence acknowledgment. Some education categories ("School" and "Degree") also had more missing data on domestic violence acknowledgement.

For models examining attitudes about "my faith community" (failure to acknowledge domestic violence in my faith community and trust in faith leaders), participants who responded "not applicable" to these questions (around 59% of the total sample) were classified as not identifying with a faith community of their own, the neutral point of the scale ("neither agree nor disagree") was assigned to these cases to allow analysis of the complete dataset and a dummy variable indicating having a faith community or not was included in the multivariate models following previous approaches (Lantz et al., 2005; Slopen et al., 2013). Using this technique, the estimate for each domestic violence attitude reflects the effect when considering only those identified as having a faith community (that is, did not respond "not applicable") (Lantz et al., 2005; Slopen et al., 2013). For these measures, chi-squared tests of difference indicated that a greater number of male (56.0%) relative to female (44.0%) participants were coded as missing, and ethnic minority participants were less likely to be missing data (20.0% missing and 27.0% included). Among the exposure variables, missing data included a greater proportion of those who never attend service (74.1% versus 29.5%), never pray (63.9% versus 25.2%) and identify as spiritual (30.3% versus 18.0%) or as neither religious nor spiritual (54.3% versus 18.6%).

Missing data were handled with multiple imputations by chained equations based on 59 imputations for each missing value, consistent with a rule of thumb that the number of imputations should match the percentage of cases with incomplete data (von Hippel, 2018). The imputation model included all study variables and was specified using those study variables with no missing data (ethnicity and both "my faith community" outcomes) to predict missing values. Primary analyses were performed using the 59 imputed datasets. Parallel analyses were also performed using complete case data (missing data were still imputed for income, however, as this covariate has a large amount of missing data). Both analyses produced very similar results; the complete case results are provided in the supplementary material. All analyses were performed using Stata/SE 16.1 for Mac using the pweight command to accommodate survey weights.

3 | RESULTS

Table 1 shows baseline sample characteristics by religious service attendance, frequency of prayer and spiritual/religious identity. The sample included slightly more women than men, and 64.88% of the sample were born in Australia (and did not identify an ethnic minority ancestry). As shown in Table 1, 54.9% of the total sample never attend religious services and 47.2% never pray. Furthermore, 38.3% did not identify as religious or spiritual, 24.6% identified as spiritual only, 14.5% as religious only and 19.6% as both religious and spiritual. Distributions between exposure categories are provided in the online supplementary material (Table S4). Associations between each of the outcome variables are also provided in supplementary material (Table S5).

3.1 | Associations with exposures

3.1.1 | National-level domestic violence attitudes

Attending religious service, either infrequently ($b = 0.15$, 95% confidence interval [CI]: 0.05, 0.25) or very frequently ($b = 0.28$, 95% CI: 0.12, 0.45), was associated with more patriarchal beliefs in adjusted models as compared with never attending (Table 2). Frequent attendance

TABLE 2 Weighted associations of religiosity with patriarchal beliefs and acknowledgement of domestic violence.

	Patriarchal beliefs				Failure to acknowledge DV as a national issue				Failure to acknowledge DV as an issue for faith communities			
	Model 1		Model 2[a]		Model 1		Model 2[a]		Model 1		Model 2[a]	
Religion exposure	***b***	**[95% CI]**	***b***	**[95% CI]**	***b***	**[95% CI]**	***b***	**[95% CI]**	***b***	**[95% CI]**	***b***	**[95% CI]**
Service attendance												
Infrequ ent	0.15	[0.05,0.26]	0.15	[0.05,0.25]	0.08	[−0.03,0.19]	0.07	[−0.04,0.17]	0.09	[−0.08,0.25]	0.09	[−0.07,0.25]
Frequent	0.28	[0.03,0.54]	0.22	[−0.02,0.47]	−0.01	[−0.20,0.19]	−0.04	[−0.24,0.16]	0.02	[−0.24,0.29]	0.02	[−0.25,0.30]
Very frequent	0.35	[0.19,0.52]	0.28	[0.12,0.45]	0.11	[−0.05,0.27]	0.08	[−0.10,0.25]	0.17	[−0.08,0.42]	0.20	[−0.07,0.47]
Prayer												
Infrequent	0.02	[−.09,0.13]	0.04	[−0.06,0.14]	0.02	[−0.10,0.15]	0.04	[−0.07,0.16]	0.04	[−0.15,0.23]	0.03	[−0.16,0.22]
Frequent	0.12	[−.00,0.24]	0.13	[0.01,0.25]	0.01	[−0.14,0.16]	0.04	[−0.11,0.19]	−0.11	[−0.33,0.11]	−0.11	[−0.34,0.12]
Very frequent	0.42	[0.27,0.57]	0.36	[0.20,0.51]	0.08	[−0.05,0.22]	0.07	[−0.08,0.22]	−0.04	[−0.24,0.16]	−0.05	[−0.27,0.16]
Identity												
Spiritual only	0.02	[−.10,0.14]	0.09	[−0.02,0.20]	−0.09	[−0.22,0.05]	0.00	[−0.13,0.13]	−0.03	[−0.24,0.18]	0.02	[−0.19,0.24]
Religious only	0.17	[0.03,0.31]	0.13	[−0.01,0.26]	−0.01	[−0.15,0.13]	−0.02	[−0.16,0.12]	−0.02	[−0.22,0.18]	−0.03	[−0.23,0.18]
Identify as both	0.20	[0.06,0.35]	0.20	[0.06,0.35]	−0.09	[−0.22,0.05]	−0.06	[−0.20,0.09]	−0.05	[−0.26,0.15]	−0.03	[−0.25,0.19]

[a]Adjusted for all covariates (age, gender, education, income, ethnicity, marital status, employment status, self-rated health and childhood attendance frequency).

was positively associated with patriarchal beliefs in the unadjusted model ($b = 0.28$, 95% CI: 0.03, 0.54), but evidence of association became weak after adjusting for covariates ($b = 0.23$, 95% CI: −0.02, 0.47). There was no evidence of an association between attendance and failure to acknowledge domestic violence either nationally or for faith communities in general. In the model examining the frequency of prayer, both frequent ($b = 0.13$, 95% CI: 0.01, 0.25) and very frequent ($b = 0.36$, 95% CI: 0.20, 0.51) prayer were positively associated with patriarchal beliefs. No relationship between prayer and acknowledgement of domestic violence at a national level was observed. Finally, identifying as both spiritual and religious ($b = 0.20$, 95% CI: 0.06, 0.35) was associated with more patriarchal beliefs, relative to those reporting being neither religious nor spiritual. Identifying as religious only was also associated positively with patriarchal beliefs, but only in the unadjusted model ($b = 0.17$, 95% CI: 0.03, 0.31). There was no evidence of an association between identity and failure to acknowledge domestic violence, however.

3.1.2 | Community-specific domestic violence attitudes

The results of the regression analyses for community-specific attitudes are presented in Table 3. Attending religious services frequently ($b = 0.40$, 95% CI: 0.15, 0.66) or very frequently ($b = 0.74$, 95% CI: 0.46, 1.02) was strongly associated with failure to acknowledge that domestic violence is common in one's own faith community. Very frequent ($b = 0.34$, 95% CI: 0.16, 0.53) prayer was also associated with failure to acknowledge domestic violence in one's own faith community, as was identifying as both religious and spiritual ($b = 0.38$, 95% CI: 0.19, 0.56). Frequent prayer was associated with failure to acknowledge domestic violence in one's own faith community, but only in the unadjusted model ($b = 0.24$, 95% CI: 0.04, 0.44). Table 3 also shows that frequent ($b = 0.47$, 95% CI: 0.31, 0.64) and very frequent ($b = 0.63$, 95% CI: 0.45, 0.81) attendance, frequent ($b = 0.23$, 95% CI: 0.05, 0.40) and very frequent ($b = 0.38$, 95% CI: 0.26, 0.51) prayer and identifying as both religious and spiritual

TABLE 3 Weighted associations of religiosity with community specific outcomes.

	Failure to acknowledge DV as an issue for my community				Trust faith leaders in my community to address DV			
	Model 1		Model 2[a]		Model 1		Model 2[a]	
Religion exposure	***b***	**[95% CI]**	***b***	**[95% CI]**	***b***	**[95% CI]**	***b***	**[95% CI]**
Service attendance								
Infrequent	0.10	[−0.02,0.21]	0.08	[−0.05,0.20]	0.05	[−0.05,0.16]	0.09	[−0.03,0.21]
Frequent	0.46	[0.21,0.71]	0.40	[0.15,0.66]	0.45	[0.30,0.60]	0.47	[0.31,0.64]
Very frequent	0.75	[0.49,1.01]	0.74	[0.46,1.02]	0.54	[0.39,0.70]	0.63	[0.45,0.81]
Prayer								
Infrequent	0.11	[−0.01,0.23]	0.08	[−0.04,0.20]	0.07	[−0.02,0.17]	0.10	[−0.00,0.20]
Frequent	0.24	[0.04,0.44]	0.20	[−0.01,0.41]	0.23	[0.06,0.40]	0.23	[0.05,0.40]
Very frequent	0.40	[0.23,0.58]	0.34	[0.16,0.53]	0.36	[0.25,0.47]	0.38	[0.26,0.51]
Identity								
Spiritual only	0.07	[−0.02,0.16]	0.08	[−0.02,0.17]	0.00	[−0.11,0.12]	0.00	[−0.11,0.11]
Religious only	0.07	[−0.08,0.23]	0.02	[−0.14,0.17]	0.10	[−0.02,0.21]	0.11	[−0.02,0.24]
Identify as both	0.44	[0.26,0.61]	0.38	[0.19,0.56]	0.40	[0.30,0.51]	0.41	[0.29,0.54]

[a]Adjusted for all covariates (age, gender, education, income, ethnicity, marital status, employment status, self-rated health and childhood attendance frequency).

($b = 0.41$, 95% CI: 0.29, 0.54) are each associated with greater trust in faith leaders to address domestic violence.

4 | DISCUSSION

Drawing on data from a large and representative sample of Australians, this study demonstrated that more frequent religious involvement and stronger religious and spiritual identities are associated with more patriarchal beliefs about gender roles. There was no evidence that religious service attendance, frequency of prayer and spiritual/religious identity were associated with failure to acknowledge domestic violence as a national issue. However, when asked about domestic violence in one's own faith community, more frequent religious involvement and stronger religious identity were associated with failure to acknowledge domestic violence both as an issue in one's faith community and via stronger trust that faith leaders will respond appropriately and support victims of domestic violence.

This study is consistent with, and extends, recent findings in Australia that religious service attendance and self-rated importance of religion in one's life were positively associated with stronger patriarchal attitudes (Perales & Bouma, 2019). The present study builds on this evidence by examining both external religious involvement via service attendance as well as internal involvement via prayer, finding that both forms of religious involvement were associated with patriarchal attitudes. Furthermore, the present study indicates that the frequency of involvement matters, with higher frequencies of both attendance and prayer more reliably associated with patriarchal beliefs relative to frequent and infrequent involvement. Finally, the present study examined dimensions of religious and spiritual identity as an additional religious exposure alongside frequency of attendance and prayer. Considering identity as aspect of religiosity is important given broader social trends that show an increase in affiliation with a spiritual but not religious identity (Lipka & Gecewicz, 2017). Findings showed an identity that included both religion and spirituality was associated with stronger patriarchal attitudes. Study findings are also consistent with international evidence (Burn & Busso, 2005; Seguino, 2011) that demonstrates higher religiosity is associated with stronger patriarchal attitudes.

As Perales and Bouma (2019) suggested, greater religious service attendance is likely associated with greater exposure to religious teaching and to sanction for errant beliefs or behaviours, as well as reduced exposure to persons and influences outside the religious group that may present alternative viewpoints. However, prayer is not always accompanied by religious service attendance, making it important that both forms of religious involvement are considered. For example, in this present study, close to a quarter (23%) of those who prayed daily reported that they attended services never or less than weekly. These may be individuals who have disaffiliated from religious organisations due to comparatively egalitarian gender beliefs, while still retaining a personal faith practice (Barna Group, 2017). Interestingly, like service attendance, this study found prayer was also associated with stronger patriarchal attitudes. Further exploration of relationships between extrinsic and intrinsic dimensions of religious involvement, religious and spiritual identity, and patriarchal attitudes is needed using large-scale longitudinal population-level data and in-depth qualitative data in Australia as well as globally to inform domestic violence prevention and response strategies.

This study identified no evidence of differences in failure to acknowledge domestic violence as a national issue, or as an issue for faith communities in general across any of the religious involvement or identity measures. However, when evaluating one's own faith community, religious service attendance, frequency of prayer and identifying as both religious and spiritual were strongly associated with failure to acknowledge that domestic violence is an issue compared to those who did not attend services, pray or who were neither spiritual nor religious,

respectively. All three exposures were also associated with more positive beliefs about the responses of faith leaders to domestic violence in one's own faith community than those who did not regularly attend services, pray or identified as neither religious nor spiritual. That is, regular service attenders, prayers and those identifying as religious and spiritual acknowledged domestic violence as an issue nationally and within faith communities generally at similar levels as nonreligious respondents. However, they were less likely to acknowledge domestic violence as an issue within their own faith communities, and more likely to consider faith leaders' responses to domestic violence appropriate. These findings are consistent with a small nonrepresentative study ($n=438$) in the UK that found considerably more churchgoers reported awareness of domestic abuse in their community (71.3%) compared with in their own church (37.6%) (Aune & Barnes, 2018).

While this interesting observed difference was not hypothesised and our study does not directly assess motivation or other mechanisms that might be driving national versus localised attitudes, we speculate that the dichotomy is consistent with a social identity theory perspective (Tajfel & Turner, 1979). Social identity theory posits that individual's identify with social groups they belong to and therefore are motivated to see those groups in a positive light to preserve their own sense of self-esteem and positive self-image. In the current findings, then, religious participants may be concerned about domestic violence in religious communities generally, but absolve their own community as, being a member of that community, acknowledging the problem would reflect poorly on themselves. Furthermore, Hoverd et al. (2012) found that—specifically regarding religious groups—strength of identity was inversely associated with the size of the group to which someone belongs. The self-esteem preserving motive should therefore be more salient when reflecting on one's own religious community relative to a national-level collective of religious communities. It would be informative to use models of motivated social cognition to examine differences in acknowledgement of domestic violence across different contexts.

The findings of the present study are consistent with evidence suggesting that denial of domestic violence remains high in Australian faith communities (Truong et al., 2020) and those in other Western countries (Aune & Barnes, 2018; le Roux et al., 2016) despite the fact that awareness is increasing in many faith contexts. Taken together with similar findings (Aune & Barnes, 2018), our research indicates that improvements in awareness are more likely operating at a broader national level and not at the localised level within faith communities. Findings related to beliefs that domestic violence is not an issue in one's own faith community are at odds with findings of the Australian State of Victoria's Royal Commission into Family Violence (Victoria, Royal Commission into Family Violence, 2016), as well as both national and international evidence (IMA World Health and Sojourners, 2018; Truong et al., 2020; Vaughan et al., 2020). Extant evidence shows that while many religious and faith communities condemn domestic violence, a lack of awareness and acknowledgement of domestic violence persists within faith communities and leaders often lacking appropriate support for victims and endorsing patriarchal beliefs about family and gender roles that exacerbate domestic violence and limit help seeking. More work is needed to explore reasons for this finding and to explain the apparent denial of domestic violence as an issue within one's own community and high levels of endorsement of faith leaders' responses despite evidence to the contrary.

4.1 | Strengths and limitations

Strengths of the research include the use of recent nationally representative data, and our ability to assess associations systematically across a range of religious experiences and identities, as well as across different outcomes relevant to domestic violence attitudes. A limitation of our study, though, is the reliance on unvalidated measures, particularly of the

central outcome of domestic violence acknowledgement. Elsewhere, domestic violence outcomes tend to reflect experiences of victims (e.g., Ford-Gilboe et al., 2016; Troisi, 2018) and intentions of perpetrators as, for example, collected in the United States Centre for Disease Control assessment tool compendium (Thompson et al., 2006). It was necessary to develop a unique measurement tool in the present analyses for the assessment of domestic violence *attitudes*, consistent with the level of analysis used to examine patriarchal beliefs, and to position the outcomes in the present study as determinants of health rather than health outcomes per se. Relatedly, we acknowledge that our measures do not capture the range of practices that individuals include in their subjective conceptions of domestic violence. A potential confounding factor in acknowledgement of domestic violence is that some respondents might only consider more extreme physical forms of abuse that are genuinely rarer than instances of control and intimidation. The measure only included items worded in the affirmative. Further psychometric validation work is needed on these measures in future studies, including expanding the measure to include both positive and negative valanced items.

Another limitation of this study is that the doctrine and religious tradition of participants is unmeasured. Future research should develop measures and collect data on doctrinal beliefs as well as affiliation and denomination. High levels of heterogeneity in doctrinal beliefs exist, and are growing, in many denominations. For example, identifying as Anglican spans a very wide range of beliefs and practices including those related to gender and relationship with some Anglican churches embracing women's ordination and leadership and sanctioning of same-sex relationships while others are strongly and vocally opposed. Capturing of constructs such as spiritual struggle, social encounters and guilt and shame would also be beneficial as this present study was limited by measures of attendance and spirituality. Further delineation of trust in faith leaders to respond to their own issues of family violence compared with others, that is, separating "I" from "someone I know" in the measure used in this study, would also be informative. Compared with other countries, including the United States, Australia has substantial and increasing Eastern religion communities partly due to its proximity to Asia, and is at the higher end of countries for the proportion of those with no religion, including around double the number in the United States (Bouma & Halafoff, 2017). The decline and ageing of Christian groups in Australia (Bouma & Halafoff, 2017) means the shift toward religious diversity (and nonaffiliation) will continue. Given these differences, as well as the specific context of the Royal Commission and subsequent media attention given to the issue of domestic violence in Australia, our results may not necessarily generalise to other national contexts or over time, and it remains unknown what specific aspects of the Australian context are impacting the associations we report. Likewise, our cross-sectional data cannot determine the process by which religious participation or identity might be associated with domestic violence attitudes, nor the direction of causality.

Future studies using longitudinal designs and adequately powered to examine subgroups of religious beliefs and practices in relation to attitudes and beliefs are needed, for example, the attitudes and beliefs of those who pray regularly but do not attend religious services and within- and between-group denominational and doctrinal differences. Longitudinal designs would also allow for examination of causal pathways and trajectories over time.

5 | CONCLUSION

This study sheds light on the associations of religious service attendance, frequency of prayer and spiritual/religious identity with domestic violence acknowledgement in Australia. More frequent religious service attendance and higher frequency of prayer, as well as stronger religious and spiritual identities, were associated with more patriarchal attitudes about gender

roles, a key determinant of domestic violence. Critically, while there was no difference in acknowledgement of domestic violence as a national issue or as an issue for faith communities in general by frequency of service attendance, prayer or religious identity, those who attended services regularly, prayed regularly or identified as spiritual and religious were less likely to acknowledge domestic violence as an issue within their own community and were more positive about faith leaders' responses to domestic violence. Domestic violence prevention in faith communities must occur in collaboration with these communities (Vaughan et al., 2020). Appropriate interventions must include acknowledgment from leaders and a willingness to examine and address patriarchal beliefs and community acknowledgement of domestic violence and other health risks. This study highlights that over-reliance on interventions that target attitudes about domestic violence as a national issue may not translate to acceptance of domestic violence as an issue closer to home.

AUTHOR CONTRIBUTIONS

Ryan Perry: Writing – review and editing; writing – original draft; software; formal analysis; project administration. **Naomi Priest:** Conceptualization; writing – original draft; methodology; writing – review and editing; resources. **Marian Esler:** Conceptualization; writing – review and editing. **Yusuf Ransome:** Conceptualization; methodology; writing – review and editing. **David R. Williams:** Conceptualization; writing – review and editing; methodology.

ACKNOWLEDGEMENTS

Open access publishing facilitated by Australian National University, as part of the Wiley - Australian National University agreement via the Council of Australian University Librarians.

CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest to disclose.

DATA AVAILABILITY STATEMENT

Data used in this study are from the 2018 Australian Survey of Social Attitudes (AuSSA), which is publicly available at https://ada.edu.au/australian-survey-of-social-attitudes-aussa/. The survey content on religion and domestic violence was supported by funding from the Australian Government Department of Social Services. The authors' original version of the manuscript has been submitted to the preprint server SocArXiv (DOI: 10.31235/osf.io/9hf6d).

ORCID

Ryan Perry https://orcid.org/0000-0001-7703-2914

REFERENCES

Abu-Raiya, H., Pargament, K.I., Krause, N. & Ironson, G. (2015) Robust links between religious/spiritual struggles, psychological distress, and well-being in a national sample of American adults. *The American Journal of Orthopsychiatry*, 85(6), 565–575. Available from: https://doi.org/10.1037/ort0000084

Aune, K. & Barnes, R. (2018) *In churches too: church responses to domestic abuse – a case study of Cumbria*. Coventry University and University of Leicester (University of Leicester). Available from: https://pure.coventry.ac.uk/ws/portalfiles/portal/19148579/In_churches_too_final_report.pdf [Accessed 27th October 2023].

Barna Group. (2017) *Research update: meet those who "Love Jesus but not the church"*. Barna Group. Available from: https://www.barna.com/research/meet-love-jesus-not-church/

Bernardelli, L.V., Kortt, M.A. & Michellon, E. (2020) Religion, health, and life satisfaction: evidence from Australia. *Journal of Religion and Health*, 59(3), 1287–1303. Available from: https://doi.org/10.1007/s10943-019-00810-0

Bouma, G.D. & Halafoff, A. (2017) Australia's changing religious profile—rising nones and pentecostals, declining British protestants in superdiversity: views from the 2016 census. *Journal for the Academic Study of Religion*, 30(2), 129–143. Available from: https://doi.org/10.1558/jasr.34826

Broady, T.R., Gray, R. & Gaffney, I. (2014) Taking responsibility: a psychological profile of men attending a domestic violence group work intervention program in New South Wales, Australia. *Journal of Interpersonal Violence*, 29(14), 2610–2629. Available from: https://doi.org/10.1177/0886260513517300

Burn, S.M. & Busso, J. (2005) Ambivalent sexism, scriptural literalism, and religiosity. *Psychology of Women Quarterly*, 29(4), 412–418. Available from: https://doi.org/10.1111/j.1471-6402.2005.00241.x

Chen, Y. & VanderWeele, T.J. (2018) Associations of religious upbringing with subsequent health and well-being from adolescence to young adulthood: an outcome-wide analysis. *American Journal of Epidemiology*, 187, 2355–2364. Available from: https://doi.org/10.1093/aje/kwy142

Davis, S.N. & Greenstein, T.N. (2009) Gender ideology: components, predictors, and consequences. *Annual Review of Sociology*, 35(1), 87–105. Available from: https://doi.org/10.1146/annurev-soc-070308-115920

Ellison, C.G. & Lee, J. (2010) Spiritual struggles and psychological distress: is there a dark side of religion? *Social Indicators Research*, 98(3), 501–517. Available from: https://doi.org/10.1007/s11205-009-9553-3

Evans, A., McNeil, N., McEachern, S., Tranter, B. & Wilson, S. (2018) Australian survey of social attitudes. *Australian Data Archive*. Available from: https://doi.org/10.26193/1U0HNI

Ferraro, K.F. & Kim, S. (2014) Health benefits of religion among Black and White older adults? Race, religiosity, and C-reactive protein. *Social Science & Medicine*, 120, 92–99. Available from: https://doi.org/10.1016/j.socscimed.2014.08.030

Flood, M. (2020) *Unpacking the man box: what is the impact of the man box attitudes on young Australian men's behaviours and wellbeing?* Jesuit Social Services (Melbourne, Australia). Available from: https://jss.org.au/wp-content/uploads/2020/07/JSS200712_UMB_Report_Digital.pdf [Accessed 27th October 2023].

Ford-Gilboe, M.C., Wathen, N., Varcoe, C., MacMillan, H.L., Scott-Storey, K., Mantler, T. et al. (2016) Development of a brief measure of intimate partner violence experiences: the Composite Abuse Scale (Revised)—short form (CASR-SF). *BMJ Open*, 6(12), e012824. Available from: https://doi.org/10.1136/bmjopen-2016-012824

Golden, S.D., Perreira, K.M. & Durrance, C.P. (2013) Troubled times, troubled relationships: how economic resources, gender beliefs, and neighborhood disadvantage influence intimate partner violence. *Journal of Interpersonal Violence*, 28(10), 2134–2155. Available from: https://doi.org/10.1177/0886260512471083

Heise, L. & Kotsadam, A. (2015) Cross-national and multilevel correlates of partner violence: an analysis of data from population-based surveys. *The Lancet Global Health*, 2(6), e332–e340. Available from: https://doi.org/10.1016/S2214-109X(15)00013-3

Homan, P. & Burdette, A. (2021) When religion hurts: structural sexism and health in religious congregations. *American Sociological Review*, 86(2), 234–255. Available from: https://doi.org/10.1177/0003122421996686

Hoverd, W.J., Atkinson, Q.D. & Sibley, C.G. (2012) Group size and the trajectory of religious identification. *Journal for the Scientific Study of Religion*, 51(2), 286–303. Available from: https://doi.org/10.1111/j.1468-5906.2012.01643.x

Idler, E.L. (2014) *Religion as a social determinant of public health*. Oxford: Oxford University Press. Available from: https://doi.org/10.1093/acprof:oso/9780199362202.001.0001

IMA World Health, & Sojourners. (2018) *Broken Silence 2.0: pastors' attitudes and actions around domestic violence and sexual violence in the #metoo era*. We Will Speak Out U.S (United States). Available from: https://wewillspeakout.us/wp-content/uploads/2018/09/broken-silence-2.0_an-update-on-pastors-attitudes-and-actions-around-domestic-and-sexual-violence-in-the-metoo-era.pdf [Accessed 25th Novermber 2020].

Institute for Family Studies & Wheatley Institution. (2019) *Mapping family change and child well-being outcomes*. New York, NY; Barcelona: Institute for Family Studies. Available from: https://ifstudies.org/ifs-admin/resources/reports/worldfamilymap-2019-051819.pdf [Accessed 27th October 2023].

ISSP Research Group. (2020) *International social survey programme: religion IV – ISSP 2018 ZA7570 data file version 2.1.0*. Cologne: GESIS Data Archive. Available from: https://doi.org/10.4232/1.13629.

ISSP Research Group, Smith, T.W., Tiliouine, H., Armah-Attoh, D., Yaw Norviewu, N., Abu-Rumman, S. et al. (2020) Based on ISSP 2018: a cross-national and comparative study of religion of additional 14 countries. Cologne, GEISIS Data Archive.Kawachi, I. 2020. "Invited commentary: religion as a social determinant of health". *American Journal of Epidemiology*, 189(12), 1461–1463. Available from: https://doi.org/10.1093/aje/kwz204

King, T.L., Kavanagh, A., Scovelle, A.J. & Milner, A. (2020) Associations between gender equality and health: a systematic review. *Health Promotion International*, 35(1), 27–41. Available from: https://doi.org/10.1093/heapro/day093

Kawachi, I. (2020) Invited Commentary: Religion as a Social Determinant of Health. *American Journal of Epidemiology*, 189(12), 1461–1463. Available from: https://doi.org/10.1093/aje/kwz204

Lantz, P.M., House, J.S., Mero, R.P. & Williams, D.R. (2005) Stress, life events, and socioeconomic disparities in health: results from the Americans' Changing Lives Study. *Journal of Health and Social Behavior*, 46(3), 274–288. Available from: https://doi.org/10.1177/002214650504600305

le Roux, E., Kramm, N., Scott, N., Sandilands, M., Loots, L., Olivier, J. et al. (2016) Getting dirty: working with faith leaders to prevent and respond to gender-based violence. *The Review of Faith & International Affairs*, 14(3), 22–35. Available from: https://doi.org/10.1080/15570274.2016.1215837

Lipka, M. & Gecewicz, C. (2017) *More Americans now say they're spiritual but not religious*. Pew Research Center. Available from: https://www.pewresearch.org/fact-tank/2017/09/06/more-americans-now-say-theyre-spiritual-but-not-religious/ [Accessed 27th October 2023].

Milstein, G., Palitsky, R. & Cuevas, C. (2020) The religion variable in community health promotion and illness prevention. *Journal of Prevention & Intervention in the Community*, 48(1), 1–6. Available from: https://doi.org/10.1080/10852352.2019.1617519

Moreira-Almeida, A. (2013) Religion and health: the more we know the more we need to know. *World Psychiatry*, 12(1), 37–38. Available from: https://doi.org/10.1002/wps.20009

Musick, M.A., House, J.S. & Williams, D.R. (2004) Attendance at religious services and mortality in a national sample. *Journal of Health and Social Behavior*, 45(2), 198–213. Available from: https://doi.org/10.1177/002214650404500206

Nason-Clark, N., Fisher-Townsend, B., Holtmann, C. & McMullin, S. (2018) *Religion and intimate partner violence: understanding the challenges and proposing solutions*. Oxford: Oxford University Press. Available from: https://doi.org/10.1080/10926771.2023.2194849

O'Connor, M., Slopen, N., Becares, L., Burgner, D., Williams, D.R. & Priest, N. (2019) Inequalities in the distribution of childhood adversity from birth to 11 years. *Academic Pediatrics*, 20, 609–618. Available from: https://doi.org/10.1016/j.acap.2019.12.004

Oman, D. & Neuhauser, L. (2018) Public health education, promotion, and intervention: relevance of religion and spirituality. In: Oman, D. (Ed.) *Why religion and spirituality matter for public health. In Religion, spirituality and health: a social scientific approach*. Cham: Springer International Publishing, pp. 211–223. Available from: https://doi.org/10.1007/978-3-319-73966-3_12

Our Watch, Australia's National Research Organisation for Women's Safety (ANROWS), & Vichealth. (2015) *Change the story: a shared framework for the primary prevention of violence against women and their children in Australia*. Melbourne, VIC: Our Watch. Available from: https://media-cdn.ourwatch.org.au/wp-content/uploads/sites/2/2019/05/21025429/Change-the-story-framework-prevent-violence-women-children-AA-new.pdf [Accessed 25th November 2020].

Pargament, K.I., Koenig, H.G., Tarakeshwar, N. & Hahn, J. (2001) Religious struggle as a predictor of mortality among medically ill elderly patients: a 2-year longitudinal study. *Archives of Internal Medicine*, 161(15), 1881–1885. Available from: https://doi.org/10.1001/archinte.161.15.1881

Pargament, K.I. & Lomax, J.W. (2013) Understanding and addressing religion among people with mental illness. *World Psychiatry*, 12(1), 26–32. Available from: https://doi.org/10.1002/wps.20005

Perales, F. & Bouma, G. (2019) Religion, religiosity and patriarchal gender beliefs: understanding the Australian experience. *Journal of Sociology*, 55(2), 323–341. Available from: https://doi.org/10.1177/1440783318791755

Priest, N. (2018) A health and social science view of domestic violence and churches. *St Mark's Review*, 243, 25–42. Available from: https://doi.org/10.3316/ielapa.504685417535068

Priest, N., King, T., Bécares, L. & Kavanagh, A.M. (2016) Bullying victimization and racial discrimination among Australian children. *American Journal of Public Health*, 106(10), 1882–1884. Available from: https://doi.org/10.2105/AJPH.2016.303328

Ransome, Y. (2020) Religion, spirituality, and health: new considerations for epidemiology. *American Journal of Epidemiology*, 189(8), 755–758. Available from: https://doi.org/10.1093/aje/kwaa022

Ringel, S. & Park, J. (2008) Intimate partner violence in the Evangelical community: faith-based interventions and implications for practice. *Journal of Religion & Spirituality in Social Work: Social Thought*, 27(4), 341–360. Available from: https://doi.org/10.1080/15426430802345317

Seguino, S. (2011) Help or hindrance? Religion's impact on gender inequality in attitudes and outcomes. *World Development*, 39(8), 1308–1321. Available from: https://doi.org/10.1016/j.worlddev.2010.12.004

Slopen, N., Kontos, E.Z., Ryff, C.D., Ayanian, J.Z., Albert, M.A. & Williams, D.R. (2013) Psychosocial stress and cigarette smoking persistence, cessation, and relapse over 9–10 years: a prospective study of middle-aged adults in the United States. *Cancer Causes & Control*, 24(10), 1849–1863. Available from: https://doi.org/10.1007/s10552-013-0262-5

State of Victoria. (2016) *Royal Commission into Family Violence: summary and recommendations, Parl Paper No 132 (2014–2016)*. Available from: http://rcfv.archive.royalcommission.vic.gov.au/MediaLibraries/RCFamilyViolence/Reports/RCFV_Full_Report_Interactive.pdf [Accessed 27th October 2023].

Statistics Canada. (2015) *Definitions, data sources and methods – visible minority of person*. Available from: https://www23.statcan.gc.ca/imdb/p3Var.pl?Function=DEC&Id=45152 [Accessed 27th October 2023].

Tajfel, H. & Turner, J.C. (1979) An intergrative theory of intergroup conflict. In: Austin, W.G. & Worchel, S. (Eds.) *The social psychology of intergroup relations*. Monterey, CA: Brooks/Cole, pp. 33–47.

Thompson, M.P., Basile, K.C., Hertz, M.F. & Sitterle, D. (2006) *Measuring intimate partner violence. A compendium of assessment tools*. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Available from: https://stacks.cdc.gov/view/cdc/11402 [Accessed 27th October 2023].

Troisi, G. (2018) Measuring intimate partner violence and traumatic affect: development of VITA, an Italian scale. *Frontiers in Psychology*, 9, 1282. Available from: https://doi.org/10.3389/fpsyg.2018.01282

Truong, M., Sharif, M., Olsen, A., Pasalich, D., Calabria, B. & Priest, N. (2020) Attitudes and beliefs about family and domestic violence in Australian faith-based communities: a qualitative study. *medRxiv*. Available from: https://doi.org/10.1101/2020.10.29.20222703

VanderWeele, T.J. (2017) Religious communities and human flourishing. *Current Directions in Psychological Science*, 26(5), 476–481. Available from: https://doi.org/10.1177/0963721417721526

VanderWeele, T.J., Yu, J., Cozier, Y.C., Wise, L., Argentieri, M.A., Rosenberg, L. et al. (2017) Attendance at religious services, prayer, religious coping, and religious/spiritual identity as predictors of all-cause mortality in the Black Women's Health Study. *American Journal of Epidemiology*, 185(7), 515–522. Available from: https://doi.org/10.1093/aje/kww179

Vaughan, C., Sullivan, C., Chen, J. & Vaid Sandhu, M. (2020) *What works to address violence against women and family violence within faith settings: an evidence guide*. University of Melbourne. Available from: https://www.faithvictoria.org.au/images/stories/mcwh-evidence-guide.pdf [Accessed 27th October 2023].

von Hippel, P.T. (2018) How many imputations do you need? A twostage calculation using a quadratic rule. *Sociological Methods & Research*, 1–20, 699–718. Available from: https://doi.org/10.1177/0049124117747303

Wallace, L.E., Anthony, R., End, C.M. & Way, B.M. (2019) Does religion stave off the grave? Religious affiliation in one's obituary and longevity. *Social Psychological and Personality Science*, 10(5), 662–670. Available from: https://doi.org/10.1177/1948550618779820

Weber, S.R. & Pargament, K.I. (2014) The role of religion and spirituality in mental health. *Current Opinion in Psychiatry*, 27(5), 358–363. Available from: https://doi.org/10.1097/yco.0000000000000080

Webster, K., Diemer, K., Honey, N., Mannix, S., Mickle, J., Morgan, J. et al. (2018) *Australians' attitudes to violence against women and gender equality. Findings from the 2017 National Community Attitudes towards Violence against Women Survey (NCAS) (Research report, 03/2018)*. Sydney, NSW: ANROWS. Available from: https://ncas.anrows.org.au/wp-content/uploads/2018/11/NCAS-report-2018.pdf [Accessed 27th October 2023].

Westenberg, L. (2017) 'When she calls for help'—domestic violence in christian families. *Social Sciences*, 6, 71. Available from: https://doi.org/10.3390/socsci6030071

World Health Organization. (2013) *Closing the health equity gap: policy options and opportunities for action*. Geneva: World Health Organization. Available from: https://apps.who.int/iris/bitstream/handle/10665/78335/9789241505178_eng.pdf?sequence=1 [Accessed 27th October 2023].

AUTHOR BIOGRAPHIES

Professor Naomi Priest is a Social Epidemiologist at the Centre for Social Research and Methods, Australian National University. She has honorary positions with the Murdoch Children's Research Institute and the University of Melbourne. Her research focusses on examining how social forces and exposures become biologically embedded and embodied and on understanding and addressing inequalities in health and development throughout the life course. Professor Priest has worked on several different projects related to family, domestic and sexual violence, including the Family and Community Safety (FaCtS) study for Aboriginal and Torres Strait Islander Communities and a number of projects related to domestic and family violence in faith communities, including with Christian young adults.

Marian Esler is a Research Fellow in the ANU Centre for Social Research and Methods with decades of experience in research, policy and practice. In her previous roles in the Australian Public Service, she was responsible for commissioning, managing and contributing to major research and evaluation projects relating to families, family law and family violence. She is currently the project leader on Australia's Disability Strategy Survey—Share with us—a longitudinal survey of community attitudes toward people with disability.

Dr. Yusuf Ransome is on a mission to empower underserved groups and communities to fast-track their way to health, well-being and long-term prosperity. Dr. Ransome earned a Doctor of Public Health degree from Columbia University, honed his expertise as a social epidemiologist at Harvard T.H. Chan School of Public Health and executes his mission as an associate professor at Yale School of Public Health. Dr. Ransome investigates how social capital, social connectedness and spirituality influence health and socioeconomic mobility.

David R. Williams is the Norman Professor of Public Health and chair of the Department of Social and Behavioral Sciences at the Harvard Chan School of Public Health and Professor of African and African American Studies and Sociology at Harvard. The author of over 500 scientific papers, his research has addressed the complex ways in which race, socioeconomic status, racism, stress, health behaviours and religious involvement can affect health.

Dr. Ryan Perry is a Senior Lecturer at the Australian National University with over 10 years of research experience across psychology, management and public health. He is also Deputy Director of the Australian Data Archive. Ryan received his PhD from the University of Auckland in 2013. His research examines interactions between traits and social environments shaping attitudinal outcomes including prejudice and political ideology. His archiving achievements include developing novel processes for data de-identification and harmonisation.

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Priest, N., Esler, M., Ransome, Y., Williams, D.R. & Perry, R. (2024) A "Dark Side" of religion? Associations between religious involvement, identity and domestic violence determinants in Australia. *Australian Journal of Social Issues*, 59, 186–205. Available from: https://doi.org/10.1002/ajs4.298