A ‘Dark Side’ of Religion?’ - Associations between Religious Involvement, Identity and Domestic Violence Determinants

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Author Note

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Abstract

This study investigates associations between religious involvement and identity and determinants of 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 of religious involvement (frequency of service attendance and prayer) and identity (religious, spiritual, or both) with determinants of 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 were 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: Religion, social determinants, domestic violence, gender, patriarchal beliefs, Australia

Background

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 & Sojourners, 2018; Milstein et al., 2020; Our Watch et al., 2015). A wide range of positive health outcomes including reduced all-cause mortality have been longitudinally associated with dimensions of individual levels of religious involvement and spiritual engagement, including religious service attendance and prayer (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) although some studies report null associations (Ferraro & Kim, 2014). Religious beliefs, interpretations of scripture and religious institutional practices and systems may have various effects on health that is partly dependent on the characteristics of places of worship (e.g., doctrine, gender norms, level of social sanctioning for sins, etc), which may be heightened if those characteristics are enforced by religious leaders (Kawachi, 2020). As such, greater attention to the possibility that religious involvement may be negatively associated with health among individuals and at the society level, the “dark side of religion,” is recognised as a critical evidence gap requiring attention (Kawachi, 2020). Evidence shows that religion does not always have positive effects on health and health determinants, and may have negative effects. 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 (Abu-Raiya et al.,

2015; Ellison & Lee, 2010; Pargament et al., 2001) and high level of shame, guilt and unforgiveness (Moreira-Almeida, 2013; Pargament & Lomax, 2013; Weber & Pargament, 2014). Structural characteristics of religious institutions have also been identified as associated with poor health. 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 compared to those who attended more inclusive congregations, and that only women who attended inclusive religious institutions had higher self-rated health compared to those who were non religious (Homan & Burdette, 2021).

The ways in which religious involvement may be associated with determinants of domestic violence is one such potential “dark side” of religion that is receiving growing attention globally both within empirical literature as well within public policy, community settings and the media (IMA World Health & Sojourners, 2018; Our Watch et al., 2015; Priest, 2018; Vaughan et al., 2020). For example, in Australia the Victorian Royal Commission into Family Violence (2016) highlighted faith communities as ‘vital settings’ for dealing with family violence, and identified the authority and influence faith leaders have over attitudes within their communities. It identified that as a result of attitudes and practices within faith-based communities, inadequate or ill-informed responses by faith leaders, and a lack of cultural understanding and sensitivity by mainstream Family and Domestic Violence (FDV) services, women experiencing FDV may face barriers seeking help (State of Victoria 2016). Domestic violence is a major public health issue and contributor to population burden of disease globally. Globally, thirty percent 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 that 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. 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 & Sojourners, 2018; Our Watch et al., 2015; Priest, 2018; Vaughan et al., 2020). Existing work on domestic violence and religious communities within western context commonly identifies beliefs and practices related to hierarchical gender roles and submission of women to men as critical drivers of domestic violence in these contexts (Nason-Clark et al., 2018; Ringel & Park, 2008; Westenberg, 2017). However, population representative empirical studies in this area remain scant, even more so outside of the United States and using contemporary population representative data.

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 of faith communities, is also mixed. While leaders can be vital sources of support and care, inappropriate, and at times harmful responses have also been identified as common. These include defensiveness, victim blaming and an over-emphasis on reconciliation and forgiveness at the expense of personal safety (IMA World Health & Sojourners, 2018; Truong et al., 2020; Vaughan et al., 2020). Explanations for such denial identified within qualitative studies, largely within evangelical and protestant churches, include: 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 & Sojourners, 2018; Truong et al., 2020; Vaughan et al., 2020). High quality prevalence data on domestic violence within faith communities remains a major research gap internationally (Priest, 2018; Vaughan et al., 2020). However a recent multi-country 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 & Wheatley Institution, 2019). Consequently, quantifying the extent of failure to acknowledge domestic violence within faith communities is important to inform action to prevent and address domestic violence.

Within religion and health research there is also now recognition of the need for 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 private forms of practice, such as prayer (Musick et al., 2004; VanderWeele, 2017). Furthermore, with 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 multi-dimensional conceptualisations of religious involvement and spiritual identity to research on religion and health, including determinants of health, across both the potential benefits and harms of such involvement and identity is an outstanding research priority.

Exploring how dimensions of religious involvement and identity relate to determinants of 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 determinants of domestic violence within a nationally representative Australian sample. We hypothesized that more frequent service attendance and prayer, along with identifying as religious will be associated with failure to acknowledge domestic violence as an issue.

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 & Halaloff, 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 not knowing how to respond to intimate partner violence, sending women back to abusive households, victim blaming, or providing inappropriate advice.

Methods

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 in 2018 (a response rate of 25.74%). Full details are provided elsewhere (Evans et al., 2018). The ISSP is administered internationally, with some content variation across countries, and each year focuses 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 Department of Social Services (DSS) and funded by DSS. Post-stratification 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).

Measures

Outcomes (Determinants of Domestic Violence)

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 five-point Likert scale. Patriarchal beliefs scores were created by averaging responses across all six items ($\alpha = 0.83$).

Failure to Acknowledge Domestic Violence as a National Issue. Attitudes about domestic violence as a national issue were measured with two items: “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 five-point scale, and the mean of both items was averaged for the analysis ($\alpha = 0.75$).

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: “Domestic violence is a serious issue for faith communities”. Response options ranged from strongly agree to strongly disagree and the mean score was used for the analysis.

Failure to Acknowledge Domestic Violence in Own Faith Community. Participants reported whether they agreed that domestic violence was common in their own faith community: “Domestic violence is common in my faith community”. Response options ranged from strongly agree to strongly disagree and the mean score was used for the analysis.

Trust in Faith Leaders' Responses to Domestic Violence. 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 across six items. 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 five-point Likert scale. A trust in faith leaders score was created by averaging responses across all six items ($\alpha = 0.83$).

Religious Exposures

Two dimensions of religious involvement examined 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.

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, several times a year); frequent (about once a month, 2-3 times a month, nearly every week); and very frequent (every week, several times a week).

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, several times a year, about once a month); frequent (2-3 times a month, nearly every week, every week, several times a week); and very frequent (once a day, several times a day).

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 or religious (“I don't follow a religion and don't consider myself to be a spiritual person interested in the sacred or the supernatural”).

Covariates

Sociodemographic Characteristics. Sociodemographic characteristics included participant age (in years), sex (female or male), highest level of education (no post-school qualifications, certificate qualification, university degree, graduate degree), marital status (married, separated/divorced/widowed, never married), and self-rated health (poor/fair/good, 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, 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).

Self-reported race or ethnicity is not routinely collected in Australia other than Indigenous status. Instead, indicators such as country of birth categories 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: 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, several times a year); frequent (about once a month, 2-3 times a month, nearly every week); and very frequent (every week, several times a week).

Statistical Analyses

Distributions of key study variables were estimated for the overall sample and by each exposure level. Proportions were calculated for each of the categorical variables and reported as percentages in Table 1. Mean scores for the continuous age variable are also reported in Table 1. To examine associations 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 regression 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, 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 was 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 was minimal missing data on religious involvement exposures (1.6% religious service attendance, 3.2% prayer frequency) with a greater amount of missing data for religious/spiritual identity responses (10.7%). Missing data on outcomes was 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 acknowledgment.

For models examining attitudes about “my faith community” (failure to acknowledge domestic violence in my faith community, trust in faith leaders) participants that 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 (cf. Slopen et al., 2013). For these measures, chi-square 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, 27.0% included). Among the exposure variables, missing data included a greater proportion of those that 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 was handled with multiple imputation 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 was 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.

Results

Table 1 shows the 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).

Associations with Exposures

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 (see Table 2). Frequent

attendance 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 association between attendance and failure to acknowledge domestic violence either nationally or for faith communities in general. In the model examining 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 was positively associated with patriarchal beliefs. No relationship between prayer and domestic violence acknowledgment 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 association between identity and failure to acknowledge of domestic violence, however.

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 ($b = 0.41$, 95%

CI: 0.29, 0.54) are each associated with greater trust in faith leaders to address domestic violence.

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 identities was associated with failure to acknowledge domestic violence an issue in one's faith community and via stronger agreement that faith leaders are responsive to domestic violence.

This study is consistent with, and extends, recent findings in Australia that found 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 expands the 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 religious and spiritual 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 an 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 in one's own faith community compared to those who did not attend services, pray, or

who were neither spiritual or religious respectively. All three 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 or 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 non-religious 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 non-representative 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).

The findings of this study are consistent with evidence suggesting that denial of domestic violence remains high in Australian (Truong et al., 2020) and (Aune & Barnes, 2018; le Roux et al., 2016) faith communities in other Western countries 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, as well as both national and international evidence (IMA World Health & 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 with 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 explanations for this 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.

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 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 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 practises 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.

A limitation of this study is that the doctrine and religious tradition of participants is unmeasured. Future research should collect data on doctrinal beliefs as well as affiliation and denomination. 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. Compared with other countries, including the US, 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 USA (Bouma & Halafoff, 2017). The decline and aging of Christian groups in Australia (Bouma & Halafoff, 2017) means the shift toward religious diversity (and non-affiliation) 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.

Conclusion

This study sheds light on the associations of religious service attendance, frequency of prayer, and spiritual/religious identity with determinants of domestic violence 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 overreliance 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.

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Tables

Table 1

Weighted Distributions of Participant Characteristics by Religious Involvement and Identity in the 2018 AuSSA, n= 1287

[illegible]

	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	
	%	%	%	%	%	%	%		%	%	%	%	%
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 <i>N (%)</i>	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)

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 [#]		Model 1		Model 2 [#]		Model 1		Model 2 [#]	
	b	[95% CI]	b	[95% CI]	b	[95% CI]	b	[95% CI]	b	[95% CI]	b	[95% CI]
Religion exposure												
Service attendance												
Infrequent	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]

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

Table 3.
Weighted Associations of Religiosity with Community Specific Outcomes

Religion exposure	Failure to acknowledge DV as an issue for my community				Trust faith leaders in my community to address DV			
	Model 1		Model 2 [#]		Model 1		Model 2 [#]	
	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]

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