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TRAUMA-INFORMED CLERGY: AN INVESTIGATION OF FACTORS PREDICTING THE TRAUMA-RELATED ATTITUDES AND BELIEFS OF CHRISTIAN CLERGY IN FLORIDA

by

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A dissertation submitted in partial fulfillment of the requirements
for the degree of Doctor of Philosophy
in the Department of Counselor Education and School Psychology
in the College of Community Innovation and Education
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ABSTRACT

Exposure to childhood trauma can have a lasting impact on the mental and emotional health of an individual (Ford & Courtois, 2009). Research on help-seeking behaviors indicate that 15% to 40% of individuals who experience mental health problems, including trauma-related concerns, initially contact a member of the clergy for help rather than contacting a medical or mental health professional (Nieuwsma et al., 2014; Wang et al., 2003); therefore, research into the trauma-related attitudes and beliefs of clergy is warranted. The purpose of this study was to understand the personal and professional factors that predict the trauma-related attitudes and beliefs of Christian clergy in the State of Florida as a first step in applying a trauma-informed care model to churches and other religious communities.

Participants (N = 235) completed an online survey that included measures of trauma-related attitudes and beliefs, trait emotional intelligence, personal trauma exposure, the completion of trauma-related training, and clergy job responsibilities (i.e., hours per week spent in counseling and pastoral care activities). Hierarchical multiple regression was utilized, and results showed that trauma-related training and trait emotional intelligence were statistically significant predictors of trauma-related attitudes and beliefs. Trauma exposure and clergy job responsibilities were not statistically significant predictors. In light of these findings, implications for mental health professionals, counselor educators, clergy training programs, and researchers are provided.

Keywords: trauma-informed care, complex trauma, clergy, pastoral care, trauma training, mental health, counselor education, trauma exposure, emotional intelligence

To survivors of trauma –
"The world is indeed full of peril, and in it there are many dark places;
but still there is much that is fair,
and though in all lands love is now mingled with grief,
it grows perhaps the greater."
J.R.R. Tolkien, *The Fellowship of the Ring*

To my students, clients, and counseling supervisees –
Your openness, courage, and kindness are astounding to witness.
Your willingness to struggle, grow, and learn brings deep joy to me in this work.

To the pastors, ministry leaders, and counselors
who have shepherded and cared for me –
Thank you for being the eyes, hands, and feet of God to me.

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CHAPTER ONE: INTRODUCTION

Epidemiological studies in the United States indicate that the majority of adults have been exposed to at least one significant traumatic event during their lifetime, with rates varying from 40-90%, depending on how trauma is defined and the sample demographics (Briere et al., 2016; Copeland et al., 2007; Finkelhor et al., 2005; Frans et al., 2005; McLaughlin et al., 2013; Merrick et al., 2018; Roberts et al., 2011). Among consumers of mental health services, lifetime trauma exposure rates are found to be as high as 91% (Cusack et al., 2004). However, many of these individuals present for services because of non-trauma-specific complaints, and approximately 80% of individuals diagnosed with post-traumatic stress disorder (PTSD) are also diagnosed with co-occurring mental health disorders such as depression (Byllesby et al., 2016), anxiety disorders (Knowles et al., 2019), substance use disorders (Mills et al., 2006), dissociative disorders (Brady, 1997), and personality disorders (Messman-Moore & Bhuptani, 2017).

Recent advances in understanding trauma's neurophysiological impacts (van der Kolk, 2014) along with the documented emergence of evidence-based treatments for addressing psychological trauma (Clark et al., 2015; Perry, 2009; van der Kolk, 2006) have brought a new awareness to the need for effective treatments for trauma. As a result of this surge in trauma-related research and the subsequent increase in trauma-related education for helpers, it is presumed that mental health practitioners are more cognizant than ever before that the experience of psychological trauma, and its resulting impact on brain and body, can disrupt an individual's life for many years after the actual traumatic event has ceased. While the wave of new trauma-focused treatments provides hope for those suffering from trauma's devastating effects, there is substantial evidence that the widespread experience of childhood psychological trauma alone has major implications for long-term public health (Felitti et al., 1998; van der

Kolk, 2014). For example, the economic burden of child maltreatment (just one form of trauma) in the United State for the year 2015 was calculated to be between $428 billion to $2 trillion, when considering both short and long-term health care costs, as well as the burden to the child welfare and criminal justice systems (Peterson et al., 2018). If all potential causes of trauma symptoms were considered (i.e., medical trauma, natural disasters, military combat, and intimate partner violence), the public health impact would be greater still.

Not all individuals who are exposed to potentially traumatizing events go on to develop adverse reactions; however, some will experience a brief acute stress reaction while others may have symptoms that meet the full criteria for PTSD. Survivors of childhood maltreatment, in particular, can develop a range of long-lasting symptoms that have been classified as *developmental trauma disorder* (van der Kolk, 2005) or *complex PTSD* (Cloitre et al., 2013). Complex traumatic responses are caused by long-term, repetitive exposure to interpersonal trauma (e.g., abuse and neglect) during critical stages of development (Ford & Courtois, 2009; van der Kolk, 2005). These adverse experiences, especially during childhood, impact a person's neurodevelopment in the areas of emotional regulation and information processing (Ford, 2009; Kindsvatter & Geroski, 2014; Messman-Moore & Bhuptani, 2017; Ogden et al., 2006). An adult with complex trauma may experience relational difficulties related to one's deficits in the areas of affect and impulse control, distorted self-perception, and tendency to dissociate (Ford & Courtois, 2009). Adults who experienced multiple adverse childhood experiences are also more likely to struggle with substance use (Dube et al., 2003), depression (Chapman et al., 2004), and suicidality (Dube et al., 2001) later in life. Thus, although complex PTSD is not contained as a unique diagnosis within the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.;

DSM-5; American Psychiatric Association, 2013), it is a widely recognized phenomenon and clinically useful distinction.

In order to focus research and funding efforts in the area of complex trauma resulting from childhood abuse, federally funded initiatives such as the National Child Traumatic Stress Network (NCTSN, n.d.) and the Interagency Task Force on Trauma-Informed Care (TIC Task Force), directed by the Center for Mental Health Services (Substance Abuse and Mental Health Services Administration, n.d.), have been created. The efforts of the NCTSN and the TIC Task Force have helped bolster the development of empirically supported treatments for PTSD and have facilitated the implementation of *trauma-informed care* (TIC) initiatives in many sectors of society. TIC efforts are based upon a recognition of the pervasiveness of trauma and its impact on private and public life. These efforts are taking root in diverse areas such as health care, human services, child welfare, education, and criminal justice. What distinguishes the TIC approach is that it goes beyond looking at how to provide trauma-specific treatment to individuals and, instead, is rooted in reforming systems to prevent ongoing trauma and to become more attuned to the needs of trauma survivors (Harris & Fallot, 2001). Trauma-informed systems are those that (a) demonstrate an awareness of the prevalence of trauma, (b) can readily identify manifestations of trauma in children and adults, (c) integrate knowledge about trauma throughout their practice, and (d) actively seek to avoid re-traumatizing trauma survivors (SAMHSA, 2014). With its systemic focus, the TIC movement has transferred the responsibility for caring for traumatized individuals away from being solely in the hands of mental health providers and into the public arena.

Background of the Study

Because of the multidimensional implications of childhood trauma on the individual,

including the physical and mental health challenges that are often co-morbid with traumatic stress, survivors of complex trauma may benefit from a multifaceted care team to assist them on the long road to healing (Barnes & Andrews, 2019; Murphy, 2010; Stevens et al., 2019). Such a team may be comprised of doctors, mental health professionals, members of the community, friends, and family and would be part of helping to mediate the pervasive difficulties experienced by survivors of child abuse and neglect. For survivors whose religion or spirituality is an integral part of their lives, members of the clergy may have an equally important role to play as part of the care team. As leaders of their congregations, clergy are frequently sought out for counsel or assistance by their parishioners.

Current studies on help-seeking behaviors indicate that 15%-40% of individuals in the United States and parts of Europe who experience mental health problems initially contact a member of the clergy for help rather than contacting a medical or mental health professional (Ellison et al., 2006; Kovess-Masfety et al., 2010; Wang et al., 2003). Similarly, clergy are frequently sought out for counsel regarding relationships and relational distress, a common area of concern for adults with complex trauma (Stewart et al., 2016). Among populations that are disproportionally impacted by traumatic stress, approximately 20% of military veterans report seeking assistance from clergy (Nieuwsma et al., 2014), while 15-40% of women who experience intimate partner violence turn to members of the clergy for counsel (Neergaard et al., 2007).

Considering the multifaceted helping roles that clergy assume, while recognizing the importance that religious organizations and systems (e.g., churches, synagogues, and non-profits) play in the lives of many individuals impacted by trauma, it is concerning that members of the clergy often do not receive sufficient training in mental health literacy or counseling skills

(Vermaas et al., 2017; Wilson, 2004). Clergy are often responsible for tasks as diverse as teaching, church administration, counseling, and leading children's programs while their education is primarily focused on the study of sacred texts and doctrines of their faith (Carroll, 2006). As such, clergy may be poorly equipped to provide competent care to congregants who turn to them in a time of distress related to psychological trauma or other mental health needs. While some clergy report a basic level of mental health literacy (Vermaas, 2016), little current scholarly literature exists related to the basic level of trauma awareness among clergy, much less the application of the trauma-informed paradigm to faith communities.

The large number of trauma-impacted individuals who seek help from clergy demonstrates that many individuals have a desire for healing after trauma to include "spiritually sensitive care" (Hipolito et al., 2014, p. 210; Callahan, 2013). Within the field of mental health care, spiritually sensitive care can be described in terms of a helper's *way of being* or particular sensitivity in the helping process (Canda & Furman, 1999; Benson et al., 2016; Callahan, 2013), as well as by the implementation of a specific set of basic competencies by the helper. From the perspective of what it means for a helper to embody a model of spiritually sensitive care, it includes authentic engagement with clients, compassion, responsiveness, and openness to engage with a client around profound existential questions, including how their spirituality and religion influence the issues they are facing (Benson et al, 2016; Callahan, 2013; Sperry, 2016). In terms of skills or competencies, spiritually sensitive care includes: (a) the helper's willingness and preparation to engage with clients' spiritual needs, (b) appropriate assessment of spiritual care needs, including referrals when needed, and (c) the use of interventions specifically designed to address the client's spiritual needs (Benson et al, 2016; Callahan, 2013; Sperry, 2016).

Because of their positions of leadership within their faith communities, clergy could be

well-situated to lead the way in providing front-line, trauma-informed, pastoral care to people in their congregations and communities, and yet they need the appropriate training. While not mentioning clergy specifically, Ko and colleagues (2008) suggested that trauma-informed helpers in various community contexts can play an import role in, "accurate risk detection and case identification; triage of clients to appropriate interventions; continuity of care across providers; and facilitation of staged, multisystemic, or flexible interventions for high-risk, treatment-refractory, or culturally diverse populations" (p. 401). However, in order to participate competently in the tasks listed by Ko and colleagues (2008), clergy must first be equipped for the task of trauma-informed care.

Clergy education and training varies greatly between denominations and religious traditions, ranging from apprenticeships (with no formal higher education) to advanced graduate degrees (Carroll, 2006). Formal clergy training has often focused on the study of religious doctrines and sacred texts, as well as the skills needed to teach others from those texts, rather than on auxiliary areas of knowledge and skills such as leadership, pastoral counseling, and administration (Holifield, 2007). Within areas related to preparing clergy to counsel, existing literature demonstrates that clergy vary in their levels of counseling training, counseling self-efficacy (Marks, 2013), mental health literacy (Vermaas, 2016), and mental health referral patterns (McMinn et al., 2005). Only two studies were found related to clergy's perceptions to work with particular mental health concerns, and both pertain to depression (Hedman, 2014; Payne, 2009). Studies evaluating clergy's knowledge of other specific mental health diagnoses (i.e., anxiety disorders, personality disorders) could not be found. Furthermore, a review of the literature revealed only one study pertaining to the readiness of clergy to provide care to those experiencing traumatic stress (Scott, 2013).

The majority of the aforementioned clergy-focused mental health studies in North America examine the training and beliefs of Christian clergy exclusively, although a few have included clergy from other faiths (Constantine et al., 2004; Mason et al., 2016). The lack of research related to non-Christian faith leaders may be due to the prevalence of adherence to Christianity (70.6%, Pew Research Center, 2015) in the United States, and thus Christian clergy, when compared to leaders from other faith traditions, are more accessible for research. In light of these limitations, and due to the author's interest in advocacy for trauma care in Christian congregations, this study will focus exclusively on Christian clergy.

Individuals impacted by traumatic stress can be found in the pews of American Christian churches, just as they can be found in every religious and secular institution. Help-seeking studies indicate that many of these survivors may never seek care from a mental health care professional (Wang et al., 2006). Thus, clergy have the opportunity to be among the first to recognize symptoms of traumatic distress among their parishioners and to accompany survivors along the long road towards recovery. Some previous scholarship has examined the role of clergy as crisis responders after natural and community disasters (Leavell et al., 2012; McCabe et al., 2008) or as referral sources for individuals suffering from PTSD (Weaver, 1993; Weaver et al., 1996), but no recent empirical studies were found related to the level of trauma-related knowledge of clergy nor the potential role clergy may play in providing trauma-informed pastoral care for survivors of complex trauma.

The trauma-informed care movement, which is largely concerned with trauma-related attitudes and beliefs of human services providers (rather than *trauma-specific* psychological treatment) has mainly grown around the needs of survivors of complex interpersonal trauma, rather than survivors of other forms of trauma (Clark et al., 2015; SAMHSA, 2014). Although

survivors of complex trauma share some post-traumatic stress characteristics with survivors of other types of traumas, the long-term consequences of complex trauma (i.e., difficulty with affect regulation, interpersonal disturbances, and negative self-concept) are less widely known and understood than the symptomology of classic PTSD. Churches are highly relational contexts in which these areas of intrapersonal (i.e., difficulty with affect regulation, negative self-concept) and interpersonal (i.e., relationship) difficulty may be exposed and misunderstood by those who lack an understanding of complex trauma. More than half of the adult population reports experiences of interpersonal trauma in childhood (Felitti et al., 1998; McCall-Hosenfeld et al., 2014); and, while some of these individuals may never meet the diagnostic criteria for PTSD, a significant number of these survivors will be profoundly impacted in the way they view themselves, manage their emotions, and relate to others because of their history of traumatic experiences (Cloitre et al., 2013; Kindsvatter & Geroski, 2014).

The application of a trauma-sensitive (Baldwin, 2018; Hunsinger, 2015) or trauma-informed care (Gingrich, 2018; Streets, 2015) model to the church has been explored conceptually and theologically, however no current empirical research considers the task of beginning to apply the trauma-informed care model to churches. While most clergy will not become experts in trauma *treatment* (as admittedly, that is not their role), it is possible for clergy to become *trauma-informed* to the extent that they (a) know enough to recognize symptoms of trauma (including complex trauma), (b) are able to avoid retraumatizing parishioners, and (c) can refer congregants to mental health professionals for ongoing care when appropriate. Ko and colleagues (2008) recommended that all systems providing services for children and families implement a trauma-informed approach. Since churches and religious institutions in the United States are organizations within which helpers (e.g., pastors, priests, and other clergy) operate,

churches have the potential to function as trauma-informed systems in order to create spaces for healing, rather than institutions that perpetuate the ongoing traumatization of individuals, families, and communities (Jones, 2009). While contemporary Christian theologians are exploring the role of the church in engaging trauma and developing a theological understanding of the impact of trauma (Arel & Rambo, 2016; Baldwin, 2018; Hunsinger, 2015; Jones, 2009; Langberg, 2015; Rambo, 2010; Worringer, 2018), little is empirically known about the trauma-related attitudes and beliefs of Christian clergy in the United States, nor the factors that influence these attitudes and beliefs (Scott, 2013). Understanding the trauma-related attitudes and beliefs of Christian clergy is the first step in understanding how to effectively develop and implement training in trauma-specific knowledge and skills which could be beneficial for pastors and their congregations.

Statement of the Problem

As leaders of faith communities, Christian clergy perform a wide variety of duties, to include providing individual pastoral care to their parishioners, preparing and delivering sermons, training staff and volunteers, administering the organization, and influencing how programs are organized (Carroll, 2006). If clergy operated in a trauma-informed manner in each of these contexts, they could establish their faith communities as places of safety and healing for trauma survivors (which, as has been noted, includes a significant portion of their congregants), rather than systems that are ignorant of the impacts of trauma (which may perpetuate retraumatization) (Streets, 2015).

In all arenas, the establishment of a trauma-informed system begins with raising awareness, influencing attitudes and beliefs, and imparting knowledge (Harris & Fallot, 2001). For example, in the field of education, common attitude and knowledge areas addressed in TIC

trainings include: (a) statistics on the prevalence of trauma among children, (b) a basic knowledge of how brain science informs the most effective ways for educating children who have experienced trauma, (c) the perspective that problematic behaviors are a reflection of what the child has experienced, rather than an intrinsic problem with their character; and (d) a focus on equipping the child with skills needed for emotional regulation, rather than shaming or punishing the child (Wilcox, 2012).

Building trauma-informed churches would necessarily begin by increasing trauma awareness and knowledge, beginning with church leaders. Attitudes and knowledge areas that need to be addressed in training clergy may bear similarities to those needed for educators (e.g., the prevalence of trauma, the impact of trauma on the brain, recognizing the differences between PTSD and complex trauma). However, clergy could also benefit from increasing their awareness around such church-specific issues as: (a) how teaching on particular biblical texts or theological concepts may impact trauma survivors, (b) providing trauma care resources to their communities, and (c) understanding the potential benefits and limitations of pastoral counseling for someone who has experienced complex trauma. While there is evidence that clergy (a) receive varying amounts of training in general counseling skills (Marks, 2013), (b) differ in their level of awareness related to mental health issues (Vermaas et al., 2017), and (c) have minimal training in trauma-specific helping skills (Scott, 2013; Weaver, Koenig, & Ochberg, 1996), little is known about the trauma-related attitudes and beliefs of Christian clergy within the United States (Scott, 2013). Knowing these attitudes and beliefs is a necessary step toward helping to shift the climate within churches to help them to become more trauma-informed systems.

In order to develop avenues for training clergy, which can effectively influence their trauma-related attitudes and beliefs, it will be important to understand the degree to which

specific factors affect those attitudes and beliefs. Regarding the trauma-related attitudes and beliefs of Christian clergy, potential influencing factors include (a) the personal experiences and emotional health of the clergy member, (b) his/her exposure to training and pastoral care experiences related to both general counseling and trauma-specific pastoral care tasks, and (c) the intersection of his/her theological beliefs about suffering with his/her attitudes related to trauma survivors. This study will seek to gain a better understanding of the first two of these factors by examining how Christian clergy's personal experiences and professional training influence their trauma-related attitudes and beliefs. This research will inform the future goals of (a) understanding the role of theological beliefs in forming trauma-related attitudes and (b) the development of effective and efficient training resources for clergy. Ultimately, it is this author's hope that trauma-informed clergy can lead the way in creating trauma-informed congregations, which in turn can serve as communities of healing for survivors of complex trauma.

Constructs

The selection of variables in a correlational study is guided by a theoretical framework that determines which factors may be related to the selected construct (dependent variable) and how these factors may be related. In this study, the selection of variables is guided by the TIC framework (Harris & Fallot, 2001; SAMHSA, 2014), along with an understanding of counselor education that is grounded in existential and humanistic theories of counseling (Elliot & Greenberg, 2007; Rogers, 1980; Yalom, 1980; Yalom & Leszcz, 2005). The existential-humanist framework considers the need to address both the personal development of the helper, as well as the helper's professional education and training experiences. Thus, the selection of variables for this study was guided by existing scholarly literature related to TIC in other helping professions, along with an existential-humanist model of educating helpers.

As a first step towards understanding the level of overall competence that clergy have in the area of trauma-informed care, this study will examine the attitudes and beliefs of Christian clergy regarding psychological trauma. Competence in any particular area is generally comprised of a set of domain-specific attitudes, knowledge, and skills. For example, within the field of professional counseling, various divisions of the American Counseling Association have previously developed competencies that have served to strengthen the profession and provide benchmarks for counselor educators in preparing future helpers to work with particular issues or populations (e.g., the Multicultural and Social Justice Counseling Competencies [Ratts et al., 2015], the Competencies for Addressing Spiritual and Religious Issues in Counseling [ASERVIC, 2009; Cashwell & Watts, 2010], and the Competencies for Counseling LGBQQIA Individuals [ALGBTIC LGBQQIA Competencies Taskforce et al., 2013]). Each set of competencies addresses important areas of knowledge about the topic; the practitioner's self-awareness of their attitudes, beliefs, and limitations related to the area; and specific skills needed to function competently within that domain. As a first step towards understanding the overall TIC competency of clergy, the current study will consider their trauma-related attitudes and beliefs, as a precursor to later developing ways to measure and understand the other areas of TIC competence (i.e., knowledge and skills).

In order to understand the trauma-related attitudes and beliefs held by Christian clergy, from the perspective of TIC competence, it is important to examine clergy's training and experiences as they relate to mental health, counseling, and trauma. For example, studies examining trauma-related attitudes and beliefs in other systems (e.g., child welfare, juvenile justice, education, and behavioral health) have considered factors such as trauma-specific training, trauma-related self-efficacy, years of prior working experience, and educational degree

(Donisch et al., 2016; Kenny et al., 2017; Sullivan et al., 2016). While there are limited existing TIC clergy studies (Krotz, 2019; Mills Kamara, 2017) to refer to, previous research related specifically to clergy and general counseling knowledge or self-efficacy have considered variables such as denomination, educational degree, position/job title, counseling-specific training, counseling self-efficacy, years in pastoral ministry, and time spent per week in counseling activities (Hedman, 2014; Marks, 2013; McMinn et al., 2005; Watson, 1992). In an effort to understand how these professional factors influence the trauma-related attitudes and beliefs of clergy, similar variables will be considered in this study under the domain of professional training and experience.

In addition to TIC, the other framework that guided the structure of this study was existential-humanistic theory. The existential-humanist theory of education emphasizes that competence as a professional helper (e.g., pastor, counselor, and educator) involves more than the knowledge and skills that can be learned in a classroom; it also requires the ongoing personal and professional development of helpers as they engage in the practice of helping others (Farber, 2014). In his seminal work, Carl Rogers (1961) emphasized the core conditions that form a foundation for learning, both in educational and counseling settings: congruence, empathic presence, acceptance, trust, and respect. In Roger's view, the focus of education for professional helpers should be on the *person of the helper* and facilitate the helper's (a) self-understanding, (b) self-confidence as a helper, and (c) understanding of the process of change (Lambers, 2013). The utilization of the existential-humanist framework led to the inclusion of variables in this study that examine the personal experiences and development of clergy.

In light of the theoretical frameworks discussed above, the author of this study seeks to understand how the trauma-related attitudes and beliefs of Christian clergy are influenced by

both personal and professional factors. However, first, it is important to understand the significance of examining the formation of trauma-related attitudes and beliefs (as opposed to other aspects of TIC competency) in this study.

Trauma-Related Attitudes and Beliefs

As a first step in examining the current level of trauma-informed competence among clergy, this study will consider clergy's attitudes and beliefs about the origins, prevalence, and treatment of psychological trauma. The lack of an agreed upon set of TIC competencies for clergy means that defining the construct of trauma-related attitudes and beliefs in the current study required the researcher to look to other helping professions for guidance in defining the construct. For example, it would be helpful to consult published competencies for trauma-informed mental health or school counseling, however none exist at this point in time. For psychologists who specialize in the area of treatment of trauma, there is an agreed upon extensive set of trauma competencies (Cook & Newman, 2014); however, these competencies are too technical and advanced to provide guidance in the current study, which focuses on trauma-informed *care* rather than trauma-specific mental health *treatment*.

Regardless of the setting or profession, it is widely agreed that the foundation of trauma-informed practice is the cultivation of trauma-informed attitudes and beliefs (Baker et al., 2016). For this study, trauma-related attitudes and beliefs were defined as a person's beliefs about the causes, prevalence, and impact of psychological trauma and attitudes towards trauma survivors; furthermore, they include "beliefs about resilience, recovery, and healing from trauma" (Baker et al., 2016; SAMHSA, 2014, p. 10). Without the existence of these attitudes and beliefs, the further development of trauma-informed knowledge, skills, and practices is unlikely. So, while TIC competency for clergy ultimately includes trauma-related attitudes, knowledge, and skills,

this study will focus solely on the trauma-related attitudes and beliefs which have frequently been the focus of previous trauma-informed care research and training in other helping professions. It is hypothesized that attitudes and beliefs will be a primary influence on how a member of the clergy interacts with and counsels trauma survivors (Baker et al., 2016); therefore, it is important to understand what factors can influence these attitudes and beliefs.

An understanding of trauma-related attitudes and beliefs among clergy can lead to the development of future studies that examine how these lead to an increase in trauma-related knowledge and the development of trauma-informed pastoral care skills among Christian clergy. Finally, in order to understand the development of trauma-informed attitudes and beliefs among Christian clergy, this study will examine a number of personal (i.e., personal trauma history; emotional intelligence) and professional (i.e., trauma-specific training; hours spent per week in counseling-related activities) factors that may influence these attitudes and beliefs. A brief review of each of these factors is provided below.

Personal Factors

Personal Trauma History

A person's personal trauma history includes both their lifetime exposure to potentially traumatic events, as well as any post-traumatic stress symptoms they have experienced. The personal experiences of a pastor or priest with trauma may be a factor in forming their current trauma-related attitudes and beliefs. For those in helping professions, it has been demonstrated that prior personal trauma history can impact a person's empathy towards others who have experienced trauma, susceptibility to vicarious trauma, and self-perception (Wilson & Thomas, 2004). Furthermore, individuals without a trauma history may be less likely than those who have experienced trauma to believe the disclosures of trauma victims (Cromer & Freyd, 2009). It is

hypothesized that the personal experience of trauma will influence the trauma-related attitudes and beliefs of Christian clergy.

Emotional Intelligence

Emotional intelligence (EI) involves the ability to recognize, understand, utilize, and manage emotions (Salovey & Mayer, 1990). The concept was popularized by Goleman (1995, 1998) who defined emotional intelligence as, "the capacity for recognizing our own feelings and those of others, for motivating ourselves, and for managing emotions well in ourselves and in our relationships" (2005, p. 43). The two main components of EI are personal emotional competence (e.g., self-awareness, internal motivation, and emotional self-regulation) and social/relational competence (e.g., social skills and empathy). Both of these components are relevant to the discussion of the trauma-related attitudes and beliefs of Christian clergy, as trauma – by definition – involves an *emotional* response to an overwhelming situation.

Repeated studies have shown that clergy, as a group, have a level of EI that is below the mean score for the broader population (Francis, 2019). However, EI is also understood to be a malleable trait that can be influenced by training (Goudarzian et al., 2019; Schutte et al., 2013; Vesely et al., 2014). If EI is found to be an important factor in the formation of trauma-related attitudes and beliefs among Christian clergy, it is possible that further training in EI skills could increase the ability of clergy to provide trauma-informed pastoral care in the future. It is hypothesized that the level of emotional intelligence possessed by a member of the clergy will influence their trauma-related attitudes and beliefs.

Professional Factors

Trauma-Related Training

In many Christian denominations, clergy are required to hold advanced degrees designed to prepare them for pastoral work, while other denominations do not require clergy to have formal theological or ministry training (Lonsway, 2007). Among congregations in the United States, 71.4% are led by a paid, full-time clergyperson (Chaves & Eagle, 2015). The Master of Divinity (M.Div.) degree is a professional degree, and it is the most commonly sought graduate degree in the United States for those pursuing pastoral ministry (Tanner, 2019). M.Div. programs at divinity schools and seminaries require students to complete between 72-106 credit hours, including topics such as ancient languages (Greek and Hebrew), the Bible, and theological studies (doctrines derived from the Bible).

Most schools that offer M.Div. degrees also require some coursework in practical theology (e.g., church growth, administration, spiritual formation, and religious education) or church leadership. In the United States, pastors spend an average of 6-10 hours per week providing congregational care (e.g., counseling, hospital visits, weddings, and funerals; Kopacz, 2012; LifeWay Research, 2009; Lonsway, 2007), yet M.Div. programs accredited by the Association of Theological Schools (ATS) are not required to include any designated coursework in pastoral care or pastoral counseling in the required curriculum (*personal communication*). Among seminary graduates who have an M. Div. from an ATS member school, the areas they most wished they had received more training in during their education included: (a) leadership, 18%, (b) pastoral care and counseling, 13%, (c) conflict resolution, 9%, and (d) intrapersonal competency, 7% (Lin & Gin, 2017). Each of these areas is in some way related to emotional, mental, or relationship development. In some cases, clergy may choose to complete

concentrations in pastoral care or pastoral counseling, an additional degree in counseling or psychology, clinical pastoral education (required for chaplains), or certifications in pastoral counseling (West, 2016). Whereas it is unknown how much trauma-specific content is included in any of these degree programs, it is hypothesized that the amount of trauma-specific training received will influence the trauma-related attitudes and beliefs of Christian clergy.

Hours Spent Per Week in Counseling-Related Activities

Clergy may fulfill a variety of roles within their churches, depending on the denomination, location, and size of their congregations (Kopacz, 2012) and often work long hours in order to meet the needs of their congregations. A 2016 survey of 8,150 ministers revealed that 54% of respondents worked over 55 hours per week, including 18% who reported working over 70 hours per week (Krejcir, 2016). One reason for these long hours is that clergy may have a wide variety of duties and responsibilities. For example, a pastor of a small rural church may be the only staff member at the church and may therefore be in charge of the preaching during weekly worship services, caring for the needs of parishioners (i.e., visiting the sick and counseling those in crisis), organizing youth activities, and conducting administrative duties. At larger churches, pastors may have a more specialized role (e.g., teaching pastor [focusing primarily on preaching], pastor of congregational care [focusing primarily on addressing the needs of members of the congregation], and executive pastor [leadership and administration]).

Pastors who dedicate more time per week to counseling generally have greater counseling self-efficacy than those who spend less time providing counseling care (Orthner, 1986; Polson & Rogers, 2007). Researchers surveyed Protestant pastors from more than 50 churches in Texas and found that the average time spent in direct counseling activities per week was two hours

(Polson & Rogers, 2007). Pastors and other staff members in larger churches spent significantly more time providing counseling than those in smaller congregations (Polson & Rogers, 2007), perhaps because there are a greater number of members who need care, but also due to the ability to delegate other tasks to church staff which may give clergy the flexibility to spend more time providing counsel. It is likely that clergy who spend more time counseling parishioners may work directly with individuals impacted by mental health concerns more frequently, and this may influence their attitudes and beliefs regarding trauma and other mental health topics. It is hypothesized that trauma-related attitudes and beliefs may be influenced by how much time clergy spend engaging in counseling or pastoral care activities.

Relationship Between Constructs

In summary, after a review of the literature, it is hypothesized the following factors are likely to be related to clergy's trauma-related attitudes and beliefs (which will be the dependent variable): (a) personal trauma history, (b) emotional intelligence, (c) trauma training, and (d) hours spent per week in counseling-related activities: each will be considered as independent variables. In an effort to contextualize the survey responses, an additional analysis of socially desirable responding bias will be included in the study (Holtgraves, 2004).

Research Questions

In order to better understand the factors that influence the disposition of clergy towards psychological trauma, this study will investigate those factors which are believed to predict the trauma-related attitudes and beliefs of Christian clergy in the United States. The primary research question to be considered in this study is:

Primary Research Question

After controlling for the effects of socially desirable responding bias (as measured by the *Marlowe-Crown Social Desirability Scale – Short Form* [MCSDS-X1; Strahan & Gerbasi, 1972]), how much of the variance in the trauma-related attitudes and beliefs of Christian clergy (as measured by the *Attitudes Related to Trauma-Informed Care -10, Human Services* scale [ARTIC-10-HS; Baker et al., 2016]) can be explained by clergy's personal trauma exposure (as measured by the *Brief Trauma Questionnaire* [BTQ, Schnurr et al., 1999]), trait emotional intelligence (as measured by the *Trait Emotional Intelligence Questionnaire– Short Form* [TEIQue-SF; Cooper & Petrides, 2010]), trauma-related training (as assessed on demographic questionnaire), and time per week spent in counseling-type ministry (as assessed on demographic questionnaire)?

Exploratory Research Questions

There are three exploratory research questions to be considered in this study. These include:

RQ2: Are there significant differences in the trauma-related attitudes and beliefs of Christian clergy based on religious affiliations; race or ethnicity; or having an advanced degree or certification in a counseling-related field? If yes, what are the differences?

RQ3: Are there significant differences in the level of emotional intelligence of clergy based on religious affiliations; race or ethnicity; or having an advanced degree or certification in a counseling-related field? If yes, what are the differences?

RQ4: What is the prevalence of trauma exposure among clergy?

Significance of the Study

The overall goal of this study is to investigate the variance in trauma-related attitudes and beliefs among Christian clergy. This study has the potential to help design pathways towards developing trauma-informed clergy, who can then lead their churches and organizations to become trauma-informed systems, which in turn can better meet the needs of trauma survivors within their communities. Trauma-informed clergy can help their congregants and communities when they (a) have the ability to recognize trauma symptoms, (b) have an awareness about trauma that helps prevent the retraumatization of their parishioners, and (c) provide referrals for congregants to appropriately trained mental health professionals for ongoing trauma care as needed. Understanding the personal, professional, and theological factors that influence the trauma-related attitudes and beliefs of clergy can allow leaders of seminaries, divinity schools, and other clergy training institutions to have a better understanding of how to train clergy to become more trauma-informed. Finally, the results of this study may help counselors and counselor educators to better understand (a) the role of clergy in providing spiritually sensitive care to trauma survivors and (b) the potential role of counselors and counselor educators in equipping clergy to gain increased knowledge and self-efficacy in the area of trauma care. Future research could explore the impact of trauma-informed training for clergy on clergy's trauma-related attitudes and trauma-specific counseling self-efficacy.

Operational Definition of Terms

Adverse Childhood Experiences (ACEs): Early life experiences such as neglect, physical or sexual abuse, the incarceration of a parent, or mental illness in the home that have been shown to predict long-term negative physical and mental health outcomes (Felitti et al., 1998).

Clergy: Pastors, ministers, priests, and other religious leaders who serve both within religious institutions (e.g., churches, synagogues, and temples) as well as in roles such as hospital or military chaplain, religious educators, or seminarians.

Complex Trauma: Exposure to multiple or ongoing traumatic experiences during childhood, including but not limited to abuse, neglect, domestic violence, community violence, and war. This early trauma has a pervasive impact on a child's ability to form a secure attachment with primary caregivers, ultimately resulting in ongoing difficulties in emotional self-regulation and interpersonal relationships (Cook et al., 2005). Also known as *Complex PTSD* (Cloitre et al., 2009) or *Developmental Trauma Disorder* (van der Kolk, 2005).

Emotional Intelligence (EI): Emotional intelligence involves the ability to recognize, understand, utilize, and manage emotions in ourselves and in our relationships (Salovey & Mayer, 1990; Goleman, 2005).

Spiritually Sensitive Care: Mental health care provided by a helper who embodies compassion, responsiveness, and openness to engage with a client around profound existential questions, including those related to spirituality and religion; as well as the competency to effectively assess and engage with a client's spiritual needs (Callahan, 2013; Benson et al, 2016; Sperry, 2016).

Trauma Exposure (TE): The types and amount of potentially traumatic events, as well as the degree of severity of these events, that a person has experienced or witnessed during their lifetime. Trauma exposure is sometimes followed by an acute or post-traumatic stress response (National Center for PTSD, n.d.)

Trauma-Informed Care (TIC): Services provided by a program, organization, or system that, "realizes the widespread impact of trauma and understands potential paths for healing;

recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings" (SAMHSA, 2014, p.11).

Trauma-Related Attitudes and Beliefs (TRAB): A person's beliefs about the causes, prevalence, and impact of psychological trauma and attitudes towards trauma survivors; furthermore, they include "beliefs about resilience, recovery, and healing from trauma" (Baker et al., 2016; SAMHSA, 2014, p. 10).

Trauma-Specific Services: Interventions designed to treat the actual sequelae of traumatic experiences such as abuse, domestic violence, or natural disasters. These treatment models are evidence-based and designed to lessen the individual's experience of distressing symptoms related to their trauma exposure (Jennings, 2008).

Chapter Summary

This chapter has provided an overview of the proposed study, including a discussion of complex trauma, trauma-informed care, mental health help-seeking from clergy, the trauma-related attitudes and beliefs of Christian clergy, and potential factors influencing those attitudes and beliefs. Constructs such as personal trauma history, emotional intelligence, the training of clergy, and the job roles of clergy have been considered in relation to how they may influence the trauma-related attitudes and beliefs of Christian clergy. This chapter aimed to provide the rationale for studying the trauma-related attitudes and beliefs of Christian clergy and the need to address this gap in the literature before beginning to provide TIC training to clergy. Chapter 2 will provide a thorough review of the literature related to these constructs.

CHAPTER TWO: LITERATURE REVIEW

The literature review found in Chapter Two begins with a brief overview of the theoretical framework for this study, as well as a consideration of the constructs of complex post-traumatic stress and religious preferences in psychological help-seeking behaviors as foundational to the significance of this study. Subsequently, both theory and research related to trauma-informed helpers are considered before examining the (a) personal [i.e., emotional intelligence and trauma history] and (b) professional [i.e., training in counseling and time spent in counseling activities] factors that may influence trauma-related attitudes and beliefs among Christian clergy.

Theoretical Framework

This study considers the formation of the trauma-related attitudes and beliefs of individual pastors, priests, ministers, and other clergy, while acknowledging that these individuals function within larger systems at the levels of the local church congregation, broader denominational systems, and clergy educational institutions (e.g., seminaries and bible colleges). Therefore, the theoretical framework for this study is two-dimensional. First, the lens of trauma-informed care is used to frame the discussion of clergy as members of systems that may or may not function according to trauma-informed principles. Secondly, existential-humanistic counseling theory highlights the importance of the *person of the helper* and the need to include factors relating to the personal experiences, as well as the emotional and relational capacities, of each pastor or priest.

Trauma-Informed Care

Over the past 25 years, a movement towards providing *trauma-informed care* has gained momentum in the fields of mental health care, education, corrections, primary care, social services, school systems, and beyond (Clark et al., 2015). After a decade of research and development, the Substance Abuse and Mental Health Services Administration (SAMHSA) created the National Center for Trauma-Informed Care in 2005, making a commitment to improve public behavioral health services to individuals impacted by trauma (SAMHSA, n.d.). The trauma-informed care movement recognizes that trauma survivors need assistance and support from a multisystemic perspective. Healing and growth for survivors of complex trauma will likely involve both trauma-informed physical and mental health care and may also include "spiritually sensitive care" from religious leaders who are part of the individual's broader social support system (Hipolito et al., 2014, p. 210; Callahan, 2013).

The trauma-informed care movement is historically rooted in reforming systems to become more attuned to the needs of trauma survivors (Harris & Fallot, 2001). While traditionally these principles have been applied in educational and health care settings, the trauma-informed paradigm can be applied to churches and other religious systems (Mills Kamara, 2017). Streets (2015) suggested that characteristics of trauma-informed churches may include: (a) clergy who have a fundamental understanding of psychological trauma and its potential impact on people across multiple domains (e.g., social, spiritual, emotional, relational, physical, etc.), (b) leaders who consider the implications of trauma on various aspects of church life (e.g., religious rituals, preaching, leadership structures), (c) clergy that collaborate with other helpers in the community to provide resources and referrals for trauma survivors, and (d) leaders that apply the spiritual wisdom and religious traditions of the faith to help support and comfort trauma survivors. Moreover, it is essential that church leaders "understand the vulnerability of

people and the tenuous nature of their sense of safety" (Streets, 2015, p. 479). For example, in a trauma-informed system, clergy strive to model healthy boundaries in their interactions with parishioners, recognizing that individuals with a history of complex trauma may tend to struggle with appropriate boundary setting (Courtois & Ford, 2009). Furthermore, trauma-informed clergy are aware of the inherent power differential that exists between a spiritual leader and members of their community.

Existential-Humanistic Theory

While the current research study is grounded in a systemic, trauma-informed care paradigm, it also acknowledges that the individual experiences and characteristics of each pastor, priest, or minister will influence their trauma-related attitudes and beliefs, which will in turn impact their effectiveness in caring for trauma survivors. To that end, systemic models for providing care to trauma survivors work in tandem with established counseling and psychological theories related to human development, psychopathology, and healing. The existential-humanistic (E-H) approach to counseling, psychotherapy, and education emerged in the mid-20th century and, in contrast to the prevailing psychoanalytic and behavioral schools, E-H theory emphasized the personal, therapeutic relationship that allowed helpers to contextually and holistically understand each individual with whom they interacted (Krug & Schneider, 2016; Messer & Gurman, 2011). Today, E-H psychotherapy is considered one of the main therapeutic schools (Watkins, 2012) and has broadly impacted the helping professions.

In light of E-H theory, the current study recognizes the need to consider personal elements (related to the *person of the helper*) in addition to systemic factors when exploring factors that may influence the trauma-related attitudes and beliefs of Christian clergy. For example, elements such as an individual's personal trauma history and self-awareness regarding

the impact of these experiences may be significant in the development of trauma-related attitudes and beliefs. Furthermore, an individual's current level of emotional intelligence may contribute to their ability to view trauma survivors with empathy and understanding.

Psychological Trauma and Post-Traumatic Stress

Having considered the theoretical framework for the current study and in order to understand the significance of this study, it is essential to explore (a) the distinctions between simple and complex PTSD, (b) the impact of widespread trauma on public health, (c) the provision of care to trauma survivors, and (d) patterns in psychological help-seeking behaviors. Across multiple research settings and with diverse populations, researchers have confirmed that 40%-90% of all adults have been exposed to traumatic events, with the clinical population falling in the top of that range (Briere et al., 2016; Cusack et al., 2004; Merrick et al., 2018). As a result of trauma exposure, many individuals experience symptoms of acute stress or post-traumatic stress, and 3%-16% will meet the full diagnostic criteria for PTSD (Alisic et al., 2014; Gulliver et al., 2021; Lowell et al., 2018) set forth in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed. [*DSM-5*]; American Psychiatric Association [APA], 2013).

Post-Traumatic Stress Disorder

Exposure to trauma is the first of five criteria required for a diagnosis of PTSD, according to the *DSM-5* (APA, 2013); traumatic events could include death, threatened or actual physical harm, and sexual assault. According to the APA (2013), exposure to trauma can happen in any of the following ways: (a) direct experience, (b) observing the event, (c) hearing that a loved one was directly exposed to a trauma, or (d) repeated, indirect exposure to details of trauma. The final category (e.g., indirect exposure) applies to those who are exposed to the details of

traumatic events, often in a professional capacity, and includes first responders such as emergency medical technicians, police officers, and mental health care providers.

In addition to exposure, the APA (2013) noted additional criteria for a PTSD diagnosis. The second criterion for PTSD is that the individual re-experiences the traumatic event emotionally, cognitively, or physically; this could include flashbacks, nightmares, intrusive thoughts, emotional distress, or physical reactivity. Avoidance of trauma-related stimuli is the third criterion, while negative thoughts and feelings related to the trauma is the fourth. Finally, an individual with PTSD experiences hyperarousal or increased reactivity (e.g., irritability, difficulty concentrating, increased startle response). These symptoms of re-experiencing, avoidance, and hyperarousal must last for more than one month and cause significant impairment or distress in order to meet the diagnostic criterion for PTSD.

The traditional diagnostic criterion for PTSD can be described as a response to *simple trauma* (that is trauma due to a single event; Zyromski et al., 2018). However, clinicians and researchers have found that individuals who were exposed to multiple adverse experiences early in life demonstrate a level of impairment that is more pervasive and complex than individuals who have developed PTSD in reaction to a one-time traumatic event (Cook et al., 2005). The cluster of symptoms experienced by those who have experienced repetitive trauma has been called *complex PTSD* or *developmental trauma disorder* (van der Kolk, 2014).

Complex Trauma

Although the diagnosis of complex traumatic stress disorder, as distinct from PTSD, is not contained within the *DSM-5* (APA, 2013), complex trauma is a widely recognized phenomenon and clinically useful distinction (Ford, 2017). Complex PTSD is included as a diagnosis in the most recent edition of the *International Classification of Diseases* (ICD-11;

World Health Organization, 2019). Complex traumatic responses primarily result from extended, repetitive exposure to interpersonal trauma (e.g., abuse, neglect) during early developmental stages (Ford & Courtois, 2009; van der Kolk, 2005). When these adverse experiences occur during childhood, a child's neurodevelopment is impacted, particularly in the areas of emotional regulation and information processing (Ford, 2009; Kindsvatter & Geroski, 2014; Ogden et al., 2006). While chronic experiences of trauma later in life may also lead to a complex trauma response, trauma experienced in childhood has been demonstrated to have the furthest reaching implications on long-term development and functioning (Cross et al., 2017; National Scientific Council on the Developing Child, 2020; Noteboom et al., 2021; Shonkoff et al., 2012). In addition to the classic symptoms associated with PTSD (i.e., avoidance; re-experiencing; alterations to cognition and mood; and increased arousal), an adult impacted by complex trauma may experience (a) long-term relational difficulties related to deficits in the areas of affect and impulse control, (b) distorted self-perception, and (c) a tendency to dissociate (Ford & Courtois, 2009). Adults who experienced multiple adverse childhood experiences are also more likely to struggle with substance abuse, depression, and suicidality (Chapman et al., 2004; Dube et al., 2001; Felitti et al., 1998; Leza et al., 2021; Noteboom et al., 2021).

Public Health Outcomes

The trauma-informed care movement has been energized by research, such as the Center for Disease Control-Kaiser Permenente's Adverse Childhood Experience Study (Felitti et al., 1998), which demonstrated that psychological trauma is a major public health issue. Peterson and colleagues (2018) calculated that the annual economic cost of childhood maltreatment in the United States is between $28 billion to $2 trillion. This figure takes into account the short-term and long-term health care costs associated with the impact of childhood trauma, as well as the

cost of providing social services to trauma survivors in the child welfare and criminal justice systems. The occurrence of mental health and substance use disorders in adulthood increases exponentially in correlation with the number of adverse childhood experiences experienced by an individual (Calmes et al., 2013; Chapman et al., 2004; Danese & Baldwin, 2017; Dube et al., 2003; Felitti et al., 1998; Leza et al., 2021; Noteboom et al., 2021). When combined, mental health and substance use disorders comprise the category of chronic health conditions that have the highest annual public health care costs in the United States (Dieleman et al., 2016; National Scientific Council on the Developing Child, 2020).

Over half of the adult population reports experiencing the kind of interpersonal trauma in childhood that can lead to complex traumatic stress in adulthood (Felitti et al., 1998; Huh et al., 2014; Karam et al., 2014). Complex traumatic stress challenges the resources of public health care systems since symptoms of complex trauma may present in a manner that is less recognized by health care providers than the symptomology of simple PTSD and because the need for counseling and other forms of treatment may extend over a longer period of time (Courtois & Ford, 2013; Oral et al., 2016). The trauma-informed care movement has largely grown around the needs of survivors of complex interpersonal trauma (Clark et al., 2015; SAMHSA, 2014). Therefore, complex trauma has been selected as a focus for this study both due to the prevalence of the experience of interpersonal trauma in childhood (Felitti et al., 1998; Karam et al., 2014) and the ongoing, pervasive impact such traumatic experiences have on personal development and relational functioning (Courtois & Ford, 2013).

Caring for Trauma Survivors

Concurrent with the rise of the trauma-informed care movement over the past two decades, developments in neuroscience have led to advancements in knowledge of how trauma

impacts the brain, as well as new treatment approaches for simple and complex PTSD (van der Kolk, 2014). Conventional treatments for PTSD may include trauma-focused psychotherapy (e.g., prolonged exposure therapy, cognitive processing therapy, or eye-movement desensitization and reprocessing [EMDR]) and medications (e.g., antidepressants, antianxiety medications). However, the treatment of PTSD is often complicated by the fact that approximately 80% of those diagnosed with PTSD are also diagnosed with co-occurring mental health disorders such as depression (Cascardi et al., 1999), anxiety disorders (Brady, 1997), substance abuse disorders (Mills et al., 2006), dissociative disorders (Brady, 1997) and personality disorders (Messman-Moore & Bhuptani, 2017). Most evidence-based treatment approaches for complex trauma begin with helping the trauma survivor reach a level of physical, emotional, and social stabilization that allows the healing and recovery process to begin (Dorrepaal et al., 2012; Herman, 2015). Stabilization includes establishing a social support network which can provide ongoing care to the trauma survivor throughout their recovery journey, and social support is highly effective, evidence-based means of reducing PTSD symptoms (Price et al., 2018; Zalta et al., 2021).

This study examines how faith communities can work concurrently with mental health and other health providers to provide support and care to trauma survivors. The American Counseling Association's (ACA; 2014) *Code of Ethics* states that ethical counseling practice includes the importance of counselors recognizing that "support networks hold various meanings in the lives of clients and consider enlisting the support, understanding, and involvement of others (e.g., religious/spiritual /community leaders, family members, friends) as positive resources, when appropriate, with client consent" (p. 4). When considering the needs of those who have experienced complex trauma, it is likely that these individuals will benefit from the

help of a multi-disciplinary, trauma-informed care team – comprised of both professionals and members of their families and communities – to assist them on their healing journey (Barnes & Andrews, 2019; Murphy, 2010; Stevens et al., 2019). Ideally the primary care physicians, psychotherapists, psychiatrists, social workers, and other medical professionals who are part of the team will provide *trauma-specific treatment*, while other helping professionals who are part of the team (e.g., teachers, clergy), as well as family members, will be *trauma-informed* and able to make valuable contributions to helping trauma survivors.

Psychological Help-Seeking

Individuals impacted by trauma may seek professional help for a variety of reasons, including mental health concerns, substance abuse issues, physical symptoms, or relational distress. Trauma survivors approach a variety of professionals for care and who they consult varies based on gender, race, ethnicity, location, and religion. A brief review of the literature on psychological help seeking reveals a nuanced picture of where people in North America turn for professional help regarding (a) general mental health concerns, (b) relationship issues, and (c) trauma-related concerns. Preferences for religious help-seeking will be considered in each of these categories.

Help-Seeking for Mental Health Concerns

Since individuals with complex trauma present with an array of co-occurring psychological concerns (Byllesby et al., 2016; Knowles et al., 2019), it is important to consider the broad patterns of psychological help-seeking in the general population. A review of the literature on psychological help-seeking reveals that 15%-40% of individuals with mental health concerns in the United States will initially contact a member of the clergy for help, rather than

consulting with a medical or mental health professional (Ellison et al., 2006; Kovess-Masfety et al., 2016; Wang et al., 2003). In a study examining attitudes related to psychological help-seeking patterns according to demographic groups (N = 189), Andrews and colleagues (2011) found that (a) men, (b) those without college or graduate degrees, and (c) those who have not previous received mental health services are statistically less likely to seek out traditional psychological services.

There are significant differences between racial and ethnic groups in preferences for religious help-seeking for mental health concerns. In a large survey of African Americans (N = 2,103), researchers found that respondents were more likely to seek help for a significant personal problem from clergy (21%) than from primary care physicians (16.1%), psychiatrists (9.4%), or other mental health professionals (8.7%; Chatters et al., 2011). According to another study (Crosby & Varela, 2014), African Americans were more likely to prefer religious help-seeking than their Caucasian or Latino/a counterparts ($p < .001$). Furthermore, in the same study, significant predictors of preference for religious help-seeking ($R^2 = .38$) included: (a) gender (males more than females; $\beta = 1.08$, $p < .05$), (b) viewing psychological problems as having spiritual roots ($\beta = .857$, $p < .05$), (c) intolerance for other faiths ($\beta = 0.05$, $p < .05$), and (d) defensive theology orientation ($\beta = 0.5$, $p < .05$).

Help-Seeking for Relationship Concerns

Since survivors of complex trauma are likely to experience long-lasting difficulties in relationships, due to difficulties in the areas of affect and impulse control (Ford & Courtois, 2009), it is also important to consider help-seeking behaviors for relationship concerns. As with general psychological help-seeking, clergy are frequently sought out for counsel regarding relationships and relational distress (Stewart et al., 2016). In one study of individuals who sought

help from clergy (N = 2,103), the most common reasons for seeking help were: (a) death of loved one (28%), (b) interpersonal relationships (23.5%), and (c) emotional difficulties (21.5%; Chatters et al., 2011). However, in contrast, some studies have found that individuals are less likely to seek help from clergy for relational concerns than they are for mental health issues. Kane & Green (2009) surveyed 186 university students regarding their help-seeking preferences based on fourteen problem scenarios. While the majority of respondents indicated a preference for help-seeking from mental health professionals (with an average of 49.7% choosing this option across the fourteen scenarios), the mean preference for help-seeking from clergy across all conditions was 28.9%. Respondents were most likely to seek help from clergy regarding religious or psychotic issues, and less likely to prefer religious help-seeking regarding personal emotional or relationship problems.

Help-Seeking for Trauma-Related Concerns

In another study of military veterans (N = 93) who had been diagnoses with PTSD and major depressive disorder, Currier and colleagues (2018) found that only 40% of participants had sought help from a doctor or mental health care provider. When asked about their likelihood of seeking help from a variety of sources, 26% indicated they would seek help from a chaplain and 25% reported they would seek help from another religious leader. However, participants reported that they were most likely to seek support from: (a) a partner or spouse (54%), (b) a parent or other family member (41%), or a friend who was also a veteran (56%).

Neergaard and colleagues (2007) studied the likelihood of women who had experienced intimate partner violence (IPV; N = 476) seek counsel from a member of the clergy, as well as the impact of these encounters. Only a quarter of the participants had sought help from a religious leader regarding the abuse occurring in their homes (n = 118, 25%). For the women

who had talked with a religious leader about IPV, 79% found the encounter to be helpful. Furthermore, women who sought pastoral care rated significantly higher in levels of self-esteem ($p = 0.003$) and self-efficacy ($p = 0.008$).

Trauma-Related Attitudes and Beliefs

The attitudes and beliefs that an individual has concerning a topic will ultimately influence their behaviors and interactions with others around that topic. In human services settings, if leaders have attitudes and beliefs that are more favorable to a TIC approach then their moment-to-moment choices and interactions are more likely to reflect the TIC model of care, and the sum of these decisions and relationships will lead to more positive outcomes for clients (Baker & Brown, 2016). In the current study, trauma-related attitudes and beliefs were defined as a person's beliefs about the causes, prevalence, and impact of psychological trauma and their attitudes towards trauma survivors; furthermore, trauma-related attitudes and beliefs include "beliefs about resilience, recovery, and healing from trauma" (Baker et al., 2016; SAMHSA, 2014, p. 10).

Trauma-Related Attitudes and Beliefs in Clergy

Individuals impacted by complex trauma, as well as other traumatic stress disorders, can be found in religious communities across North America, just as they can be found in every institution. The previous exploration of help-seeking behaviors revealed that trauma survivors may never seek care from a mental health professional. Thus, clergy have the opportunity to be among the first to recognize symptoms of traumatic distress among their parishioners. Until recently, scholarship related to clergy and trauma care has been primarily focused on clergy as crisis responders (Benson et al., 2016; Noullet et al., 2018; Roberts & Ashley, 2008; Rose &

Bigler, 2012; Shannon-Lewy & Dull, 2005; Trader-Leigh, 2008; Weaver et al., 1996), instead of exploring the role of clergy in caring for survivors of childhood or complex trauma. A search for scholarly literature using academic databases (e.g., Academic Search Premiere, APA PsychInfo, Atla Religion Database, ERIC) and Google Scholar did not lead to any empirical studies concerning the trauma-related attitudes and beliefs of religious leaders. Subsequently, a broader search related to research about clergy and trauma care, counseling, and mental health was then completed, and a review of this literature can be found after a discussion of trauma-related attitudes and beliefs in other populations of helping professionals.

Trauma-Related Attitudes and Beliefs in other Helping Professions

In the two decades since Harris and Fallot (2001) first began writing about applying the trauma-informed care model to systems, it has been applied in a variety of contexts (e.g., medical, child welfare, juvenile justice). Due to the lack of previous empirical research concerning applying TIC to religious institutions and communities, and a similar lack of investigation around the trauma-related attitudes and beliefs of mental health professionals, a brief overview of investigations into the trauma-related attitudes and beliefs of other helping professionals will be considered here. In particular, research in the areas of understanding the trauma-related attitudes and beliefs of leaders in the fields of (a) education and (b) counseling and human services will be reviewed. Beyond these categories, other recent studies have considered the application of TIC within residential juvenile justice programs (Ford & Blaustein, 2013), homelessness service settings (Hopper et al., 2010), intellectual and developmental disability organizations (Keesler, 2014), domestic violence programs (Wilson et al., 2015), psychiatric nurses (Vincenti et al., 2021; Young et al., 2019), and the justice system (McKenna & Holtfreter, 2021).

Education

The trauma-informed framework has many applications within educational systems (Chafouleas et al., 2016; Dorado et al., 2016; Mendelson et al., 2015; Overstreet & Chafouleas, 2016); however, studies related to understanding the trauma-informed attitudes and beliefs of educators have the most relevance to the current study. For example, in a study designed to assess administrator's attitudes and beliefs about TIC, Abdussatar (2020) sent study materials to 96 principals from urban school districts in one area of Ohio and received 19 responses (for a 20% response rate). The principals worked in elementary, middle, or high school settings. Abdussatar (2020) focused on this population so that "by understanding principal awareness towards trauma-informed care, school officials may become better equipped to ameliorate the effects of trauma on students and in the school environment" (p. 96). The sample was 68% female, and the racial groups most represented within the sample were (a) White/Caucasian, 79% and (b) Black/African American, 21%. Abdussatar's study utilized the 45-item version of the ARTIC scale and found that mean scores for the sample (N = 19) were favorable to trauma-informed attitudes and beliefs (M = 5.56, SD = 0.42, range = 4.60 to 6.16). Cronbach's alpha was .82 indicating a high level of internal consistency for the ARTIC-45 in this study.

In another study of educators, Vanderburg (2017) had teachers from six schools in the New Orleans Trauma-Informed Schools Learning Collaborative completed the full version of the ARTIC before and after a TIC training. The overall number of participants in the study was 163 and the respondents were 68.7% female and 58.9% White. Vanderburg focused the analysis on subscales from the ARTIC-45 and training had a statistically significant impact the change between pre-test and post-test scores on several subscales. First, scores for understanding the underlying causes of behavior were more trauma-aligned post-training (pre-test, M = 5.31, SD = 0.79; post-test, M = 5.77, SD = 0.78; $t(162) = -9.53$, $p < .001$). Participants also indicated an

increased self-efficacy for TIC approaches at work after the training (pre-test, $M = 5.50$, $SD = 0.88$; post-test, $M = 5.81$, $SD = 0.78$; $t(162) = -5.77$, $p < .001$). Finally, participants indicated more personal support for trauma-informed approaches after completing the training (pre-test, $M = 5.61$, $SD = 0.98$; post-test, $M = 6.01$, $SD = 0.80$; $t(56) = -2.83$, $p = .007$).

Together these two studies (Abdussatar, 2020; Vanderburg, 2017) revealed that attitudes and beliefs among some educators are becoming more aligned with the values of trauma-informed care and that trauma-informed training can have a significant impact on educators. Both studies also emphasized the need for leaders to buy into the trauma-informed model so that teachers can be supported in implementing new practices in their classrooms. Therefore, influencing the trauma-related attitudes and beliefs of school administrators is the first step in implementing TIC in educational settings.

Counseling and Human Service Professionals

In regard to trauma-related attitudes and beliefs among human services professionals, Sundborg (2019) designed a study to explore the relationship between basic knowledge about TIC and affective commitment to TIC (i.e., attitudes about TIC), and included the constructs of (a) TIC self-efficacy, (b) beliefs about trauma, and (c) leadership support for TIC in the structural equation model (see Figure 1). Sundborg collected data from 118 human services professionals (79% from behavioral or public health) who had previously participated in a TIC training provided by the researcher. Scales for all constructs (except for basic knowledge about trauma) were structured as 7-point Likert scale items (1 = *strongly disagree*, 7 = *strongly agree*).

Mean scores for the individual study constructs revealed that participants had high levels of affective commitment to TIC ($M = 6.28$, $SD = 1.29$) and moderately high levels of (a) trauma-informed beliefs ($M = 5.46$, $SD = .71$), (B) TIC self-efficacy ($M = 5.46$, $SD = 1.12$); and (c)

perceived leadership support for TIC (M = 5.13, SD = 1.17). Considering bivariate correlations, affective commitment to TIC (i.e., attitudes) was significantly correlated with (a) TIC beliefs, r = .576, $p < .05$; (b) basic trauma knowledge, r = .602, $p < .05$; (c) TIC self-efficacy, r = .651, $p < .05$; and (d) perceived leadership support for TIC, r = .597, $p < .05$. The overall model was a good fit for the data, $\chi^2(1) = .672$, p = .412; CFI = 1.00; RMSEA = .000; and explained 65% of the variance in affective commitment to TIC. Within the structural equation model, trauma-related knowledge significantly predicted beliefs about trauma (explaining 14% of variance) and TIC self-efficacy (explaining 24% of variance). The direct effects of TIC beliefs on affective commitment to TIC were also significant, ß = 0.316, $p < .01$, 95% *CI* (.163, .460), while the strongest mediated path from basic trauma knowledge to affective commitment to TIC went through TIC beliefs (ß = .116). This study illustrates the interconnectedness of trauma-related knowledge, attitudes, and beliefs and suggests that training in foundational trauma knowledge can significantly predict a corresponding change towards more trauma-informed attitudes and beliefs.

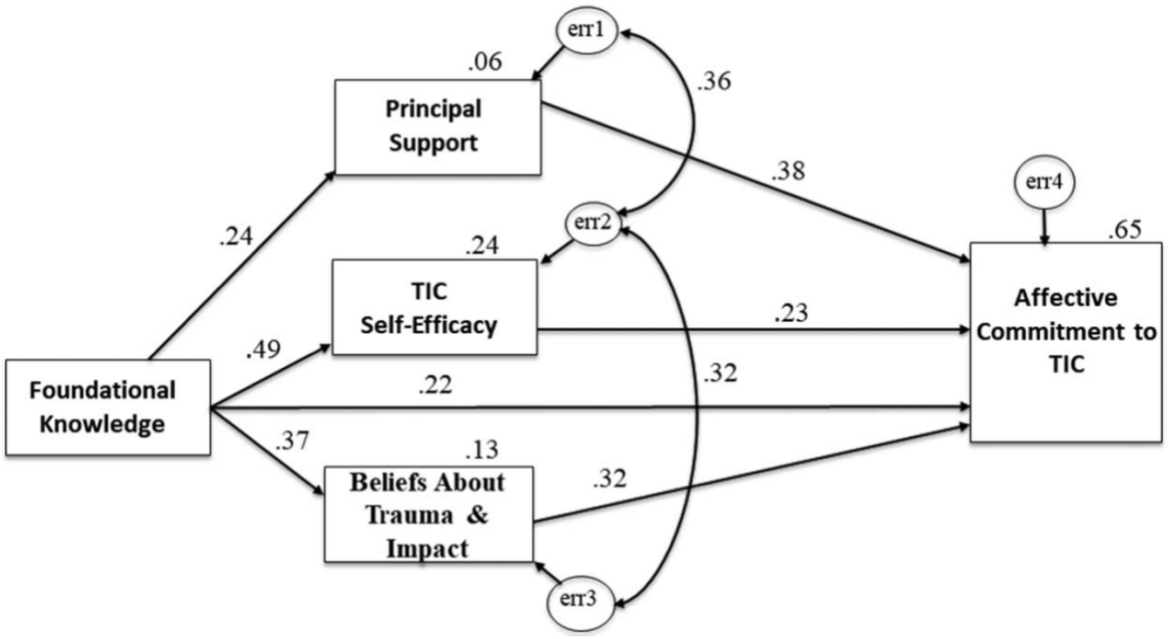

Figure 1: Structural equation model for TIC attitudes in human service professionals (reproduced from Sundborg, 2019, p. 228)

Clergy Studies Related to Counseling and Mental Health

In light of the absence of previous research specifically related to the trauma-related attitudes and beliefs, studies about clergy were considered that related to (a) attitudes about mental illness, (b) self-efficacy related to counseling and pastoral care, (c) mental health literacy, (d) the readiness of clergy to provide care to trauma survivors, and (e) clergy attitudes towards the integration of psychology and church ministry. Each of these studies will be considered in order to explore the context within which the current study is situated.

Attitudes About Mental Illness

In a qualitative study of seminary students, from ATS-accredited seminaries from Mainline Protestant denominations, Stull and colleagues (2020) asked students (*N* = 25*)* about

their awareness and knowledge related to mental health topics. When asked to describe mental illness, the most common responses indicated a general awareness of anxiety and depression, and many brought up the topic of suicidality. Furthermore, participants indicated an awareness that mental illnesses exist on a spectrum of severity (from mild to severe). The majority of interviewees recognized that the causes of mental illness are varied and interactive. Almost all participants (n = 24) mentioned that there are some spiritual issues that contribute to mental illness, including both a lack of spirituality and hyper-spirituality. While some participants did discuss the role of sin and demonic activity in mental illness, most approached those topics with caution, not wanting to over-spiritualize the cause. There was also a wide-spread awareness of other potential causes of mental illness including: (a) biological causes (e.g., brain chemistry imbalance, genetic predisposition); (b) environmental causes (e.g., trauma, abuse, childhood development, lack of social support); and (c) psychological factors (e.g., mindset, lack of emotional health). While this study did not specifically explore trauma-related issues, it did find that most seminary students had some level of understanding that environmental factors, such as trauma exposure in childhood, could impact mental health later in life.

Clergy Counseling Self-Efficacy and Pastoral Care

In regard to the perceptions of clergy concerning their ability to effectively provide counseling care, Marks (2013) examined the counseling self-efficacy (i.e., beliefs regarding counseling capabilities) of Christian pastors in one urban area in Virginia (N = 104). In this study, the construct of *pastoral care* (i.e., the work of the pastor, priest, or minister to provide faith-based, relational care directed toward the guidance, healing, and support of persons; Clebsch & Jaekle, 1964) was included alongside the construct of counseling. As distinct from pastoral care, Marks posits that *pastoral counseling* integrates traditional pastoral care practices

with training in mental health care and/or psychology and focuses on this kind of integrative pastoral counseling in their research.

The majority of participants in this study were White/Caucasian, 97.1% (n = 99) and had completed an M.Div., 71.2% (n = 74). The average length of time in pastoral work was 17.16 years, and participants reported spending between 0-15 hours per week in formal counseling activities (M = 2.07). Marks asked the pastors about their denominational affiliations and found that most were Methodist (60.6%, n = 63), while the rest of the sample represented other Protestant denominations. Based on a multiple regression analysis ($F(5, 83) = 6.913$, $p < .001$; adj. $R^2 = .251$), Marks found that the variance in counseling self-efficacy could be partially explained by (a) years of experience, (b) hours per week spent in counseling activities, and (c) previous training in counseling and/or psychology. Previous counseling training had the largest effect on the model ($B = .272$) while the hours spent per week in counseling had a similar effect ($B = .262$). When asked about the three topics regarding which church members most often seek counseling, the most often endorsed items were: (a) family relationships, n = 65, (b) romantic relationships, n = 55 (c) spiritual concerns, n = 52 and (d) grief and loss, n = 49.

Clergy Mental Health Literacy

While Marks (2013) examined the counseling self-efficacy of Christian pastors, Vermaas and colleagues (2017) considered predictors of mental health literacy (i.e., knowledge) in Christian clergy (N = 238). The multiple linear regression model in this study included predictors for mental health literacy such as: (a) denominational affiliation, (b) educational variables, and (c) demographic variables. The researchers relied on publicly available contact lists for pastors to send out invitations to participate and the response rate for the survey was low (4.0%). Participants were largely male (69.1%, n = 162) and represented four main denominational

groups: (a) Evangelical Protestant, 49.6% (*n* = 188), (b) Mainline Protestant, 32.8% (*n* = 78), (c) Roman Catholic, 16.4% (*n* = 39), and (d) Historically Black Protestant, 1.3% (*n* = 3).

Regarding denominational affiliation, researchers found no significant difference in levels of mental health literacy between participants the four main denominational groups, $F(3, 237) = 1.840$, $p = .141$. As to educational variables, the only significant predictor of mental health literacy in the regression model was clinical mental health training (ß = 0.178, $p = .005$, 95% *CI* (0.07, 0.44). Finally, regarding demographic variables, only female gender was a significant predictor of mental health literacy scores (ß = 0.171, $p = .008$) but it represented only a small effect size (adj. $R^2 = .025$, $f^2 = 0.03$).

Clergy and Trauma Care

Although trauma-informed clergy are situated to be an integral part of cross-disciplinary care teams for trauma survivors (Sigmund, 2003), only one study related to the readiness of clergy to provide care to those experiencing traumatic stress could be found (Scott, 2013). In this study, Scott examined clergy's self-perceived abilities to respond to the needs of trauma survivors using a researcher created survey (*N* = 102). The predominant demographic characteristics of the study participants were: (a) male (70.6%, *n* =72), (b) White/Caucasian (82.4%, *n* =84), (c) had completed a master's degree (44.1%, *n* = 45). Scott (2013) included clergy from various religious tradition in the study; however, the majority of participants were either Christian (58.8%, *n* = 60) or Jewish (37.3%, *n* = 38). In this study, 96.1% of participants (*n* = 98) reported providing counseling, pastoral care, or personal guidance to members of their congregations, including many clergy who indicated they were sometimes sought out for care by trauma survivors (70.4%, *n* = 69). Of clergy who had received training about how to identify trauma responses (*n* = 49), the mean score for confidence in being able to identify symptoms of

traumatic stress was 5.1 (*SD* = 1.1) on a 7-point Likert scale that ranged from 1 (*not at all confident*) to 7 (*extremely confident*). Furthermore, clergy who had previously received any training in caring for trauma survivors (*n* = 56) indicated that they were somewhat confident in being able to effectively help or counsel people who have experienced trauma (*M* = 4.5, *SD* = 1.4) on the same 7-point scale. Other results from this study will be explored in the section on clergy and trauma-related training below.

Clergy Attitudes Towards the Integration of Psychology and Church Ministry

Finally, in a national sample of Protestant pastors (*N* =394), Hodge and colleagues (2019) explored the attitudes of religious leaders towards the integration of psychology into church ministry settings. Of the pastors who participated in this study, 94.2% were male and 94.5% were White. The denominational affiliation of participants was distributed across three main denominational groupings: (a) Evangelical Protestant (53.8%), (b) Mainline Protestant (21.6%), and (c) Catholic (24.6%). The majority of participants also had completed either a master's (64.6%) or doctoral (19.7%) degree. Hodge and colleagues assessed the which relational, mental health, and psychological issues religious leaders most frequently see in the people in their churches. The 23 most common concerns, along with mean scores (on a 5-point Likert scale, 1 = *not at all common*, 5 = *very common*) are shown in Table 1. Many concerns that are directly related to trauma were mentioned (e.g., grief and loss, trauma, abuse, domestic violence) along with many concerns that are often co-occurring in trauma survivors (e.g., anxiety, depression, shame/guilt, suicidal thoughts, eating disorders, self-injury).

When considered together these five studies related to clergy, mental health, and counseling support the assertion of this study that all religious leaders will have individuals with either post-traumatic stress or co-occurring mental health and relationship disruptions within

their congregations. Clergy have highly varied levels of training in the areas of mental health, counseling, and trauma. Combined with the studies from education and human services, it is clear that trauma-related training is one of the factors that is most likely to change attitudes and beliefs about mental health related issues (Abdussatar, 2020; Marks, 2013; Scott, 2013; Vanderburg, 2017; Vermaas et al., 2017).

Table 1: Prevalence of Mental Health Concerns Expressed to Clergy (Hodge et al., 2019)

	Concerns	*Mean (SD)*		Concerns	*Mean (SD)*
1.	Grief and loss	4.47 (0.80)	13.	Sexual values	3.80 (1.18)
2.	Anxiety	4.39 (0.89)	14.	Trauma	3.23 (1.15)
3.	Parenting challenges	4.39 (0.88)	15.	Abuse	3.14 (1.17)
4.	Unforgiveness	4.27 (0.96)	16.	Empty nest issues	2.97 (1.14)
5.	Family conflict	4.25 (0.91)	17.	Special needs children	2.92 (1.10)
6.	Depression	4.24 (0.91)	18.	Suicidal thoughts	2.71 (1.11)
7.	Aging	4.23 (1.02)	19.	Domestic violence	2.68 (1.11)
8.	Shame/Guilt	4.21 (0.95)	20.	Sexual identity/Orientation	2.63 (1.14)
9.	Marital distress	4.14 (0.90)	21.	Eating disorders	2.63 (1.16)
10.	Addiction	3.96 (1.03)	22.	Severe mental illness	2.50 (1.10)
11.	Life transitions	3.87 (1.08)	23.	Self-Injury/Cutting	2.36 (1.16)
12.	Sexual issues (e.g., pornography, infidelity)	3.87 (1.20)			

Note. a. *N* =394; Christian religious leaders from a national sample. b. Participants were asked how common these concerns were among congregants in their ministry setting. Scores are based on a 5-point Likert scale (1 = not at all, 3 = somewhat common, 5 = very common)

Clergy Personal Factors

The remainder of this literature review is dedicated to exploring the personal and professional factors that are hypothesized to have an influence on trauma-related attitudes and

beliefs in the current study. The two personal or individual factors considered are (a) personal trauma exposure and (b) trait emotional intelligence. The two professional or job-related factors are: (c) previous trauma training and (d) hours spent per week providing counseling or pastoral care. Reasons for including these factors will be explained following the consideration of the existing literature on each factor.

Trauma Exposure

Within the helping professions, it has been demonstrated that a high percentage of helpers have a history of trauma exposure (Black et al., 1993; Elliot & Guy, 1993), and that this personal history can have an influence on how they function in their professional roles (Cromer & Freyd, 2009; Wilson & Thomas, 2004). While an individual's personal trauma history includes both their lifetime exposure to potentially traumatic events, as well as any post-traumatic stress symptoms they have experienced, this study focuses on the total exposure to trauma during a person's lifetime. As there are not existing studies related to trauma exposure in clergy, literature related to trauma exposure in other helping professionals is considered. It has been demonstrated that childhood, interpersonal trauma (i.e., emotional abuse and neglect, sexual abuse) is related to interpersonal relationship difficulties in adulthood, particularly in those with mood and anxiety disorders (Huh et al., 2014). Since the helping professions are inherently relational, it can be inferred that helpers with childhood interpersonal trauma may struggle more in the relational components of their work, which would subsequently interact with a helper's ability to stay connected to the compassion and interpersonal presence that are inherent in the trauma-informed care approach.

Rates of Trauma Exposure in Helping Professionals

A study of trauma exposure among master's level social work (MSW) students (N = 116; Black et al., 1993) revealed significantly higher levels of psychosocial trauma among the MSW students when compared to students in a graduate business program. MSW students reported the following exposure rates within their family context to various adverse childhood experiences: alcoholism (55%), substance abuse (27%), physical abuse (24%), sexual abuse (22%), emotional abuse (38%), significant illness (56%), mental illness (28%), death in family (72%), and suicide (12%). Black and colleagues (1993) concluded that early exposure to psychosocial traumatic factors is associated with the selection of a career in a helping profession later in life, in this case social work. Another foundational qualitative study on the frequency of trauma exposure in psychologists (N = 14; Racusin et al., 1981) also found that significant physical illness, mental illness, and abuse were common in the childhood families of psychologists, concluding that "therapists' early experiences in interpersonal relations may, therefore, have served as training grounds for sensitivity to interpersonal stress" (p. 275).

Lee and colleagues (2017) examined the incidence and implications of adverse childhood experiences (ACEs) in child welfare professionals. Participants were from a Midwestern state and worked either within the Department of Human Services (DHS) or as community providers who partnered with DHS. The ACE questionnaire was used to determine how many types of adverse experiences the participants had been exposed to in childhood (range 0-10). Participants had significantly higher ACE scores than the general population, with 31% of participants reporting a score of 4 or higher which was more than double the rate in the general population (12.5%). Of the child welfare participants, 87.4% had ACE score of at least one, compared to 55%-60% of general population. In a similar study, Hiles Howard and colleagues (2015) found that human services providers in an urban setting in the southern United States also had double

the rate of high ACE scores (defined as 4+) than the general population (25.1% v. 12.5%; χ^2 = 17.30, $p < .001$.), with 75% of participants reporting at least one ACE.

Impact of Personal Trauma Exposure on Helping Professionals

Deighton and colleagues (2007) studied a group of German speaking trauma therapists (N = 100) who worked with torture survivors. While the main goal of the study was to investigate the relationship between how frequently therapists were able to help clients directly work through trauma experiences and work-related stress and distress, they also looked at how therapists who had previously exposure to severe traumatic experiences were impacted by the work. Trauma therapists who reported experiences of severe traumatic events in their own lives (n = 29*)* scored significantly higher on measures of burnout, $t(98) = 3.56$, $p < .001$, and compassion fatigue, $t(98)=3.60$, $p < .001$, than therapists who did not have a history of personal trauma. Furthermore, the therapists with a personal trauma history also had significantly higher levels of emotional exhaustion, $t(98) = 2.09$, $p < .05$, and lower levels of perceived personal accomplishment at work, $t(98) = 3.28$, $p < .001$. Deighton and colleagues also examined whether or not years of professional experience was correlated with levels of burnout, compassion fatigue, or emotional exhaustion and did not find any significant results, noting that "these findings indicate that it is not the exposure itself so much as what the therapist does in the face of the exposure, which represents a risk factor for work-related symptoms" (p. 71-72).

The impact of a history of personal trauma is not entirely negative for adults in helping professions. Rollins (2010) completed a series of case studies with psychotherapists (N = 10) who were also trauma survivors. While a history of trauma exposure was associated with some difficulties (e.g., negative emotions, maladaptive coping patterns, isolation), the professional impact of personal trauma exposure was described in terms of greater empathy and clinical

effectiveness when working with trauma survivors. Some participants described a strong affinity for working with a specific population of trauma survivors because they felt empowered by their own experiences to help others in similar situations. Meanwhile, Hiles Howard and colleagues (2015) found that higher ACE scores were not associated with higher rats of burnout. In fact, participants with higher ACE score (i.e., more childhood trauma) had statistically higher levels of compassion satisfaction and resilience than those with lower ACE scores. In summary, while helping professionals consistently report higher levels of trauma exposure than the general population, the impact of this exposure is mixed and may depend on how the individual has dealt with their experiences.

Emotional Intelligence

The concept of emotional intelligence (EI) can be traced as far back as Thorndike (1920) but the construct as it is current understood was defined by Salovey and Mayer (1990). EI involves the ability to recognize, understand, utilize, and manage emotions, both within oneself and in relationship to others. The EI concept was introduced into popular culture by Goleman (1995, 1998) who defined emotional intelligence as, "the capacity for recognizing our own feelings and those of others, for motivating ourselves, and for managing emotions well in ourselves and in our relationships" (2005, p. 43). Another early contributor to the EI literature, Bar-On (1997, 2004), was also the first to make an assessment with psychometric properties that specifically measured emotional intelligence. However, early measures of EI varied widely, with some containing items that had right/wrong answers (Mayer et al., 1999) and others focusing on self-report items (Schutte et al., 1998). These two ways of assessing EI also reveal the differing assumptions underlying the construct of EI, which are known as: (a) *ability EI* and (b) *trait EI*. Assessments of ability EI evaluate cognitive-emotional abilities using maximum-performance

testing but can be difficult to evaluate (since emotional experience is inherently subjective) and have limited predictive validity (see Petrides, 2013). Trait emotional intelligence, in contrast, is explicitly defined as a measure of emotional self-efficacy, or one's self-perceptions regarding their own emotional abilities, thus acknowledging the inherent subjectiveness of such experiences (Petrides & Furnham, 2000).

Trait Emotional Intelligence

The primary measure of trait emotional intelligence is the *Trait Emotional Intelligence Questionnaire* (TEIQue; Petrides, 2009) and the developers of this instrument recognized that much of what is discussed in the realm of EI research actually concerns mutable personality traits (e.g., self-control, emotional expression, empathy) rather than cognitive abilities. Petrides (2010) describes 15 facets of trait emotional intelligence (see Table 2), viewing the combination of these facets as a multidimensional construct known as *global trait EI*. Within the model of trait emotional intelligence, it is recognized that a high score in one facet of EI is not automatically positive and adaptive in all situations (Petrides, 2010; Sevdalis et al., 2007), which means that attention is required to accurately interpreting TEIQue scores within specific applications. However, in general, higher EI scores are adaptive and lower EI scores are maladaptive (Petrides et al., 2016).

Several meta-analyses of trait EI studies have demonstrated that higher trait EI scores are a positive predictor of overall mental health and well-being (Martins et al., 2010; Mikolajczak et al., 2009; Petrides et al., 2007; Williams et al., 2010) and a negative predictor of psychopathology (Petrides et al., 2011; Sinclair & Feigenbaum, 2012). Research considering the relationship between interpersonal relationship skills and trait EI demonstrates that higher trait EI scores are associated with higher relationship quality, satisfaction in marriage, and constructive

communication patterns (Malouff et al., 2014). Finally, the overwhelming majority of studies considering whether or not EI training can improve trait EI scores indicate that significant, meaningful, and long-lasting gains in EI can be made in adulthood (Kotsou et al., 2011; Mikolajczak & Pena-Sarrionanda, 2015; Perez-Gonzalez et al., 2016).

Table 2: Petrides' Facets of Trait Emotional Intelligence (2010)

Facets	High scorers view themselves as…
Adaptability	flexible and willing to adapt to new conditions
Assertiveness	forthright, frank, and willing to stand up for their rights
Emotion expression	capable of communicating their feelings to others
Emotion management (others)	capable of influencing other people's feelings
Emotional perception (self and others)	clear about their own and other people's feelings
Emotion regulation	capable of controlling their emotions
Impulsiveness (low)	reflective and less likely to give in to their urges
Relationships	capable of maintaining fulfilling personal relationships
Self-esteem	successful and self-confident
Self-motivation	driven and unlikely to give up in the face of adversity
Social awareness	accomplished networkers with superior social skills
Stress management	capable of withstanding pressure and regulating stress
Trait empathy	capable of taking someone else's perspective
Trait happiness	cheerful and satisfied with their lives
Trait optimism	confident and likely to "look on the bright side" of life

Note. Table is reproduced from *The Domain of Trait Emotional Intelligence*, Petrides, 2010.

Emotional Intelligence in Clergy

In the workplace, trait EI is strongly associated with positive job performance outcomes (O'Boyle et al., 2011; Schutte & Loi, 2014). Leaders with higher trait EI scores facilitate workplace environments with lower overall levels of stress and higher levels of job satisfaction (Furnham et al., 2012). In many studies, trait EI serves as a protective factor and is associated with decreased work-related stress levels (van Kan, 2004) and decreased burnout at work (Mikolajczak et al., 2007). Within the context of clergy and EI, Oswald (2016) states that EI is "essential for pastoral effectiveness" because the pastor's work is "all about relationships" (p. 102). Oswald found that one of the primary reasons that clergy are fired is because of lack of interpersonal skills. The few studies that have empirically considered clergy and either trait or ability EI are discussed below.

Francis and colleagues (2019) examined the emotional intelligence of Anglican clergy in the Church of Wales (N = 364) using the *Schutte Emotional Intelligence Scale* (EIS, 1998) which is based on the ability model of EI and is evaluated using a 5-point Likert-type scale. The mean EI score for clergy in this study was significantly lower than the mean scores for the general population. Clergymen had a mean score of 116.33 (SD = 12.51) as compared to a mean score of 124.78 (SD = 16.52) for men in the general population ($p < .001$), while clergywomen had a mean score of 121.79 (SD = 10.55) as compared to a mean score of 130.93 (SD = 15.09) for women in the general population ($p < .001$). Francis and colleagues note that their study is consist with other studies of EI among clergy in Britain in finding that clergy have significantly lower EI scores than the general population. In a similar study, Hendron and colleagues (2014) also utilized the *EIS* (Schutte et al., 1998) to study the EI of clergy in Ireland and Northern Ireland (N = 226). The mean score for Irish clergy was 120.19 (SD = 13.24), with a significant difference found between the genders (Males, M = 119.01, SD = 13.24; Females, M = 124.91, SD

= 10.26; p = .007). Hendron and colleagues noted that clergy EI scores were equivalent to those of prisoners (M = 120.08, SD = 17.71) and individuals in treatment for substance abuse (M = 122.23, SD = 14.08). Furthermore, the clergy in this sample scored significantly lower than other professional helpers, in particular, therapists (M = 134.92, SD = 20.25).

Using the Bar-On (2004) *EQ-i* assessment, which is based on a mixed-model approach to EI, or a combination of ability and trait EI factors), Oney (2010) surveyed Assemblies of God pastors (N = 136). Using five subscales from assessment (i.e., intrapersonal, interpersonal, stress management, adaptability, general mood), Oney found that adaptability (which includes reality testing, flexibility, and problem solving) was the only significant predictor of pastors who exceeded denominational performance guidelines ($p < .05$) in any area (in this case, conversions reported). White and Kimmons (2019) used the updated Bar-On assessment (*EQ-i 2.0*, 2011) to study the EI of United Methodist Clergy (UMC) in Kentucky (N = 112), finding that clergy scored highest in the EI domains of social responsibility, self-actualization, impulse control, and emotional expression. While both male and female clergy scored lower on the subscales for flexibility, self-regard, problem-solving, and independence, the female UMC pastors scored significantly higher than the males in the areas of emotional self-awareness, emotional expression, and optimism.

Finally, Carrington (2015) sampled ministers from the United Pentecostal Church (N = 81), using the TEIQue-SF to assess trait emotional intelligence as part of a larger study on pastoral leadership, and found a significant positive correlation between trait EI (M = 5.4, SD = 0.47) and leadership behaviors (r = 0.56, $p < .01$). Carrington suggests that further research is needed in order to determine the impact on an EI training and education program and clergy EI scores. Although there is limited data regarding clergy and EI, the existing research shows that

EI in clergy is correlated with some areas of clergy job performance (Oney, 2010). The only studies to compare clergy EI scores to the general population (Francis et al., 2019; Hendron et al., 2014) found that clergy had significantly lower overall EI scores than both the general population and other professional helpers.

Professional Factors

Clergy Training and Preparation

The education and training of ordained clergy is not standardized across Christian denominations in North America (Carroll, 2006). For example, within the Roman Catholic Church, priests must complete specified graduate seminary training that includes formation in four key areas: (a) human / personal, (b) spiritual, (c) academic, and (d) pastoral (United States Conference of Catholic Bishops, n.d.). In contrast, the Assemblies of God does not have any specific academic degree requirements and states that educational requirements can be met through a self-study program; however, the denomination does encourage candidates for ministry to complete training in a denominational postsecondary school (General Council of the Assemblies of God, 2019).

While formal pastoral education is more common in North America than in many parts of the world, Kohl (2021) states that less than 5% of Christian clergy worldwide have a recognized degree in theology or ministry, but more than 90% have attended informal programs of theological or ministry education. Nevertheless, in North America, the accrediting body for schools that offer theological or ministry-related postbaccalaureate degree programs is known as the Association of Theological Schools in the United States and Canada (ATS). The degree most frequently offered by the 270 accredited Christian and Jewish graduate schools is the Master of Divinity (ATS, n.d.). In order to be accredited, an M.Div. program must require students to

complete at least 72 semester credit hours in the areas of: (a) religious heritage, (b) cultural context, (c) personal and spiritual formation, and (d) religious and public leadership, along with supervised practical ministry experiences (Commission on Accrediting, 2020). No specific coursework in counseling or pastoral care is part of the ATS M.Div. requirements.

Required Coursework in Counseling

In order to determine how many ATS-accredited M.Div. programs require coursework in counseling or pastoral care, the researcher completed an informal review of the curricula from 225 Catholic and Protestant M.Div. programs and found that 143 programs (63.6%) require at least one graduate course in counseling or pastoral care as part of the M.Div. curriculum requirements, while others offer optional courses in pastoral counseling, chaplaincy, or other counseling-related topics. However, with this brief review of curricula, it was not possible to assess what content is offered in these courses. A representative selection of course titles related to helping relationships can be found in Table 3.

Table 3: Sample Titles for Required M.Div. Courses in Counseling and Pastoral Care

Pastoral Care Courses
Essentials of Pastoral Care
Pastoral Care and Counseling
Theology of Pastoral Care
Introductory Counseling Courses
Principles of Christian Counseling
Theological Foundations for Counseling
Foundations of Pastoral Counseling
Pastoral Psychology & Counseling
Counseling Skills Courses
Professional Care Skills
Basic Counseling Skills

Note. Course names were compiled from a survey of curriculum requirements for 225 ATS-accredited M.Div. programs at Catholic and Protestant institutions in North America.

Other Coursework Related to Mental Health & Trauma

When M.Div. graduates from ATS-accredited programs were asked about areas in which they wish they had received more training during seminary, many of the most frequently mentioned categories were related to emotional, mental, or relationship issues: (a) leadership, 18%, (b) pastoral care and counseling, 13%, (c) conflict resolution, 9%, and (d) intrapersonal competency, 7% (Lin & Gin, 2017). As part of a qualitative study related to clergy, job satisfaction, and emotional intelligence, West (2016) completed a document analysis the educational transcripts and course materials of Canadian pastors and classified their undergraduate and graduate coursework into five categories: (a) academic (theology, philosophy, history), (b) church administration; (c) communication (public speaking, education, composition), (d) practical experiences; and (e) courses with a focus on emotional intelligence. West classified courses with EI content according to whether or not language in the course description or syllabus was congruent with one of Goleman's (2013) core EI competencies. While 21 of 224 courses contained EI-related content (9.4%), more than half of these courses were found in non-ministry related degrees completed by the pastors (e.g., social work, education). In ministry-related courses, EI content was found in courses such as church administration, public speaking, and internship.

In the area of serious mental illness, Ross and Stanford (2014) surveyed the curricula of 70 ATS-accredited seminaries from various denominations and found that 88% offered courses that considered the topic of mental illness to some extent, while only 31% offered a course (required or elective) specifically dedicated to the topic of mental illness. Ross and Stanford found that 53% of the seminaries required one counseling class and 17% of the schools did not require any counseling classes. Of the counseling classes offered, most focused on relationship issues (i.e., marriage and family) or grief counseling. The majority of seminaries (79%, $n = 55$)

reported that they rarely hosted extracurricular guest speakers or seminars that addressed mental illness.

Although mental health training may be rare in seminary settings, clergy report that it is useful post-graduation (Lin & Gin, 2017), and some empirical studies demonstrate that prior training increases clergy competency in mental health situations. A 2016 study about clergy and suicide assessment (Mason et al.) found that the completion of more counseling training hours was significantly associated with the ability to accurately assess suicidal ideation.

Finally, in the only study to directly investigate the trauma-related training completed by clergy, Scott (2013) found that less than half of the participants (48%, $n = 49$) reported receiving any training concerning normal acute stress and post-traumatic reactions, while 54.9% ($n = 56$) reported completing some training about how to counsel a person who has experienced psychological trauma. While pastoral education related to counseling, mental health, and trauma varies greatly across denominations and settings, there is more consistency in the types of counseling or care-giving activities that most clergy report as part of their job responsibilities.

Clergy Job Responsibilities

Pastors, priests, ministers, and other members of the clergy may serve in a wide variety of roles within their jobs. Examples of clergy job responsibilities and roles can include preacher, teacher, evangelist, scholar, relationship counselor, social activist, grief specialist, fundraiser and administrator (Beck, 1997; Carroll, 2006; DeShon, 2010). Clergy in smaller and more rural churches report having a wider variety of responsibilities, including fulfilling secretarial, janitorial, and information technology roles (Beck, 1997; DeShon, 2010).

Beck (1997) analyzed detailed logs from 187 pastors in Iowa and analyzed how much time pastors spent in various roles per week. After analyzing these logs, Beck divided the roles

and responsibilities of clergy into four major categories: (a) relational (e.g., counselor, visiting the sick, spiritual guide), (b) administrative (e.g., running meetings, organizational leadership, strategic planning), (c) communications (e.g., preacher, teacher, evangelist, worship leader, and (d) custodial / clerical. The mean for total amount of time worked per week was 59.6 hours with pastors reporting engaging in up to 23 different roles per week (M = 15.75, SD =2.86). Pastors reported spending 24% of their work time in relational roles, including 2.5 hours per week counseling and 1.8 hours per week providing crisis care. Beck found that the more roles played by a pastor per week, the more likely they were to be dissatisfied with their jobs and to experience burnout. However, reported levels of burnout and job dissatisfaction were lower than anticipated, which Beck hypothesized might be due to the impact of socially desirable response bias in clergy studies. Faucett and colleagues (2013) also found that the issues related to role conflict (β = -0.296, p < .01) and role ambiguity (β = -0.484, p < .01) explained 41.7% of the overall job satisfaction of clergy in the United Methodist Church in Arkansas (N = 179).

DeShon (2010) divided the work tasks of clergy into 13 distinct task clusters: (a) administrative, (b) care giving, (c) communication, (d) evangelism, (e) facility construction, (f) fellowship, (g) management, (f) development of others, (g) preaching & public worship, (h) relationship building, (i) rituals and sacraments, (j) self-development, and (k) denominational responsibilities. The study focused on pastors in the United Methodist Church (N = 341) and asked participants to rank task clusters by both frequency and perceived importance. The four most frequently completed tasks clusters were (1) communication, (2) self-development, (3) preaching & public worship, and (4) caregiving. The caregiving roles of pastors included counseling (regarding relationships, grief, & addiction), crisis intervention, visiting the sick, and arranging care for individuals with physical needs. While caregiving tasks ranked fourth in

frequency, pastors rated them second in importance, behind the task cluster for preaching and public worship. In regard to work responsibilities, the mismatch between the focus of formal pastoral education and the on-the-job requirements may leave clergy feeling ill-prepared to fulfill caregiving, counseling, and crisis intervention roles.

Chapter Summary

Post-traumatic stress and complex trauma concerns that impact many individuals and communities across North America. Since clergy are frequently sought out for care in the areas of mental, emotional, and relational health (including trauma-related stress), it is beneficial to gain an understanding of what individual and work-related factors predict the trauma-related attitudes and beliefs of religious leaders. As a population, members of the clergy can vary greatly in their attitudes related to trauma and mental health issues, personal experiences of trauma, emotional intelligence, training, and job responsibilities. Research related to clergy and their role in response to complex trauma is new; therefore, the aim of this research study was to examine how trauma exposure, EI, training, and job roles predict their basic trauma-related attitudes and beliefs.

CHAPTER THREE: METHODS

Introduction

Chapter 3 presents the methodology, research design, and procedures related to the research study. The purpose of this study was to examine the relationship among Christian clergy's trauma-related training, professional experiences, personal trauma histories, emotional intelligence, and trauma-related attitudes and beliefs. Because there is little literature concerning the factors that influence clergy in caring for parishioners impacted by trauma, this correlational study was designed to lead to an increased understanding of the phenomenon, which may serve as a guide to future practice for clergy, counselors, and counselor educators, and serve as a potential starting point for future research.

The primary research question for this study was: After controlling for the effects of socially desirable responding bias (SDRB), how much of the variance in the trauma-related attitudes and beliefs of Christian clergy can be explained by trauma-related training, time per week spent in counseling-type ministry, trait emotional intelligence (EI), and clergy's personal trauma exposure (TE)? Exploratory research questions examined the relationship between demographic variables and trauma-related attitudes and beliefs, the relationship between demographic variables and trait emotional intelligence, and the prevalence of trauma exposure among clergy. This chapter provides both the specifics of the research design and implementation, as well as the rationale behind the data analysis that was employed.

Research Design

In order to better understand the relationship between Christian clergy's trauma-related attitudes and beliefs, emotional intelligence, personal trauma exposure, trauma-related training,

and counseling-related work experience, a non-experimental, multivariate, correlational design was selected. Correlational research is useful for understanding the relationships among variables within a specified population, as opposed to studying the impact of an intervention (Curtis et al., 2016; Gall et al., 2007). This design type was selected in order to best answer the primary research question which quantitatively investigated the relationships between the identified constructs.

In constructing correlational studies, Curtis et al. (2016) identified several important factors for consideration, including the (a) identification of variables, (b) sample selection, and (c) appropriate measurement tools. Each of these will be reviewed below, in relationship to the proposed study.

Variables

As discussed in Chapter 1, both the research question and the selected variables were chosen using the framework of trauma-informed care (TIC) and an existential-humanistic understanding of the professional development of helpers. Within the primary research question, the construct of trauma-related attitudes and beliefs, as measured by the ARTIC-10-HS (Baker et al., 2016) served as the dependent variable. The constructs that were chosen as independent variables represented aspects of the personal and professional development of clergy. The variables of (a) trauma-related training and (b) time per week spent in counseling-type responsibilities (both measured via a researcher-designed demographic questionnaire) were selected in light of existing research regarding the professional experiences that can influence trauma-related attitudes and beliefs in other populations of helpers (Donisch et al., 2016; Kenny et al., 2017; Sullivan et al., 2016). The variables of (c) trait emotional intelligence (as measured by the TEIQue [Cooper & Petrides, 2010]) and (d) personal trauma exposure (as measured by the

BTQ [Schnurr et al., 1999]) were selected based on the hypothesis that a helper's personal experiences and emotional development have a relationship to their trauma-related attitudes and beliefs. This hypothesis is supported by an existential-humanistic understanding of human development, along with other studies that have correlated aspects of the *person of the helper* with professional development (e.g., Farber, 2014; Herman, 1995; Krug & Schneider, 2016). Finally, the construct of socially desirable responding bias, as measured by the MCSDS-X1 (Strahan & Gerbasi, 1972), was selected as a moderating variable in order to control for the tendency for respondents to answer self-report items in a way that makes them appear more socially favorable than they truly are (Tracey, 2016).

Population and Sampling Procedures

Inclusion Criteria

The target population in this study consisted of Christian clergy in the State of Florida. In order to participate in this study, participants had to: (a) be 18 years old or older, (b) be an ordained pastor, priest, minister, or other member of the Christian clergy, and (c) currently work at a church in the State of Florida. For this study, clergy were defined as pastors, priests, deacons, elders, chaplains, and other individuals ordained by established Christian churches and/or denominations. It is difficult to know the total number of active Christian clergy in the United States and current estimates may be inflated (Chang, 2004), but the most recent edition of the *Yearbook of American and Canadian Churches* (Association of Statisticians of American Religious Bodies [ASARB], 2010) estimated that there are up to 600,000 Christian clergy in the United States. The 2010 U.S. Religion Census (ASARB, 2010), which is the most recent year for which data are available, estimated that there are approximately 345,000 religious congregations in the United States. The 20 largest denominations in the United States have an 85% overlap

with the 20 largest denominations in Florida, making Florida a reasonable representation of the broader religious affiliations of the United States (see Table 4).

Furthermore, Florida is the third most populous state in the U.S. (US Census Bureau, 2019), has a population that was accessible to the researcher, and is a state with considerable racial and ethnic diversity. Recent population estimates reveal the four largest racial and ethnic groups in Florida are: (a) White, non-Hispanic, 53%, (b) Hispanic or Latino, 26.4%, (c) Black or African American, 16.9%, and (d) Asian, 3%. These numbers are roughly comparable with the national racial and ethnic demographics: (a) White, non-Hispanic, 60.1%, (b) Hispanic or Latino, 18.5%, (c) Black or African American, 13.4%, and (d) Asian, 5.9%. It is important that this study sought to use a population with significant racial and ethnic diversity due to the fact that clients' preference for religious help-seeking behaviors are highly correlated with race and ethnicity (Chatters et al., 2008; Chatters et al., 2011; Crosby & Varela, 2014; Kane & Williams, 2000).

Given that this study focused on Christian clergy associated with established churches in the state of Florida (which is estimated to be home to more than 15,000 religious congregations; ASARB, 2010), a proportional, stratified random sample that was representative of the 20 largest Christian denominations in Florida was selected to receive an invitation to participate in the study. Lists of congregations were compiled using publicly available online resources and denominational lists, and contact email addresses for clergy were collected from church websites.

Table 4: Comparison of Largest Christian Denominations in the United States and Florida (Association of Statisticians of American Religious Bodies, 2010)

	United States		Florida	
	Denomination	Adherents	Denomination	Adherents
1.	Roman Catholic	58,927,887	Roman Catholic	2,513,839
2.	Southern Baptist	19,896,279	Southern Baptist	1,247,345
3.	Non-Denominational	12,241,329	Non-Denominational	868,527
4.	United Methodist	9,860,653	United Methodist	468,080
5.	LDS (Mormon)	6,144,582	Assemblies of God	246,270
6.	Evangelical Lutheran	4,181,219	LDS (Mormon)	136,925
7.	Assemblies of God	2,944,887	Episcopal Church	129,482
8.	Presbyterian (USA)	2,451,980	Presbyterian (USA)	127,670
9.	Lutheran (MO Synod)	2,270,921	National Baptist Convention (USA)	122,811
10.	Episcopal Church	1,951,907	Seventh Day Adventist	119,209
11.	National Baptist Convention (USA)	1,881,341	African Methodist Episcopal	111,300
12.	Church of Christ	1,584,162	Church of God (TN)	109,332
13.	American Baptist	1,560,572	Church of Christ	70,094
14.	Christian Churches	1,453,160	Evangelical Lutheran	68,140
15.	United Church of Christ	1,284,296	Lutheran (MO Synod)	65,448
16.	Seventh Day Adventist	1,194,996	Christian Churches	53,140
17.	Church of God (TN)	1,109,992	Church of the Nazarene	44,889
18.	African Methodist Episcopal	1,009,682	Presbyterian Church in America (PCA)	36,595
19.	Church of the Nazarene	893,649	National Baptists of America	33,439
20.	Christian Church (Disciples of Christ)	785,776	Greek Orthodox	32,587

Power Analysis and Sample Size

Researchers use statistical power analysis in order to ascertain whether their sample size is adequate to reject the null hypothesis (Gall et al., 2007). Statistical power is calculated based on the sample size, desired level of significance, directionality, and effect size (Gall et al., 2007). An *a priori* power analysis was completed for this study, using G*Power 3.1, in order to calculate the sample size that was needed in order to have adequate statistical power. The analysis for the primary research question involved using a linear multiple regression model involving five predictor variables to analyze the data. Therefore, the following options were selected in G*Power: (a) Test family: *F* tests; (b) Statistical test: Linear multiple regression: Fixed model, R^2 deviation from zero; and (c) Type of power analysis: A priori: Compute required sample size – given α, power, and effect size. Sample sizes were calculate based on both small (0.02) and medium (0.15) effect sizes (Cohen, 1992), using a power level of .80. Thus, for a multiple linear regression analysis to detect a medium effect size (0.15) at a level of $\alpha = 0.05$, with a power level of .80, a sample size of 92 would be necessary; while in order to detect a small effect size (0.02) at a level of $\alpha = 0.05$, with a power level of 0.80, a sample size of 647 would be necessary.

Response rates for email and internet-based surveys with a length of 10-30 minutes range from approximately 25 to 35 percent (Deutskens et al., 2004; Galesic & Bosnjak, 2009; Marcus et al., 2007), and recent web-based counseling studies involving clergy have resulted in response rates of 30-35 percent (Hedman, 2014; Payne, 2009). Therefore, to achieve 647 participants (assuming a response rate of 25%), the researcher attempted to gather a minimum of 2,588 clergy email addresses.

Recruitment Procedures

Efforts were made to obtain lists of clergy contact information from the selected denominations. In the case that such a list could not be obtained, the researcher used systematic internet searches to compile lists of clergy contact information from church websites. Once these lists were completed, a stratified random sample (according to denomination size) was selected to be contacted via email. Thus, more invitations to participate were sent to clergy affiliated with the largest denominations (i.e., Roman Catholic, Southern Baptist, United Methodist, etc.) while fewer invitations were sent to clergy affiliated with the smaller denominations on the list.

Incentives

In order to thank participants for their time, upon completing the survey, they had the opportunity to choose one of the following options: (a) for a $1 donation to be made on their behalf to support the work of International Justice Mission (IJM; www.ijm.org), (b) for a $1 donation to be made on their behalf to the Trauma Healing Institute (THI), which is a partner ministry of the American Bible Society (https://traumahealinginstitute.org/), or (c) for no donation to be made on their behalf. Donations to IJM and THI were made once the survey closed (see Appendices J & K).

Data Collection Procedures

Before collecting data, the researcher submitted an application to the Institutional Review Board (IRB) at the University of Central Florida (UCF) to conduct research with human subjects, a process that ensured that the study was conducted in an ethical manner. This study was designed to provide only minimal risks to participants. Initial IRB approval was received on September 10, 2018 (see Appendix A). In order to achieve a sufficient number of survey

responses, the researcher used the steps suggested by Dillman and colleagues (2009) to increase the response rate for an online survey. This involved sending an initial explanation of the study to participants, followed by an invitation to complete the study and two follow-up reminders.

Permissions

Permission to use copyrighted instruments was obtained from instrument developers and/or publishers prior to distributing the study materials. In particular, the researcher paid the publisher of the ARTIC scale in order to use the scale in academic research (see Appendix B). All other instruments were available for use without further permission from the publishers.

Risk for Participants

All responses were deidentified and no participant names were collected in order to protect the privacy of participants. Since it was possible that being asked about personal traumatic experience could trigger emotional discomfort or distress for participants, language was included in the study materials regarding this risk and participants were able to stop taking the assessments at any point in time without penalty. In the event that instrument questions provoked emotional discomfort, a list of online and print resources for trauma survivors was provided at the end of the study materials, as was a description of how to locate a local mental health provider (see Appendix I).

Informed Consent

An email was sent to clergy inviting their participation in the study, including abbreviated information about the study. Once the individual clicked on the link to the study materials, they were taken to the first page of the materials, which was comprised of the full informed consent information (see Appendix C). After reading the informed consent document, participants were

given the option to continue with the study by clicking on the "next" arrow, or to exit the study and withdraw from participation.

Data Collection

All data collection instruments were combined into a single online survey using Qualtrics, a web-based research survey program with multiple layers of security. Once data was exported from Qualtrics, it was immediately de-identified, encrypted, and stored on a password-protected hard drive.

Instrumentation

A total of five instruments were selected to collect data for this study: (a) the *Attitudes Related to Trauma-Informed Care Scale-10, Human Services* (ARTIC-10; Baker et al., 2016), (b) the *Brief Trauma Questionnaire* (BTQ; Schnurr et al., 1999), (c) the *Trait Emotional Intelligence Questionnaire– Short Form* (TEIQue-SF; Cooper & Petrides, 2010), (d) the *Marlowe-Crown Social Desirability Scale – Short Form* (Strahan & Gerbasi, 1972); and (e) a demographic questionnaire. The instruments were combined into a single, online survey that could be completed on both personal computers and mobile devices. Prior to distribution, the researcher recruited three individuals to complete the study materials in order to check for errors, readability, and determine the time needed to complete the materials. Based on these initial tests, it was expected that participants would need approximately 15-20 minutes to complete the study materials.

Attitudes Related to Trauma-Informed Care-10, Human Services

In the context of the current study, trauma-related attitudes and beliefs were defined as a person's beliefs about the causes, prevalence, and impact of psychological trauma and their

attitudes towards trauma survivors. Several measures of trauma-related attitudes and beliefs have been validated and published in recent years, with most designed to assess the implementation of trauma-informed practices in a particular system (e.g., child welfare organizations [Hendricks et al., 2011; Madden et al., 2017], health and human service organizations [Bassuk et al., 2017], etc.). The *Attitudes Related to Trauma-Informed Care* scale (ARTIC; Baker et al., 2016, Baker et al., 2020; see Appendix D) is designed to measure trauma-related attitudes and beliefs of educators and human services providers. The ARTIC was selected for this study because it includes a version appropriate for individuals who have had no prior exposure to trauma-informed practice (as opposed to individuals within organizations that are currently implementing trauma-informed training), has a 10-item short-form appropriate for use in internet-based studies, and the items were broad enough to be applicable to the work of clergy. Although the title of the instrument emphasizes that it is a measure of trauma-related *attitudes*, many of the items also assess trauma-related *beliefs* (see Table 5).

For this study, the summary score from the 10-item short form of the ARTIC human services scale (ARTIC-10-HS) was used. Each item is scored using a bipolar seven-point scale, with opposing attitudes appearing at each end of the scale. Before calculating the summary score, items 2, 4, 6, 8, and 9 are reverse coded. Then the individual items scores are totaled and averaged producing a final score between one (less trauma-informed) and seven (more trauma-informed). The initial sample (N = 760) used to develop and evaluate the ARTIC was comprised of human service, mental health, and health care workers, along with educators. Each form of the ARTIC was further studied for reliability and validity using a sample of 1,395 similar professionals (Baker et al., 2020). Internal consistency reliability for the ARTIC-10-HS was 0.82. Test-retest reliability for the ARTIC-10-HS at ≤ 120 days was 0.82 (Baker et al., 2016).

While the short form was utilized in this study, two longer versions of the assessment have also been published for use with human services organizations. First, the ARTIC-35-HS contains 35 items and provides scores for five core sub-scales as well as an overall summary score. The subscales are related to: (a) beliefs about the root causes of problem behavior, (b) response styles to problem behavior, (c) control-focused vs. empathy-focused on-the-job behavior, (d) self-efficacy at work, and (e) vicarious traumatization (Baker et al., 2016). The short form also addresses each of these dimensions of TIC but does not produce separate scores for subscales. Finally, the ARTIC-HS-45 adds two supplementary subscales related to attitudes and beliefs about the implementation of TIC in settings where a TIC model is already in place.

Table 5: Sample ARTIC-10-HS Scale Items (Baker et al, 2016)

	1	2	3	4	5	6	7	
Clients could act better if they really wanted to.	O	O	O	O	O	O	O	Clients are doing the best they can with the skills they have.
If clients say or do disrespectful things to me, it makes me look like a fool in front of others.	O	O	O	O	O	O	O	If clients say or do disrespectful things to me, it doesn't reflect badly on me.
Clients do the right thing one day but not the next. This shows that they are doing the best they can at any particular time.	O	O	O	O	O	O	O	Clients do the right thing one day but not the next. This shows that they could control their behavior if they really wanted to.
Clients need to experience real life consequences in order to function in the real world.	O	O	O	O	O	O	O	Clients need to experience healing relationships in order to function in the real world.

Since its publication, the ARTIC has been utilized in many published research studies related to trauma-informed care in a variety of settings (e.g., non-profit human services agencies [Marvin & Volino Robinson, 2018], nursing [Stokes et al., 2017], and teaching [Kim et al., 2021]). The construct validity of the instrument was examined and higher scores on the ARTIC were found to be correlated with higher levels of familiarity with trauma-informed care and more compassion satisfaction. In contrast, high ARTIC scores were inversely related to scores related to burnout and vicarious traumatization (Baker et al, 2020). One difficulty in determining the construct validity of the ARTIC scale is the lack of other reliable and valid measures of trauma-informed care assessments at this time.

Brief Trauma Questionnaire

The *Brief Trauma Questionnaire* (BTQ, Schnurr et al., 1999; see Appendix E) is a 10-item self-report trauma exposure (TE) measure recommended by the U.S. Department of Veterans Affairs National Center for PTSD (https://www.ptsd.va.gov/professional/assessment /te-measures/index.asp) and was developed from the *Brief Trauma Interview* (BTI; Schnurr, et al., 1995). The BTQ assesses whether or not an individual has experienced an event that would be classified as traumatic under the criterion established in the DSM-5 (APA, 2013). If an item is endorsed, then the respondent is asked to also respond to two further questions: (a) “Was there a realistic threat to your life/a sense of fear for your life?” and (b) “Were you physically injured?” In this study, the BTQ was used to measure the life-time trauma exposure (TE) of participants. The total score on the BTQ ranges from zero to ten and indicates the number of items that the respondent has endorsed. Thus, a score of zero would mean that the individual had not been exposed to any of the potentially traumatic events asked about on the BTQ, while a score of ten

would indicate that the individual had been exposed to at least one potentially traumatic event in each of the ten BTQ categories during their lifetime.

The BTQ has been used to gather data on TE in several significant longitudinal studies that have examined the long-term impact of TE (e.g., the Nurses' Health Study II [Koenen et al., 2009], the Mind Your Heart Study [Kalapatapu et al., 2017], the VA Normative Aging Study [Kang et al., 2016]). Research on the validity and reliability of the BTQ is based on an analysis of the original BTI. The BTI was developed using a sample of 436 male participants in the Department of Veterans Affairs' Normative Aging Study (Kang et al., 2016; Lee et al., 2019). The instrument measures exposure to potentially traumatic events, as well as the respondents' perceptions of the event (i.e., whether or not they believed their life was in danger or they may be seriously harmed). Schnurr and colleagues (2002) found that the BTI had good to excellent interrater reliability with all Kappa coefficients for the presence of trauma above 0.70 (range = 0.74-1.00) for all categories except for the categories of illness (0.69) and other life-threatening events (0.60). The BTI was also found to have criterion validity when compared with the DSM criteria for potentially traumatic events.

Table 6: Sample BTQ Items (Schnurr et al., 1999)

Event	Has this ever happened to you?	If the event happened, did you think your life was in danger or you might be seriously injured?	If the event happened, were you seriously injured?
Have you ever been in a serious car accident, or a serious accident at work or somewhere else?	No Yes	No Yes	No Yes
Have you ever had a life-threatening illness such as cancer, a heart attack, leukemia, AIDS, multiple sclerosis, etc.?	No Yes	No Yes	No Yes
Has anyone ever made or pressured you into having some type of unwanted sexual contact?	No Yes	No Yes	No Yes
Has a close family member or friend died violently, for example, in a serious car crash, mugging, or attack?	No Yes	*N/A*	No Yes

Trait Emotional Intelligence Questionnaire – Short Form

The Trait Emotional Intelligence Questionnaire - Short Form (TEIQue-SF; Cooper & Petrides, 2010; see Appendix F) was used to measure emotional intelligence (EI). The TEIQue was selected over other common EI assessments (e.g., Bar-On, 1997; Salovey et al, 1995; Schutte et al., 1998; Wong & Law, 2002) because it was designed to measure *trait* emotional intelligence, also known as *trait emotional self-efficacy*, rather than ability EI (i.e., maximal performance; Petrides & Furnham, 2000). Furthermore, the TEIQue is grounded in trait EI theory and has strong psychometric properties that have been proven over many years of systematic research (Petrides, 2009). Unlike other EI instruments that have been developed

primarily for coaching or personal development in business and educational settings (i.e., Bar-On, 1997), the TEIQue was developed with research and clinical applications in mind (Petrides, 2009).

The TEIQue-SF is a 30-item questionnaire designed to measure overall emotional intelligence (i.e., global trait EI). It is a shortened form of the original 153-item assessment and includes two items from each of the 15 domains of trait emotional intelligence that are assessed in the original TEIQue long form. Selection of items for inclusion in the TEIQue-SF was based on item correlations with the corresponding total factor scores (Cooper & Petrides, 2010; Petrides & Furnham, 2006). The TEIQue items are presented in a seven-point Likert-style question format, ranging from one (completely disagree) to seven (completely agree). The global score on the TEIQue-SF is a sum of all item scores divided by the number of items completed, with global trait EI scores ranging from one to seven (*mean* = 5.11, *SD* = 0.89, $\alpha = 0.88$; Petrides, 2009), with higher scores indicating a higher level of trait emotional intelligence. While scores for the four trait EI factors (i.e., well-being, self-control, emotionality, and sociability) can be calculated for the TEIQue-SF, these factor scores have lower internal consistency values than the longer form; therefore, it is not recommended that these factors scores be included for analysis (Petrides, 2009).

The psychometric properties of the TEIQue-SF were examined in two studies by Petrides (2009). The first study included 1,119 participants (58% female) who were recruited from both the local community and in a university setting. Mean age of participants was 32.18 years (*SD* = 11.52). The education levels of participants ranged from high school diploma (21%) to undergraduate degrees (41%) to postgraduate degrees (35%). The mean global trait EI score for men was 5.02 (*SD* = 0.73), while the mean score for women was 5.18 (*SD* = 0.68). Cronbach's

alpha for the men was 0.89 and for the women was 0.88. Men scored significantly lower on the TEIQue-SF than the women (t[1106] = 3.67, $p < .0001$) , however the effect size was small (d = 0.23). All items had discrimination values in the moderate to high range, with the exception of item 25 *("I tend to 'back down' even if I know I'm right"*).

Table 7: Sample TEIQue-SF Scale Items (Cooper & Petrides, 2010)

	1	2	3	4	5	6	7
	1 = completely disagree						7 = completely agree
I often find it difficult to see things from another person's viewpoint.	O	O	O	O	O	O	O
I generally don't find life enjoyable.	O	O	O	O	O	O	O
Many times, I can't figure out what emotion I'm feeling.	O	O	O	O	O	O	O
Those close to me often complain that I don't treat them right.	O	O	O	O	O	O	O
Generally, I'm able to adapt to new environments.	O	O	O	O	O	O	O

The second study included 866 participants (48% female) with a mean age of 26.97 years (SD = 10.29) and examined an updated version of the TEIQue-SF (Petrides et al., 2010) in which four items had been altered. The education levels of participants ranged from high school diploma (20%) to undergraduate degrees (41%) to postgraduate degrees (29%). The mean global trait EI score for men was 5.05 (SD = 0.69), while the mean score for women was 4.94 (SD = 0.67). Cronbach's alpha values for both men and women were high (α_{men} = 0.88, α_{women} = 0.87). In this study, the men scored significantly higher on the TEIQue-SF than the women (t[846] = 2.35, $p < .05$), however the effect size was again small (d = 0.16). All items had discrimination

values in the moderate to high range, with the exception of item 23 *("I often pause and think about my feelings"*).

Marlowe-Crowne Social Desirability Scale – Short Form X1

The results obtained from self-report measures, such as those used in the current study, can be compromised by the effects of answer patterns that conform to norms of social desirability (Holtgraves, 2004; Tracey, 2016).

In the case of the current study, clergy might choose the answers that would sound the best, or which are congruent with their perceptions of what clergy should think, rather than the answers that align most with their actual beliefs and experiences. In order to control for this bias, the researcher chose to include a measure of socially desirable response bias (SDRB) in order to adjust scores in the final analysis. The *Marlowe-Crowne Social Desirability Scale – Short Form X1* (MCSDS-X1, Strahan & Gerbasi, 1972) is a widely used assessment used to control for socially desirable response patterns (Barger, 2002; see Appendix G). The with 10 true/false items, the MCSDS-X1 is derived from the original 33-item *Marlowe-Crowne Social Desirability Scale* (MCSDS; Crowne & Marlowe, 1960). Total scores on the MCSDS-X1 range from 0 to 1, with higher scores indicating that the respondent is answering items with a bias towards providing the socially acceptable answer. While the reliability coefficient drops considerably from the MCSDS ($\alpha = 0.73$-0.87) to the MCSDS-X1 ($\alpha = 0.59$-0.70), the MCSDS-X1 is generally regarded as sufficient in instances where the brevity of the measure is essential (Ballard, 1992; Barger, 2002; Loo & Loewen, 2004; Strahan & Gerbasi, 1972). Various versions of the MCSDS (full or short-forms) have been used in many other clergy related studies over the past thirty years (e.g., Abdelsayed et al., 2013; Ferrari & Guerrero, 2017, 2018; Kappler et al., 2013; Weaver, 1996) in order to control for the tendency to "fake good" on self-report measures.

Table 8: Sample MCSDS-X1 Items (Strahan & Gerbasi, 1972)

Item		
I'm always willing to admit it when I make a mistake.	True	False
I never resent being asked to return a favor.	True	False
I like to gossip at times.	True	False

Demographic Questionnaire

A researcher-created demographic questionnaire was designed to gain the data needed for the proposed analyses, including information on trauma-specific training and time spent per week in pastoral care or pastoral counseling activities (see Appendix H). Furthermore, as a result of the literature review and what has been determined to potentially impact participants' perspectives about trauma, the researcher included questions that asked about (a) denominational affiliation, (b) gender, (c) race/ethnicity, (d) years worked in pastoral ministry, (e) educational degrees attained, (f) mental health licensure and certifications, (g) full-time work status, and (h) church congregation size.

Finally, due to the fact that this study was completed approximately one year into the global COVID-19 crisis, a final demographic question was added to the questionnaire in order to assess whether or not respondents had been directly affected by the virus. The respondents were asked: (a) whether they had personally been hospitalized due to COVID-related medical reasons, (b) if anyone in their family had been hospitalized with or died from COVID-related illnesses, and (c) if anyone in their church congregation had been hospitalized with or died from COVID-related illnesses.

Data Analysis

Primary Research Question

In order to analyze the relationship between the trauma-related attitudes and beliefs of Christian clergy, personal trauma exposure, completed trauma-related training, time per week spent in counseling-type ministry, and trait emotional intelligence, while controlling for the effects of socially desirable responding bias (SDRB), a hierarchical multiple regression was conducted. In step one, SDRB was entered, and the remaining variables were entered in step two (Cohen & Cohen, 1983; Petrocelli, 2003). In the full regression model (see Figure 1), it does not matter if the impact is direct or indirect, instead it demonstrates that trauma-related attitudes and beliefs are predicted using all independent variables and acknowledges measurement error. For this study, data analysis was conducted using IBM SPSS statistical software. Findings will be discussed in chapters 4 and 5.

Dependent Variable

The researcher selected trauma-related attitudes and beliefs as the dependent variable for the current study, since later training in trauma-informed care will be most effective if there is an understanding the attitudes and beliefs of leaders in the system (in this case, in the church environment). Therefore, trauma-related attitudes and beliefs (as measured by ARTIC-10-HS; Baker et al., 2016) were defined as the beliefs and attitudes of clergy that are related to their parishioners, their jobs, and themselves that impact their ability to engage people with trauma histories in their churches, by recognizing the impact of trauma on the lives of the people in their congregations (Baker et al, 2016). The ARTIC-10-HS is a ten-item measure that produces a mean score ranging from 1-7.

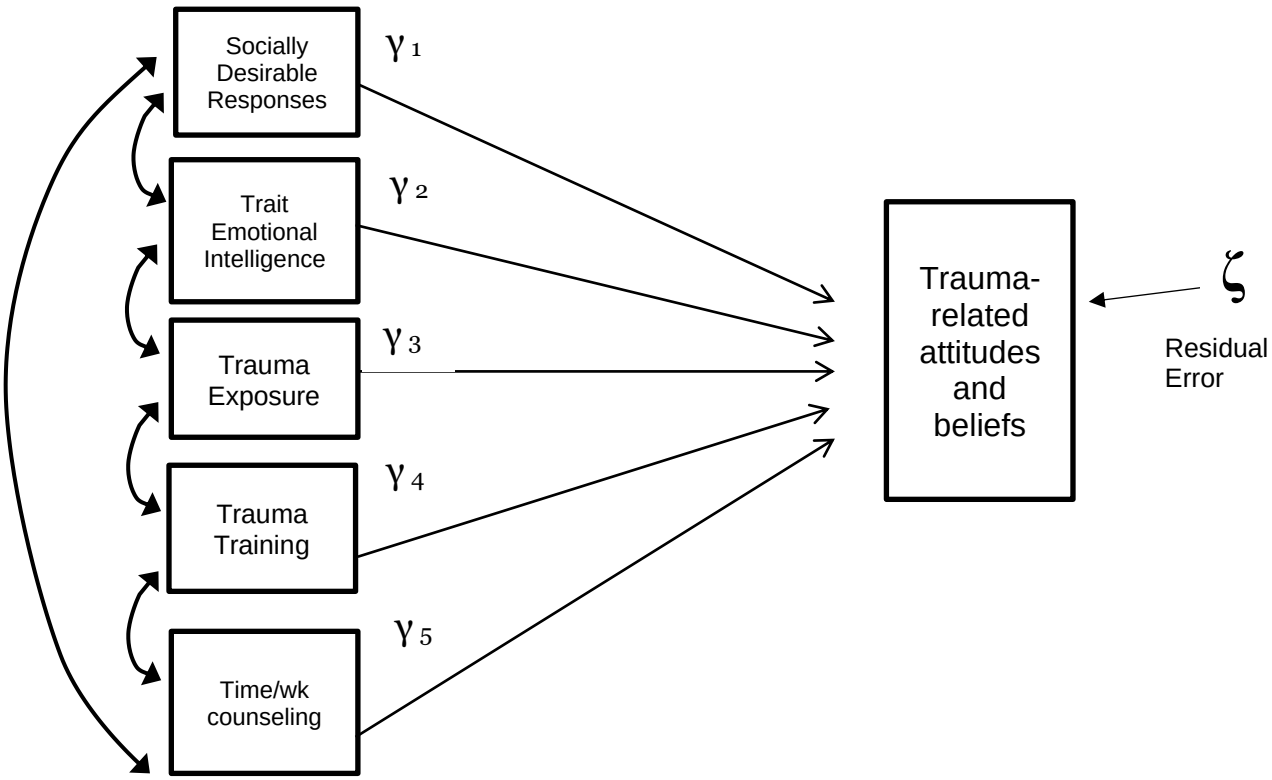

Figure 2: Multiple Regression Model for Trauma-Related Attitudes and Beliefs

Independent Variables

The researcher utilized total scores from measures for (a) trait EI (TEIQue-SF, Cooper & Petrides, 2010) and (b) life-time TE (BTQ, Schnurr et al., 1999) for the first two IVs. The TEIQue-SF is comprised of 30 items and produces a global trait emotional intelligence mean score, ranging from 1-7, while the BTQ is a 10-item assessment of life-time trauma exposure with scores ranging from 0-10. Furthermore, the numeric responses to a demographic question related to hours per week spent in pastoral care or counseling were used as a third IV. The fourth IV was a binary measure (yes/no) of whether or not the participant had received any level of trauma-related training in the past. Finally, the fifth IV was the mean score from the measure of

SDRB (MCSDS-X1, Strahan & Gerbasi, 1972) to control for bias in responses on self-report measures to answer in ways that are viewed as more socially acceptable, with scores ranging from 0-1.

Exploratory Research Questions

The first two exploratory research questions were included in order to look for differences in scores related to (a) trauma-related attitudes and beliefs and (b) trait emotional intelligence between members of various demographic groups. For example, scores were compared by race/ethnicity, religious affiliations (i.e., denominations), and having an educational degree or advanced certification in a counseling-related field. For this kind of between group comparisons of scores for one continuous dependent variable, data analysis is best done using a one-way ANOVA (analysis of variance) test to consider the variability of mean scores between groups (Lomax & Hahs-Vaughn, 2012). The final exploratory research question was included in order to quantitatively assess the prevalence of trauma exposure among clergy.

Chapter Summary

The study was designed to analyze the associations between the trauma-related attitudes and beliefs of Christian clergy and a variety of personal and professional factors. Chapter 3 provided an outline of the research design and methodology used in the study including: (a) the selection of appropriate variables, (b) population and sampling procedures, (c) data collection (including instrumentation), and (d) plans for data analysis. This study was conducted using an online instrument package and invitations to participate were sent to clergy from the twenty largest Christian denominations in Florida. Furthermore, the psychometric properties of the selected measurement instruments (e.g., ARTIC-10-HS, BTQ, TEIQue-SF, and MCSDS-X1)

were considered for reliability and validity and found to be appropriate to measure the constructs of interest in this study. Finally, Chapter 3 gave a brief outline of the data analysis plan for both the primary and exploratory research questions.

CHAPTER FOUR: RESULTS

In Chapter 4, the research findings and statistical analyses will be reported. The purpose of this study was to assess how much of the variance in the trauma-related attitudes and beliefs of Christian clergy from the 20 largest denominations in Florida could be explained by selected personal and professional factors. A hierarchical multiple regression model was used to analyze the primary research question, while analyses of variance were used for the exploratory research questions. In this chapter, the researcher will (a) review the primary and exploratory research questions, (b) explain sampling and data collection procedures, (c) discuss the data cleaning process and statistical assumptions for multiple regression, and (d) review the initial results of the data analysis of the primary and exploratory research questions.

The primary research question in this study was: After controlling for the effects of socially desirable responding bias (as measured by the *Marlowe-Crown Social Desirability Scale – Short Form* (MCSDS-X1; Strahan & Gerbasi, 1972), how much of the variance in the trauma-related attitudes and beliefs of Christian clergy (as measured by the *Attitudes Related to Trauma-Informed Care -10, Human Services* scale [ARTIC-10-HS; Baker et al., 2016]) can be explained by clergy's personal trauma exposure (as measured by the *Brief Trauma Questionnaire* [BTQ, Schnurr et al., 1999]), trait emotional intelligence (as measured by the *Trait Emotional Intelligence Questionnaire– Short Form* [TEIQue-SF; Cooper & Petrides, 2010]), trauma-specific training (as assessed on demographic questionnaire), and time per week spent in counseling-type ministry (as assessed on demographic questionnaire)?

The exploratory research questions in this study can be summarized as: (a) Are there significant differences in the trauma-related attitudes and beliefs of Christian clergy by religious affiliations, race or ethnicity, or having a graduate degree/advanced certification in counseling?,

(b) Are there significant differences in the level of emotional intelligence of clergy based on religious affiliations, race/ethnicity, or having a graduate degree/advanced certification in counseling?, and (c) What is the prevalence of trauma among clergy?

Reliability of Instruments

The questionnaire used to gather data for this study was comprised of 71 items to measure the constructs of (a) trauma-informed attitude and beliefs [10 items], (b) personal trauma history [10 items], (c) trait emotional intelligence [30 items], (d) trauma-specific training [1 item], (e) hours of pastoral care work per week [1 item], and (f) socially desirable response bias [10 items]. The remaining nine items collected demographic information about the participants.

For the scales measuring trauma-related attitudes and beliefs, trait emotional intelligence, and socially desirable response bias, the researcher utilized SPSS to calculate the internal consistency of each scale using Cronbach's alpha. The 10-item scale measuring trauma-related attitudes and beliefs (ARTIC-10-HS; Baker et al., 2016) had a low level of internal consistency ($\alpha = .653$) but was still within the acceptable range (Green et al., 1977; Spector, 1992). This result is lower than the internal reliability calculated by Baker et al. (2016) for the same instrument ($\alpha = .82$). In contrast, the scale used to measure trait emotional intelligence (TEIQue-SF; 30 items; Cooper & Petrides, 2010) had a high level of internal consistency ($\alpha = .888$). Finally, the *Marlowe-Crown Social Desirability Scale – Short Form* (MCSDS-X1; Strahan & Gerbasi, 1972) had a lower level of internal consistency ($\alpha = .694$).

Sampling and Data Collection Procedures

In order to be included in this study, participants had to match three criteria: (a) age 18 or

older, (b) ordained pastor, priest, minister or other member of the Christian clergy, and (c) work at a church in Florida. While the *a priori* analysis indicated a need for a minimum of 92 completed surveys to calculate medium effect sizes, during the course of the data collection a total of 235 surveys were completed using Qualtrics survey software online.

Recruitment Methods

In order to create the participant contact list, a collection of 2,759 active email addresses was compiled using information that was publicly available on the internet. These addresses were primarily found on the websites of individual church congregations. Participants were recruited from the 20 largest Christian denominations in Florida. Finally, the email addresses were sorted into two sub-lists: (a) direct contact emails for clergy members (n = 1872) and (b) general contact email addresses for churches (n = 887). An attempt was made to gather more contact information for the largest denominations (e.g., Roman Catholic, Southern Baptist, non-denominational Protestant, United Methodist, and Assemblies of God), with fewer email addresses gathered for groups with fewer congregations and members in Florida (e.g., Church of the Nazarene, Presbyterian Church in America (PCA), Greek Orthodox Church, etc.). Of the twenty largest denominations in Florida, it was not possible to find any publicly available email addresses for clergy from two denominations: the Church of Jesus Christ of Latter-day Saints (Mormon/LDS) and the Seventh-Day Adventist Church. Attempts to make contact with regional church leaders from these denominations were not successful. Additionally, significantly less information was found online regarding the African-American Episcopal Church (AME) and the National Baptists of America, both historically black denominations. While attempts were made to contact denominational leaders in order to gain contact information for more pastors from these denominations, a lack of response limited the racial diversity of the sample. See Table 9 for

detailed information about the distribution of study invitations and participants according to denominational affiliations.

Table 9: Largest Denominations in Florida, Study Invitations Sent, and Completed Responses

	Denomination	Adherents in FL[a]	Invitations to Participate[b]	Completed Responses	% of Sample
1.	Roman Catholic	2,513,839	468	26	11.1%
2.	Southern Baptist	1,247,345	381	38	16.2%
3.	Non-Denominational	868,527	414	32	13.6%
4.	United Methodist	468,080	350	18	7.7%
5.	Assemblies of God	246,270	237	4	1.7%
6.	LDS (Mormon)*	136,925	--	--	--
7.	Episcopal Church	129,482	323	27	11.5%
8.	Presbyterian (USA)	127,670	224	26	11.1%
9.	National Baptist Convention (USA)	122,811	50	2	0.8%
10.	Seventh Day Adventist*	119,209	--	--	--
11.	African Methodist Episcopal	111,300	43	3	1.3%
12.	Church of God (TN)	109,332	113	3	1.3%
13.	Church of Christ	70,094	70	2	0.8%
14.	Evangelical Lutheran	68,140	72	9	3.8%
15.	Lutheran (MO Synod)	65,448	99	12	5.1%
16.	Christian Church / Disciples of Christ	53,140	44	8	3.4%
17.	Church of the Nazarene	44,889	227	5	2.1%
18.	Presbyterian Church in America (PCA)	36,595	158	10	4.3%
19.	National Baptists of America*	33,439	--	--	--
20.	Greek Orthodox	32,587	22	0	0
	*Other***			10	4.3%
		Totals:	3,295	235	100%

Note. *No public listing of email addresses found for these denominations. **Invitations were sent to the 20 denominations listed, but some participants indicated belonging to other denominations. a. Association of Statisticians of American Religious Bodies, 2010; b. Denominational contact lists were compiled using public listings of email addresses on church and denominational websites.

The researcher received initial approval from the Institutional Review Board of the University of Central Florida on September 5, 2018 (see Appendix A). Due to various delays, data collection did not occur until March 2021. All data collection occurred online, using Qualtrics survey software. The initial study invitation was sent to participants via Qualtrics on March 16, 2021, followed by two reminder emails (on March 22, 2021 and April 9, 2021). Data collection continued for a total of one month and closed on April 15, 2021. As an incentive, participants who completed the survey could select that a donation of $1.00 be made to one of two trauma-focused non-profit groups: International Justice Mission (www.ijm.org) or the Trauma Healing Institute (http://thi.americanbible.org/). Donations were made on May 9, 2021 to each organization ($100 to THI [see Appendix J], $150 to IJM [see Appendix K]).

Response Rate

While a list of 2,759 email addresses was compiled, separate response rates were calculated for (a) the list of direct contact emails for clergy members and (b) the list of general contact email addresses for churches. The list of direct contact emails included email addresses that appeared to be directly connected to individual clergy members, in contrast to the general contact list which included email addresses that were designated for a church administrator or general informational inquiries. For the direct clergy contact list (n = 1872), the response rate was 11.4%. Of the 262 surveys that were started, 82% were completed (n = 215). For the general contact email addresses for churches (n = 887), the response rate was 5.7%. Of the 78 surveys started, 65% were completed (n = 51).

Participant Demographic Information

Data collection resulted in a final sample of 235 Christian clergy who fully completed the

study materials. The majority of participants identified themselves as male (*n* = 198, 83.9%) compared to female (*n* = 37, 15.7%). The majority of respondents also identified their racial and/or ethnic identity as Caucasian (*n* = 202, 85.6%), while other respondents indicated that that their racial and/or ethnic identity was: (a) Hispanic and/or Latino/a (*n* = 11, 4.7%), (b) Black or African-American (*n* = 14, 5.9%), (c) Asian or Asian-American (*n* = 4, 1.7%), (d) Middle Eastern or North African (*n* = 1, 0.4%), and (e) Multiracial (*n* = 4, 1.7%).

Regarding the length of time that participants have worked in pastoral ministry, the mean length of service was 21.99 years (*n* = 235, *SD* = 12.25) with participants responding with answers ranging from one to 55 years. The mean amount of time spent in activities related to providing pastoral care or counseling was 13.64 hours per week (*n* = 235, *SD* = 13.41) with responses ranging from one to 60 hours per week. Almost all participants reported working full-time (more than 30 hours per week) within a church context (*n* = 217, 91.9%), while only 7.6% reported working in a part-time clergy role (*n* = 18).

Church Characteristics

The clergy who responded to the survey represented churches of various sizes: (a) less than 100 members and regular attenders (*n* = 41, 17.4%), (b) 100-250 members and regular attenders (*n* = 48, 20.3%), (c) 250-500 members and regular attenders (*n* = 56, 23.7%), (d) 500-1000 members and regular attenders (*n* = 42, 17.8%) and (e) over 1000 members and regular attenders (*n* = 48, 20.3%). The largest number of participants identified that they worked as clergy for the Southern Baptist Church (*n* = 38, 16.2%), while many other Christian denominations were also represented in the sample (see Table 10): (a) Non-denominational or independent (*n* = 32, 13.6%); (b) Episcopal Church (*n* = 27, 11.5%); (c) Roman Catholic Church (*n* = 26, 11.1%); (d) Presbyterian Church, USA (*n* = 26, 11.1%); (e) United Methodist Church (*n*

= 18, 7.7%); (f) Lutheran Church, Missouri Synod (*n* = 12, 5.1%); (g) Presbyterian Church in America (*n* = 10, 4.3%); (h) Evangelical Lutheran Church in America (*n* = 9, 3.8%); (i) Baptist, other (*n* = 8, 3.4%); (j) Disciples of Christ (*n* = 8, 3.4%); (k) Church of the Nazarene (*n* = 5, 2.1%); (l) Assemblies of God (*n* = 4, 1.7%); (m) African Methodist Episcopal Church (*n* = 3, 1.3%); (n) Church of God, Cleveland, TN (*n* = 3, 1.3%); (o) Church of Christ (*n* = 2, 0.9%); (p) National Baptist Conference (*n* = 2, 0.9%); and Other, Evangelical (*n* = 2, 0.9%). When these denominations are grouped into major denominational families (according to the taxonomy used by the Pew Research Center [2015]), the participants represented four major groups: (a) Evangelical Protestant (*n* = 116, 49.4%), (b) Mainline Protestant (*n* = 88, 37.4%), (c) Historically Black Protestant (*n* = 5, 2.1%), and (d) the Roman Catholic Church (*n* = 26, 11.1%).

Table 10: Participants' Denominational Affiliations by Denominational Family

Denomination	*n*	Total Percent
Evangelical Protestant*	116	49.4%
Southern Baptist Church	28	16.2%
Non-denominational / Independent	32	13.6%
Lutheran (Missouri Synod)	12	5.1%
Presbyterian Church in America (PCA)	10	4.3%
Baptist (other)	8	3.4%
Church of the Nazarene	5	2.1%
Assemblies of God	4	1.7%
Church of God (Cleveland, TN)	3	1.3%
Church of Christ	2	0.9%
Other, Evangelical	2	0.9%
Mainline Protestant*	88	37.4%
Episcopal Church	27	11.5%
Presbyterian Church (USA)	26	11.1%
United Methodist Church	18	7.7%
Evangelical Lutheran Church in America	9	3.8%
Disciples of Christ	8	3.4%
Historically Black Protestant*	5	2.1%
African Methodist Episcopal Church	3	1.3%
National Baptist Conference	2	0.9%
Roman Catholic Church*	26	11.1%
Totals *N* =	235	100%

Note: *Denominational groupings correspond with the taxonomy established by the Pew Research Center (2015)

Education and Training

In the demographic questionnaire, participants were asked several questions related to their education and training. When asked about the highest educational degree completed, only 1.3% of the sample reported no education beyond secondary school (n = 3). The rest of the participants had completed the following degree programs: (a) Associate of Arts or Sciences (n = 5, 2.1%), (b) Bachelor of Arts or Sciences (n = 26, 11.0%), (c) Master of Arts or Sciences in a mental health field (n = 9, 3.8%), (d) Master of Theology or Biblical Studies (n = 12, 5.1%), (e) master's degree, other (n = 9, 3.8%), (f) Master of Divinity (M.Div., n = 133, 56.6%), (g) Doctor of Ministry (n = 25, 10.6%), and (h) Doctor of Philosophy (PhD), other (n = 13, 5.5%). Of the entire sample, 168 participants (71.5%) held the degree of M.Div. (although some had also attained a higher degree) and 67 participants did not have an M.Div. (28.5%). About one third of the clergy who responded to the survey had obtained either an advanced degree or certification in a mental health or pastoral counseling field (n = 70, 29.8%) while the majority did not have any advanced degrees or certifications in these areas (n = 165, 70.2%).

Additionally, participants were asked whether they had completed any training specifically about caring for individuals and communities who have experienced trauma; less than half of the participants answered affirmatively (n = 105, 44.7%). For participants who indicated that they had completed trauma-related training, they were asked to specify what kind of training they had completed by writing in a response. Responses broadly fell into three categories: (a) graduate level training in mental health care, pastoral counseling, or chaplaincy, (b) crisis and disaster response, and (c) trauma-informed trainings related to foster care, adoption, and parenting. A sampling of answers can be found in Table 11.

Table 11: Sample of Narrative Responses Regarding Completed Trauma-Related Trainings

Graduate-level course work
Clinical Pastoral Education (CPE, chaplaincy training courses)
Pastoral counseling courses at seminary
Graduate level mental health counseling or social work courses
Crisis and Disaster Response trainings
Traumatic event management course
Workshops on disaster relief care
Psychological First Aid training / Red Cross Disaster Readiness
American Association of Christian Counselors' Grief, Crisis, & Disaster training
Grief counseling training
Suicide prevention training
Trauma-Informed Foster Care, Adoption, & Parenting trainings
Empowered to Connect (course for foster and adoptive parents)
Trust-Based Relational Intervention (TBRI) training
Adverse Childhood Experiences (ACEs) workshop

Data Screening and Statistical Assumptions

In order to investigate the primary research question, the researcher utilized hierarchical multiple regression for data analysis. All study instruments were completed in the online Qualtrics platform and then the data was exported directly from Qualtrics into SPSS. Total scores for each instrument (ARTIC-10-HS, BTQ, TEIQue-SF, and MCSDS-X1) were calculated using the COMPUTE VARIABLE function in SPSS. Then the researcher examined the data for errors, including missing values and outliers. Subsequently, the data was screened to see if it met all of the assumptions of the hierarchical multiple regression model. In the next section, the researcher will describe each of these steps and the results of the analyses.

Data Cleaning

Error Checking

Since errors within the data can distort the results of statistical analyses, the researcher created frequency tables for each variable and screened the data by looking for missing values and outliers. Since all data was directly exported from Qualtrics into SPSS, this prevented any data entry errors from occurring. However, while a total of 273 unique individuals responded to the study materials, some responses were incomplete, indicating that the respondent did not fully complete the materials. In these cases, the incomplete materials were removed from the data set using listwise deletion, leaving 236 fully completed materials.

Missing Values Analysis

By using the online survey software, participants were forced to respond to each item before moving on to the next. However, the researcher failed to choose the "forced response" option for a set of four items in the TEIQue-SF and in three cases one or more of these items was left blank. However, since these were the only missing values in the data set, the overall percentage of missing data was determined to be less than 5% by using the explore function of Descriptive Statistics in SPSS. In order to check whether the missing values were missing at random, Little's test was run for the data collected from the TEIQue-SF. The results of Little's test were not significant (*Chi-Square* = 99.337, *df* = 106, *p* = .663), indicating that the missing values from the TEIQue-SF were missing completely at random (MCAR) and unlikely to influence the multiple regression analysis (Osborne, 2013). Therefore, the researcher consulted the technical manual for the TEIQue (Petrides, 2009) in order to follow the scale developer's recommendation for dealing with missing values (which involved replacing the missing value with the mean value [e.g., a 4, which is the mean score on the 1-7 Likert-type scale used in this

instrument]). After completing this process, the researcher was able to keep these three cases in the final data analysis. Since these were the only values missing from the data set, no further analyses were run related to missing data from other instruments.

Assumptions for Multiple Regression Analysis

In order to obtain accurate results from a hierarchical multiple regressions analysis, the data must meet eight basic assumptions: (a) a continuous dependent variable, (b) two or more continuous or categorical dependent variables, (c) independence of observations (or errors), (d) a linear relationship between the dependent variable and independent variables, (e) homoscedasticity of residuals, (f) absence of multicollinearity, (g) no significant outliers or unusual cases, and (h) normal distribution of residuals (Laerd Statistics, 2015; Tabachnick & Fidell, 2013). The dependent variable for this study was the trauma-informed attitudes and beliefs of Christian clergy as measured by the ARTIC-10-HS (Baker et al., 2016). Total scores on the ARTIC-10-HS range from one (least trauma informed) to seven (most trauma informed); therefore, it meets the requirement of being a continuous variable. Furthermore, the five independent variables in this study (e.g., trait emotional intelligence, personal trauma history, hours spent per week providing pastoral care or counseling, previous trauma-related training, and socially desirable response bias) all met the criteria of being either continuous or categorical variables. Below, the remaining six assumptions are considered in more depth.

Independence of Observations

When using multiple regression analysis, it is important to test for the independence of observations (also known as independence of errors). While the design of this study made it highly unlikely that the observations would be related, the Durbin-Watson test was used to

statistically assess the independence of errors. With values ranging from zero to four, the Durbin-Watson test indicates independence of errors when it is near two (Laerd Statistics, 2015). For this regression model, the Durban-Watson statistic was 1.928, indicating that the data meets the assumption of independence of observations.

Linear Relationship Between Dependent and Independent Variables

The assumption of linearity means that there must be (a) a linear relationship between the collective independent variables and the dependent variable and (b) a linear relationship between each independent variable and the dependent variable. The relationship between the dependent variable and the collective independent variables was determined by examining scatterplots of the studentized residuals against the predicted values, which indicated that a linear relationship did exist and, therefore, the first part of the assumption (a) was met. In order to establish if there was a linear relationship between the dependent variable and each independent variable (separately), partial regression plots were examined and demonstrated linear relationship (therefore meeting the second part of this assumption [b]).

Homoscedasticity of Residuals

In order to meet the assumption of homoscedasticity, "the standard deviations of errors of prediction [must be] approximately equal for all predicted dependent variable scores" (Tabachnick & Fidell, 2013, p. 127). Homoscedasticity can be examined by visually examining the scatterplots of studentized residuals and unstandardized predicted values for the dependent variable (Laerd Statistics, 2021): this was completed and resulted in meeting the assumption of homoscedasticity.

Multicollinearity

To accurately calculate a multiple regression analysis, there must be an absence of multicollinearity between variables. This means that no two (or more) independent variables should be highly correlated with one another because that could cause difficulty in understanding the contribution of each independent variable to the regression model (Tabachnick & Fidell, 2013). The data in the current study was screened for multicollinearity "through an inspection of correlation coefficients and tolerance/VIF values" (Laerd Statistics, 2021, Hierarchical Multiple Regression Assumptions, para. 14). In the regression model used for this study, the tolerance values were examined, and no values were found to be less than 0.1; thus, it was unlikely that a problem with collinearity existed (Hair et al., 2014).

Unusual Cases and Outliers

In multiple regression models, extreme or unusual cases can interfere with the generalization of the regression equation (Laerd Statistics, 2015). The data in this study was examined for (a) outliers, (b) high leverage points, and (c) highly influential points. In order to detect outliers, the casewise diagnostics table was examined for any standardized residual values greater than ±3 standard deviations. The only assessment that had any potential outliers was the ARTIC-10-HS, with three cases that had scores that could be considered outliers. Subsequently, the studentized deleted residuals were examined to see if any of these were great than ±3 standard deviations and the same three cases were again identified as outliers.

Next, the data was examined for high leverage points that could distort the analysis. All leverage values were less that 0.2 and were thus considered safe (Laerd Statistics, 2015). Finally, the data was screened for influential points by examining the Cook's Distance values for each case. All values for Cook's distance were below 0.5 and did not require further investigation

(Laerd Statistics, 2015). As a result of these three analyses, the three cases that included ARTIC-10-HS scores that were outliers were reconsidered. Although none of the cases were high leverage values or highly influential, following the recommendations of Tabachnick & Fidell (2013) for studies when $N < 1000$, the researcher decided to remove one case (the most extreme outlier) that had a standardized residual in excess of ±3.3. The case was removed from the data set and the analysis was re-run.

Distribution of Residuals

Multiple regression analyses are "fairly robust to deviations from normality" (Laerd Statistics, 2015, Multiple Regression Checking for Normality, para. 3). Nevertheless, it is important to check the assumption of normality to ensure that the data is approximately normally distributed. The researcher checked for normality by looking at the distribution of the residuals using the histogram and P-P Plot and found that the assumption of normality was met.

Data Analysis

Preliminary Analysis Results

Univariate Descriptive Statistics

Before beginning the multiple regression analysis, the researcher examined the mean scores for the four data collection instruments used in this study: (a) the ARTIC-10-HS (Baker et al., 2016), (b) the TEIQue-SF (Cooper & Petrides, 2010), (c) the BTQ (Schnurr et al., 1999), and (d) the MCSDS-X1(Strahan & Gerbasi, 1972). Descriptive statistics for the total scores from each instrument can be found in Table 12. The mean score on the ARTIC-10-HS was 5.35 [*SD* = .59] and scores ranged from 3.5 to 6.9, with higher scores indicating a more trauma-informed perspective. For the BTQ, participants were asked to report trauma exposure in various

categories over their lifetime. The mean total score for the BTQ was 3.14 [*SD* = 1.92] and the range of scores was from 0 to 9 (with higher scores representing more trauma exposure). TEIQue-SF total scores ranged from 2.43 to 7.0 with higher scores indicating a higher degree of trait emotional intelligence. The mean total score on the TEIQue-SF was 5.49 [*SD* = 0.67]. Finally, the MCSDS-X1 was used to measure socially desirable response patterns. The mean total score for the MCSDS-X1 was 0.54 [*SD* = .23] and scores ranged from 0 to 1.

Table 12: Descriptive Statistics for Total Scores from Data Collection Instruments

Instrument	*N*	Min	Max	Mean	*SD*	Skewness		Kurtosis	
						Statistic	Std. Error	Statistic	Std. Error
ARTIC-10	235	3.50	6.90	5.35	.59	-.064	.159	-.098	.316
BTQ	235	0	9	3.14	1.92	3.680	.558	.159	.062
TEIQue-SF	235	2.43	7.00	5.49	.67	-.973	.159	1.801	.316
MCSDS-X1	235	.00	1.00	.54	.229	-.158	.159	-.633	.316

Bivariate Correlations

Once it was determined that all assumptions were met for the multiple regression analysis, the researchers examined the direction and strength of the linear relationships between each variable in the study (e.g., trauma-related attitudes and beliefs, personal trauma history, trait emotional intelligence, prior trauma-informed training, hours spent per week in pastoral counseling or care tasks, and socially desirable response bias) by using the Pearson product-moment correlation coefficient. This allowed the researcher to understand the relationship

between each pairing of variables. The Pearson correlation coefficient (r) can range from -1 to +1. Values closer to ±1 indicate a stronger association between variables, while a value of 0 indicates that no relationship exists between the variables. The statistically significant relationships between variables are discussed below.

First, correlations between trauma-informed attitudes and beliefs and the independent variables were considered using Pearson's product-moment correlation coefficient. There was a small, positive correlation between trauma-related attitudes and beliefs (as measured by the ARTIC-10-HS [Baker et al., 2016]) and trauma-informed training, $r = 0.152$, $n = 235$, $p = 0.01$. The data demonstrated that participants who had completed any trauma-informed training had higher levels of trauma-related attitudes and beliefs. The relationship between trauma-related attitudes and beliefs and trait emotional intelligence (as measured by the TEIQue-SF [Cooper & Petrides, 2010]) was also significant, demonstrating a medium, positive correlation between these variables, $r = .0.359$, $n = 235$, $p < 0.001$. In other words, individuals with higher levels of trauma-related attitudes and beliefs also had higher levels of trait emotional intelligence.

Next, the relationships between personal trauma history and each of the other variables were also examined using Pearson's r. There was a small, positive correlation between personal trauma history (as measured by the BTQ [Schnurr et al., 1999]) and having attended any trauma-informed training, $r = 0.16$, $n = 235$, $p = 0.007$. Thus, individuals who had higher levels of prior exposure to potentially traumatic events were more likely to have attended a trauma-informed training. Additionally, there was a small, statistically significant, negative correlation between personal trauma history and socially desirable responding bias (as measured by MCSDS-X1 [Strahan & Gerbasi, 1972]), $r = -0.14$, $n = 235$, $p = 0.016$. The data demonstrated that individuals who had higher levels of prior exposure to potentially traumatic events were less likely to answer

to the questionnaire with a bias towards a socially desirable response pattern. Finally, socially desirable responding bias had a medium, positive linear relationship with trait emotional intelligence (as measured by the TEIQue-SF [Cooper & Petrides, 2010]) that was statistically significant, $r = .397$, $n = 235$, $p < 0.001$. In other words, higher levels of trait emotional intelligence were significantly associated with a bias towards a socially desirable response pattern.

Results of Hierarchical Multiple Regression Analysis

In order to discover how much of the variance in the trauma-related attitudes and beliefs of Christian clergy (as measured by the *Attitudes Related to Trauma-Informed Care -10, Human Services* scale [ARTIC-10-HS; Baker et al., 2016]) was predicted by (a) clergy's personal trauma history (as measured by the *Brief Trauma Questionnaire* [BTQ, Schnurr et al., 1999]), (b) trait emotional intelligence (as measured by the *Trait Emotional Intelligence Questionnaire– Short Form* [TEIQue-SF; Cooper & Petrides, 2010]), (c) trauma-specific training (as assessed on demographic questionnaire), and (d) time per week spent in counseling-type ministry (as assessed on demographic questionnaire), while also controlling for (e) the effects of socially desirable responding bias (as measured by the *Marlowe-Crown Social Desirability Scale – Short Form* (MCSDS-X1; Strahan & Gerbasi, 1972), the researcher utilized hierarchical multiple regression with trauma-related attitudes and beliefs as the dependent variable and trauma history, emotional intelligence, trauma training, time spent counseling, and socially desirable responding bias as predictor variables.

Initial Regression Analysis

Initially, socially desirable response bias (total score on MCSDS-X1) was entered into

block 1, and the remaining dependent variables were entered in block 2, as it was hypothesized that socially desirable response bias may impact response patterns on the ARTIC-10-SF. However, socially desirable response bias did not significantly predict trauma-related attitudes and beliefs in model 1, $F(1, 233) = 0.000$, $p = .987$; adj. $R^2 = -0.004$, $f^2 = 0.000$ (see Table 13). Yet, in this analysis model 2 did predict the variability in trauma-related attitudes and beliefs in a statistically significant way, $F(4, 229 = 9.185$, $p < 0.001$; adj. $R^2 = 0.167$, $f^2 = 11.481$.

Table 13: Initial Model Summary [c] of Hierarchical Multiple Regression Analysis with MCSDS in Model 1

Model	*R*	R^2	Adj. R^2	Std. Error of Est.	R^2 change	*F* change	df1	df2	sig. *F* change
1	.001[a]	.000	-.004	.59493	.000	.000	1	233	.987
2	.409[b]	.167	.149	.54769	.167	11.481	4	229	.000

Note. a. Predictors: (Constant), MCSDS; b. Predictors: (Constant), MCSDS, Pastoral Care, Trauma-Related Training, BTQ, TEIQue-SF; c. Dependent Variable: ARTIC-10-HS.*

Final Regression Analysis

Based on these results, and a reassessment of the theoretical framework of the study, the researcher changed the hierarchical regression model to load trauma-informed training into block 1 in order to isolate the degree to which trauma-informed training predicated change in trauma-related attitudes and beliefs. All other independent variables were loaded into block 2 and then the researcher ran another multiple regression analysis. In this analysis, both models significantly predicted the variance in trauma-related attitudes and beliefs among participants: Model 1, $F(1, 233) = 5.519$, $p = .020$; adj. $R^2 = .019$, *F Change* = 5.519; Model 2, $F(4, 229) = 9.185$, $p < 0.001$;

adj. R^2 = 0.149, *F Change* = 9.891 (see Table 14).

Table 14: Final Model Summary [c] of Hierarchical Multiple Regression Analysis with Trauma-Related Training in Model 1

Model	*R*	R^2	Adj. R^2	Std. Error of Est.	R^2 change	*F* change	df1	df2	sig. *F* change
1	.152[a]	.023	.019	.58800	.023	5.519	1	233	.020
2	.409[b]	.167	.149	.54769	.144	9.891	4	229	.000

Note. a. Predictors: (Constant), Trauma-Informed Training; b. Predictors: (Constant), Trauma-Related Training, Pastoral Care, BTQ, TEIQue-SF, MCSDS; c. Dependent Variable: ARTIC-10.*

The summary of the final hierarchical regression analysis can be found in Table 15. The adjusted R^2 value of 0.019 in Model 1 indicates that a small, but statistically significant (ß = .152; $p < 0.05$) amount of the variance in trauma-related attitudes and beliefs can be predicted by prior participation in any kind of trauma-informed or trauma-specific training. However, Model 2 (which includes all independent variables) predicts a greater amount of the variance in trauma-related beliefs (adjusted R^2 = 0.149, $p < 0.001$). The total R^2 value of 0.167 for the combined models reveals that almost 17% of the variance in trauma-related attitudes and beliefs of participants was predicted by the regression model. The regression equation for the full model is expressed in the following form:

TRAB = 3.529 + .002 (TE) + .364 (EI) + .131 (Training) – .389 (SDRB) - .002 (Hours)

While trauma training had a statistically significant effect on Model 1, two other variables had statistically significant effects in Model 2: (a) trait emotional intelligence ($p < .001$) and (b) socially desirable response bias ($p = .025$). The size and direction of the relationships suggests that an increase in a pastor's trait emotional intelligence has the largest positive effect on trauma-

related attitudes and beliefs (ß = .411, $p < .001$) of any of the examined variables.

Table 15: Summary of Final Hierarchical Multiple Regression Analysis

Model	Variable	*B*	SE_b	ß	*t*	Sig.	Tolerance	VIF
1	(Constant)	5.269	.052	--	102.174	.000	--	--
	Trauma Training	.181	.077	.152	2.349	.020*	1.000	1.000
2	(Constant)	3.529	.311	--	11.345	.000	--	--
	Trauma Training	.131	.074	.110	1.785	.076	.955	1.047
	Trauma Exposure	.002	.019	.006	.100	.921	.932	1.073
	Emotional Intelligence	.364	.059	.411	6.201	.000*	.828	1.208
	Hours per Week	-.002	.003	-.050	-.813	.417	.974	1.026
	Social Desirability	-.389	.173	-.150	-2.251	.025*	.820	1.219

Note. * $p < .05$; *B* = unstandardized regression coefficient; SE_b = Standard error of the coefficient; ß = standardized coefficient.

Analysis of Exploratory Research Questions

Trauma-Related Attitudes and Beliefs

Subsequent to the main analysis, the researcher explored between group differences in trauma-related attitudes and beliefs (as measured by the *Attitudes Related to Trauma-Informed Care -10, Human Services* scale [ARTIC-10-HS; Baker et al., 2016]), particularly considering: (a) religious affiliations (i.e., denomination), (b) race/ethnicity, and (c) mental health degrees and certification. Two kinds of analyses were used to compare means: (a) independent-sample t-test and (b) one-way analysis of variance (ANOVA). An independent-sample t-test is used to compare means between two groups only, while an ANOVA is used to compare means between more than two groups. In order to run these analyses, the researcher verified that the data met several assumptions, which had been examined previously when conducting the multiple

regression analysis: (a) no significant outliers, (b) normal distribution, and (c) homogeneity of variance.

Religious Affiliations

The total sample size (N = 235) did not allow for meaningful comparisons between individual denominational groups, so the researcher combined denominations into larger denominational families which correspond with the taxonomy established by the Pew Research Center (2015): (a) Evangelical Protestant (n = 116), (b) Mainline Protestant (n = 88), (c) Historically Black Protestant (n = 5), and (d) the Roman Catholic Church (n = 26). Because of an insufficient number of responses, the Historically Black Protestant group was not included in the one-way analysis of variance (ANOVA). Trauma-related attitudes and beliefs increased from Evangelical Protestant (M = 5.20, SD = .58), to Roman Catholic (M = 5.26, SD = .50), to Mainline Protestant (M = 5.59, SD = .58), however the only statistically significant difference was between the Evangelical Protestant and the Mainline Protestant groups, $F(2,227) = 11.709$, $p < .001$), with the Mainline Protestant group having the highest level of trauma-related attitudes and beliefs.

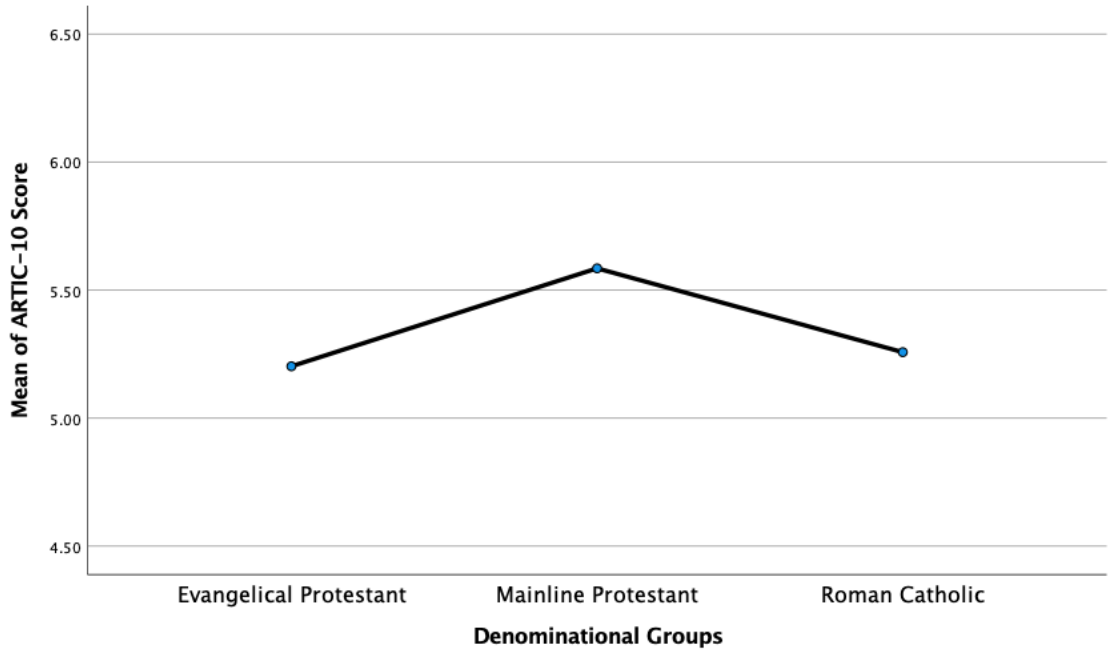

Figure 3: Comparison of Mean ARTIC-10 scores by Denominational Group

Race/Ethnicity

In order to have large enough groups to perform a one-way ANOVA, some racial and ethnic groups were combined, resulting in four groups: (a) White/Caucasian (n = 201), (b) Hispanic and/or Latino/a (n = 11), (c) Black or African-American (n = 14), and (d) other (n = 9). There was no significant difference in trauma-related attitudes and beliefs between racial and ethnic groups, $F(3,231) = 1.357$, $p = .257$).

Mental Health Degrees and Certifications

Participants were divided into two groups: (a) those who had an advanced mental health degree (i.e., Master's in Counseling, Master's in Social Work) or certification (Certified Pastoral Counselor) in counseling or another mental health care field (n = 70) and those who did not report having an advanced degree or certification in the mental health field (n =165). An

independent-samples t-test was run to determine if there were differences in trauma-related attitudes and beliefs between the two groups. Participants with an advanced degree or certification in the mental health field had higher levels of trauma-related attitudes and beliefs (M = 5.37, SD = .71) than those who did not (M = 5.34, SD = .54), a statistically significant difference with moderate effect size, M = .024, 95% CI [-.1913, .1431], $t(233) = .284$, $p = .007$, Cohen's $d = .5948$.

Emotional Intelligence

The researcher then compared levels of emotional intelligence (as measured by the *Trait Emotional Intelligence Questionnaire – Short Form* [TEIQue; Cooper & Petrides, 2010]) between groups, particularly considering: (a) religious affiliations (i.e., denomination), (b) race/ethnicity, and (c) mental health degrees and certification. No statistically significant differences were found in levels of emotional intelligence between any of these demographic groups.

Religious Affiliations

Mean total EI scores were compared for clergy from three major denominational groups: (a) Evangelical Protestant (n = 116), (b) Mainline Protestant (n = 88), and (c) the Roman Catholic Church (n = 26). Because of an insufficient number of responses, the Historically Black Protestant group was not included in the one-way analysis of variance (ANOVA). Trait emotional intelligence scores increased from Roman Catholic (M = 5.38, SD = .76), to Evangelical Protestant (M = 5.44, SD = .63), to Mainline Protestant (M = 5.60, SD = .68), however the differences between groups were not statistically significant, $F(2,227) = 2.073$, $p = .128$).

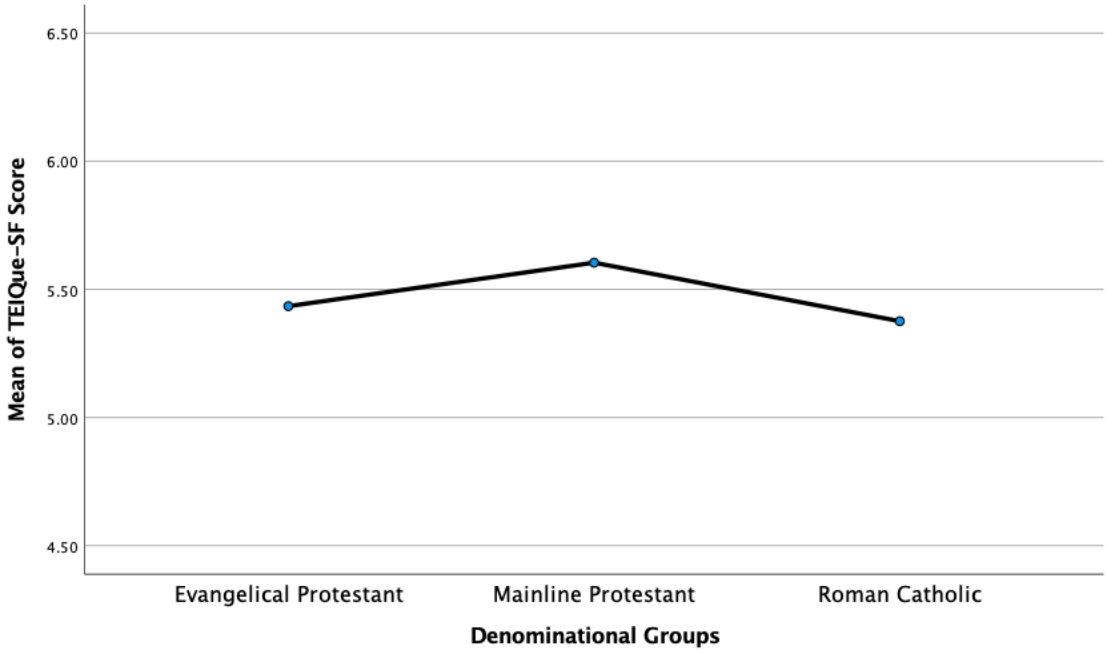

Figure 4: Comparison of Mean TEIQue-SF scores by Denominational Group

Race/Ethnicity

In order to have large enough groups to perform a one-way ANOVA, some racial and ethnic groups were combined, resulting in four groups: (a) White/Caucasian (n = 201), (b) Hispanic and/or Latino/a (n = 11), (c) Black or African-American (n = 14), and (d) other (n = 9). There was no significant difference in trait emotional intelligence scores between racial and ethnic groups, $F(3,231) = 2.086$, $p = .103$.

Mental Health Degrees and Certifications

Participants were divided into two groups: (a) those who had an advanced mental health degree (i.e., Master's in Counseling, Master's in Social Work) or certification (Certified Pastoral Counselor) in counseling or another mental health care field (n = 70) and those who did not report having an advanced degree or certification in the mental health field (n =165). An

independent-samples t-test was run to determine if there were differences in trait emotional intelligence scores between the two groups. Participants with an advanced degree or certification in the mental health field had equivalent levels of trait EI (M =5.49, SD = .77) as those who did not have an advanced degree or certification (M = 5.49, SD = .62), $t(233) = -.020$, $p = .984$.

Trauma Exposure

Although the total sum score on the *Brief Trauma Questionnaire* (BTQ; Schnurr et al., 1999) was used for the multiple regression analysis, the assessment also provided frequencies related to how many respondents had been exposed during their lifetimes to ten types of potentially traumatizing events (see Table 16). The four most common types of trauma exposure among participants (N = 235) were: (a) having been in "a major natural or technological disaster (such as a fire, tornado, hurricane, flood, earthquake or chemical spill)," n = 152, 64.4%; (b) witnessing "a situation in which someone was seriously injured or killed, or a situation in which you feared that someone would be seriously injured or killed," n = 120, 50.8%; (c) having been in "a serious car accident, or a serious accident at work or somewhere else," n = 84, 35.6%; and (d) having someone make or pressure you into having "some type of unwanted sexual contact [Note: By sexual contact we mean any contact between someone else and your private parts or between you and someone else's private parts]," n = 68, 28.8%. The item endorsed by the fewest participants was related to having "served in a war zone" or "served in a noncombat job that exposed you to war-related casualties" (n = 24, 10.2%). In terms of total trauma exposure (see Table 17), the median number of items endorsed was three (n = 42, 17.9%) and the mode was two (n = 49, 20.9%). Only 23% of the sample (n = 54) endorsed more than four BTQ items and the maximum number of items endorsed was nine (n = 2, 0.9%).

Table 16: Types of trauma exposure on the Brief Trauma Questionnaire (Schnurr et al., 1999)

BTQ Item	*n*	% Yes
1. Served in a war zone or exposure to war related casualties	24	10.2 %
2. Serious car accident, accident at work, or other accident	84	35.6 %
3. Major natural disaster	152	64.4 %
4. Life-threatening illness	51	21.6 %
5. Childhood physical abuse	62	26.3 %
6. Other physical assaults (attacked, beaten, mugged)	62	26.3 %
7. Sexual assault (childhood or adult)	68	28.8 %
8. Other situation that caused serious injury	66	28.0 %
9. Close family member or friend died violently	52	22.0 %
10. Witnessed someone else be seriously injured or killed	120	50.8 %

Note: $N = 235$, See the full Brief Trauma Questionnaire (Appendix E) for exact wording of items

Table 17: Frequency table for total lifetime trauma exposure on the BTQ (N = 235)

Number of BTQ items endorsed	Frequency	Percentage	Cumulative percentage
0	14	6.0 %	6.0 %
1	35	14.9 %	20.9 %
2	49	20.9 %	41.7 %
3	42	17.9 %	59.6 %
4	41	17.4 %	77.0 %
5	30	12.8 %	89.8 %
6	10	4.3 %	94.0 %
7	8	3.4 %	97.4 %
8	4	1.7 %	99.1 %
9	2	.9 %	100.0 %
10	0	0 %	--

COVID-19 Related Experiences

Due to the fact that data collection took place one year into the COVID-19 pandemic, participants were asked a final demographic question related to their personal experiences and their congregants' experiences during the pandemic related to traumatic illness and death. Respondents were asked about the experiences of (a) family and close friends, (b) members of their church congregation, and (c) themselves (see Table 18). Almost 30% of participants had a close friend or family member that had been hospitalized due to COVID-19 (n = 70, 29.8%), while almost a fourth of the participants had a close friend or family member who had died due to COVID-19 related causes (n = 54, 23%). Over half of the clergy who responded to this item reported that someone in their church congregation had been hospitalized due to COVID-19 (n = 126, 53.6%) and 43.4% of respondents had a member of their church congregation die due to COVID-19 related causes (n = 102). Finally, six of the respondents (2.6%) reported that they had

personally been hospitalized for reasons related to COVID-19.

Table 18: COVID-19 related experiences (N = 235)

Item	*n*	% Yes
Someone in my family or a close friend has been hospitalized due to COVID-19	70	29.7%
Someone in my family or a close friend has died due to COVID-19	54	22.9%
Someone in the congregation that I lead has been hospitalized due to COVID-19	126	53.4%
Someone in the congregation that I lead has died due to COVID-19 related reasons	102	43.2%
I have been personally hospitalized for reasons related to COVID-19	6	2.5 %

Chapter Summary

In this chapter, the researcher: (a) reviewed the primary and exploratory research questions, (b) explained the sampling and data collection procedures for the study, (c) discussed the data cleaning process and statistical assumptions for multiple regression, and (d) reviewed the initial results of the data analysis of the primary and exploratory research questions. Results were presented for (a) participant demographic information, (b) univariate descriptive statistics, (c) bivariate correlations, (d) hierarchical multiple regression, (e) comparison of means (independent-sample t-test and one-way ANOVA), and (f) frequencies. In the final chapter, the researcher will discuss these findings and explore the implications of this study.

CHAPTER FIVE: DISCUSSION

In this chapter, an overview of the study will be presented, along with a comparison of the results of this study with the research findings that were presented in the literature review. Specifically, the results of the primary and exploratory research questions will be explained and discussed. In addition, chapter five presents: (a) a review of the study limitations, (b) implications for counselors, clergy, counselor education, and clergy preparation, and (c) recommendations for future research.

Study Summary

The majority of adults have been exposed to at least one significant traumatic event during their lifetime, and many individuals have experienced multiple adverse experiences in childhood (Merrick et al., 2018). Repetitive exposure to trauma during the critical developmental periods of childhood can lead to pervasive, long-term impairment in areas such as emotional regulation, distorted self-perception, and difficulty in relationships (Ford & Courtois, 2009), as well as contribute to many serious physical health concerns (Felitti et al., 1998). Considering the prevalence and impact of traumatic exposure, all pastors, ministers, and priests will have trauma survivors among the members of their congregations; therefore, clergy need to have an awareness of the particular needs of these individuals, as well as the implications that trauma has on how an individual may experience and interact with their religious community (Baldwin, 2018). Before discussing the results of the study, a brief review of the theoretical framework that guided the study and a review of the study methodology will be presented.

The theoretical framework for this study was two-dimensional. First, the lens of trauma-informed care was used to frame the discussion of pastors, priests, and ministers as leaders of

systems that may or may not function according to trauma-informed principles. Secondly, existential-humanistic counseling theory highlighted the importance of the *person of the helper* and the need to include individual factors, such as personal trauma exposure and emotional intelligence, in order to understand what predicts the trauma-related attitudes and beliefs of members of the clergy.

The trauma-informed care (TIC) model (Harris & Fallot, 2001) has been applied to many human services sectors over the past two decades and theoretical work around applying TIC to churches and other religious communities has been explored (Gingrich, 2018; Streets, 2015). However, empirical research into the trauma-related attitudes and beliefs of clergy had not been conducted previously. Therefore, this study sought to understand what personal and professional factors would predict the trauma-related attitudes and beliefs of Christian clergy through the use of hierarchical multiple regression analysis. The purpose of this study was to understand the unique contributions of these factors (i.e., trait emotional intelligence, trauma exposure, trauma training, and clergy job responsibilities) to the variance in levels of trauma-related attitudes and beliefs among members of the clergy as a first step in understanding how to apply the TIC model to churches and other religious communities.

Given that the intent of this study was to understand the relationship between Christian clergy's trauma-related attitudes and beliefs, trait emotional intelligence, personal trauma exposure, trauma-related training, and counseling-related work experience, a non-experimental, multivariate, correlational design was selected. Four main predictor variables were selected in order to investigate the role that each played in explaining the variance in the trauma-related attitudes and beliefs of Christian clergy in a multiple regression analysis: (a) personal trauma exposure, (b) trait emotional intelligence, (c) prior trauma-related training, and (d) time spent per

week providing counseling or pastoral care. Additionally, socially desirable response bias was considered as a possible moderating variable.

Approval from the University's IRB was received, and data collection took place online from March 16, 2021 to April 15, 2021. Approximately 2,750 invitations to participate were sent via email to clergy members from the 20 largest denominations in Florida. Contact information was found via church and denominational websites and was sorted into two lists: (a) direct email addresses for clergy (n = 1872, response rate = 11.4%) and (b) general church contact email addresses that may have been monitored by an administrator or other staff member (n = 887, response rate = 5.7%). All participants completed the study materials which included 71 items measuring: (a) trauma-informed attitude and beliefs, (b) personal trauma exposure, (c) trait emotional intelligence, (d) trauma-specific training, (e) hours of counseling or pastoral care work per week, and (f) socially desirable response bias.

Discussion of Findings

In this section, the results of the statistical analyses presented in chapter four will be reviewed and discussed. A descriptive data analysis will be presented in order to contextualize the subsequent discussion and exploration of the results of the primary research question. Then, the results related to the exploratory research questions will be examined and discussed in light of the existing research literature. Finally, practical implications and applications of the results will be explored for the work of pastors and counselors, as well as in regards to pastoral preparation and counselor education.

Descriptive Data Analysis

In the following section, the sample demographics and the descriptive data found in this study are compared with demographics and descriptive data from other similar studies. The final sample (N = 235) in the current study was predominately comprised of male (83.9%) and Caucasian/White (85.6%) respondents. In order to evaluate how well the sample represented the target population, the researcher compared participant demographics to other studies that examined clergy and mental health topics. As it relates to gender, given that traditional interpretations of the Bible limit the role of pastor or priest to men only, it is not surprising that the sample in this study was predominately male (n = 198, 83.9%) compared to female (n = 37, 15.7%). Although most Mainline Protestant denominations now ordain women into pastoral roles, the Roman Catholic Church and most Evangelical Protestant churches still only ordain men into the roles of pastor or priest. Other recent studies on clergy and mental health have had similar gender demographics among respondents, with samples that were 69.1% to 94.2% male (Francis et al., 2019; Hodge et al., 2019; Miller-Clarkson, 2013; Scott, 2013; Vermaas et al., 2017). In terms of race, whereas the racial and ethnic diversity of participants in this study was not representative of the population of Florida or the United States, it was similar to the racial and ethnic demographics of other studies related to clergy and mental health: in actuality, the current study represented a more racially diverse sample than those obtained in other similar studies (Hodge et al. [2019], 94.5% Caucasian; Marks [2013], 95.1% Caucasian; Miller-Clarkson [2013], 92.4% Caucasian).

An attempt was made to gather data from a proportional, stratified random sample that was representative of the 20 largest Christian denominations in Florida and the participants in this study represented 17 denominations from four major denominational groupings: (a) Evangelical Protestant (n = 116, 49.4%), (b) Mainline Protestant (n = 88, 37.4%), (c) Historically

Black Protestant (n = 5, 2.1%), and (d) the Roman Catholic Church (n = 26, 11.1%). The current study had participants from a more denominationally diverse group of participants than most studies related to clergy and mental health, which have tended to focus solely on one particular denomination (e.g., Carrington, 2015; Francis et al., 2019; Oney, 2010).

In regard to education, 85.5% of respondents in the study held a master's degree or higher, with the most frequently obtained degree being the M.Div. (n = 168, 71.5%). Other studies related to clergy and mental health have similarly found that the majority of pastors have advanced educational degrees. For example, Marks (2013) found that 71.15% of participants from churches in northern Virginia (N = 104) had completed an M.Div., while another study that used a national, interdenominational sample found that nearly 80% of participants had a master's degree or higher (Vermaas et al., 2017).

The mean amount of time spent in activities related to providing pastoral care or counseling was 13.64 hours per week (n = 235, SD = 13.41). This finding is higher than the findings of Marks (2013), who asked clergy how many hours a week they spent in formal pastoral counseling activities and found a mean of 2.07 hours per week (range 0-15). This could be due to the differences in the phrasing of the demographic question between the two studies (i.e., "how many hours a week do you spend in activities related to providing pastoral care or counseling" versus "how many hours a week do you spend in formal counseling activities"). Beck (1997) had pastors log their daily activities week and found that pastors reported spending 24% of their work time in relational roles (which included serving as a spiritual guide or visiting congregants), but only indicated spending 2.5 hours per week counseling and 1.8 hours per week providing crisis care.

Preliminary Analyses

Using Pearson correlations, the bivariate relationships between study variables were analyzed and several statistically significant correlations were found. First, there was a positive correlation between trauma-related attitudes and beliefs (as measured by the ARTIC-10-HS [Baker et al., 2016]) and trauma-related training (r = 0.152, n = 235, p = 0.01), indicating that clergy who had completed any kind of trauma training had higher levels of trauma-related attitudes and beliefs (i.e., attitudes and beliefs that are congruent with TIC) than those without any trauma-related training. These results are consistent with a study that found a positive change in ARTIC scores of teachers after TIC training (Vanderburg, 2017), particularly on three subscales: (a) understanding the underlying causes of behavior (pre-test, M = 5.31, SD = 0.79; post-test, M = 5.77, SD = 0.78; t(162) = -9.53, p < .001); (b) self-efficacy for TIC approaches at work (pre-test, M = 5.50, SD = 0.88; post-test, M = 5.81, SD = 0.78; t(162) = -5.77, p < .001), and (c) personal support for trauma-informed approaches (pre-test, M = 5.61, SD = 0.98; post-test, M = 6.01, SD = 0.80; t(56) = -2.83, p = .007). Whereas a thorough review of the available literature revealed no previous studies that examined the relationship between clergy's trauma-related attitudes and beliefs and trauma-related training, there has been some research that demonstrated a positive correlation between clergy's attitudes and beliefs regarding other topics related to mental health (i.e., mental health literacy [Vermaas et al., 2013] and counseling self-efficacy [Marks, 2013]) and the training clergy have received related to mental health topics.

Individuals with higher levels of trauma-related attitudes and beliefs (as measured by the ARTIC-10-HS [Baker et al., 2016]) had higher levels of trait emotional intelligence (as measured by the TEIQue-SF [Cooper & Petrides, 2010]; r =.0.359, n = 235, p < 0.001). To date, this specific correlation has not been noted in any previous research studies. Another unique result found in this study is that clergy who had higher levels of prior exposure to trauma (as measured

by the BTQ [Schnurr et al., 1999]) were significantly more likely to have attended a trauma-informed training than those with lower levels of trauma exposure ($r = 0.16$, $n = 235$, $p = 0.007$). Additionally, clergy who had higher levels of prior exposure to trauma were less likely to respond to the study materials with a bias towards a socially desirable response pattern (as measured by MCSDS-X1 [Strahan & Gerbasi, 1972]), $r = -0.14$, $n = 235$, $p = 0.016$. These relationships between variables have not been noted prior to this study.

Finally, higher levels of trait emotional intelligence (as measured by the TEIQue-SF [Cooper & Petrides, 2010]) were significantly associated with socially desirable response bias (SDRB) ($r = .397$, $n = 235$, $p < 0.001$). Previously, Mesmer-Magnus and colleagues (2006) used the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960) to compare SDRB with emotional intelligence (EI) (as measured by a 16-item EI measure [Law et al., 2004]) in an undergraduate population and found that SDRB was significantly correlated with EI ($r = .44$, $n = 198$, $p < 0.01$) at a level similar to this study. Mesmer-Magnus and colleagues (2006) suggest that their findings indicate that individuals with higher levels of EI are more likely to respond to self-report questionnaires with a bias towards a socially desirable response pattern.

Primary Research Question Results and Discussion

The primary research question for the current study was the following: After controlling for the effects of socially desirable responding bias (as measured by the *Marlowe-Crown Social Desirability Scale – Short Form* (MCSDS-X1; Strahan & Gerbasi, 1972), how much of the variance in the trauma-related attitudes and beliefs of Christian clergy (as measured by the *Attitudes Related to Trauma-Informed Care -10, Human Services* scale [ARTIC-10-HS; Baker et al., 2016]) can be explained by clergy's personal trauma exposure (as measured by the *Brief Trauma Questionnaire* [BTQ, Schnurr et al., 1999]), trait emotional intelligence (as measured by

the *Trait Emotional Intelligence Questionnaire– Short Form* [TEIQue-SF; Cooper & Petrides, 2010]), trauma-related training (as assessed on demographic questionnaire), and time per week spent in counseling-type ministry (as assessed on demographic questionnaire)? The following section compares the results of this study to those found by other investigators.

Initially, socially desirable response bias (total score on MCSDS-X1) was considered separately (model 1), then in combination with the other independent variables (model 2). However, since SDRB did not significantly predict trauma-related attitudes and beliefs the model was reconsidered in light of the theoretical framework of the study. subsequently the researcher changed the hierarchical regression model to analyze trauma-informed training separately (model 1), to isolate the degree to which trauma-informed training predicated change in trauma-related attitudes and beliefs. In this analysis, both models significantly predicted the variance in trauma-related attitudes and beliefs among participants: Model 1, $F(1, 233) = 5.519$, $p = .020$; adj. $R^2 = .019$, *F Change* = 5.519; Model 2, $F(4, 229) = 9.185$, $p < 0.001$; adj. $R^2 = 0.149$, *F Change* = 9.891. The regression equation for the full models is expressed in the following terms:

TRAB = 3.529 + .002 (TE) + .364 (EI) + .131 (Training) – .389 (SDRB) - .002 (Hours)

A small, but statistically significant (ß = .152, $p < 0.05$, adj. $R^2 = 0.019$) amount of the variance in trauma-related attitudes and beliefs was predicted by prior participation in any kind of trauma-informed or trauma-specific training, demonstrating that direct training is one important avenue for influencing the trauma-related attitudes and beliefs of clergy. This is consistent with studies concerning the attitudes, beliefs, and skills of clergy related to other mental health topics. For example, Vermaas and colleagues (2013) found that the number of courses completed in clinical mental health training significantly predicted levels of mental health literacy in clergy (training: ß = 0.178, $p = .005$, 95% *CI* [0.07, 0.44]). In another 2013

study of predominately Methodist clergy (N = 104), Marks found that levels of counseling self-efficacy were predicted by the number of counseling or psychology courses taken during seminary (training: B = .272, full model: $F(5, 83) = 6.913$, $p < .001$; adj. R^2 = .251). In this model, prior training was a stronger predictor of counseling self-efficacy than years worked as a pastor (B = .054), CPE engagement (B = -.133), and experience providing lay counseling (B = -.123). Marks found that hours spent per week in counseling activities had a similar effect on counseling self-efficacy (B = .262) as number of courses taken. Thus, it is consistently demonstrated that training can significantly influence the attitudes and beliefs of clergy regarding mental health.

The combined hierarchical regression model in this study predicted almost 17% of the variance in trauma-related attitudes and beliefs (adjusted $R^2 = 0.167$, $p < 0.001$). While trauma training had a statistically significant effect on Model 1, two other variables had statistically significant effects in Model 2: (a) trait emotional intelligence ($p < .001$) and (b) socially desirable response bias ($p = .025$). The size and direction of the relationships indicate that an increase in a pastor's trait emotional intelligence had the largest positive effect on trauma-related attitudes and beliefs (ß = .411, $p < .001$) of any of the examined variables. Given that SDRB has been previously shown to be significantly correlated with emotional intelligence in other populations, it is likely that the significance of SDRB in the regression model is primarily due to that association ($r = .44$, $n = 198$, $p < 0.01$; Mesmer-Magnus et al., 2006), since SDRB was not a significant predictor of trauma-related attitudes and beliefs when it was isolated in the original hierarchical regression model. In addition to the significant impact of providing clergy with trauma-related training, the results of the current study suggest that it is also essential to develop emotional intelligence in clergy in order to equip them to lead trauma-informed churches.

Exploratory Research Questions Results and Discussion

Trauma-Related Attitudes and Beliefs (RQ2)

In addition to the primary research question, there were three exploratory research questions. The first exploratory research question for the current study was the following: Are there significant differences in the trauma-related attitudes and beliefs of Christian clergy based on religious affiliations; race or ethnicity; or having an advanced degree or certification in a counseling-related field? The mean score for all participants on the ARTIC-10-HS was 5.35 [*SD* = .59], with higher scores indicating a more trauma-informed perspective. Mean scores for trauma-related attitudes and beliefs for the three major denominational groups were: (a) Evangelical Protestant, $M = 5.20$, $SD = .58$, (b) Roman Catholic, $M = 5.26$, $SD = .50$, and (c) Mainline Protestant, $M = 5.59$, $SD = .58$. The only statistically significant difference between groups was between the Evangelical Protestant and the Mainline Protestant groups, $F(2,227) = 11.709$, $p < .001$, with the Mainline Protestant group having the highest level of trauma-related attitudes and beliefs. In a study on clergy mental health literacy, Vermaas and colleagues (2017) found no significant difference in levels of mental health literacy between participants from the same major denominational groups, $F(3, 237) = 1.840$, $p = .141$. None of the other studies related to clergy and mental health made between-group comparisons using denominations or major denominational groups.

Evangelical Protestant denominations and Mainline Protestant differ regarding religious beliefs, practices, and origins (Pew Research Center, 2015). In comparison with evangelicals, Mainline Protestant denominations are generally regarded as more theologically liberal, more likely to acknowledge the history of oppression of certain populations within church contexts, and more oriented towards social engagement (McKinney, 1998). Within this context, the

findings of this study that clergy from Mainline Protestant churches are more likely to have attitudes and beliefs consistent with TIC than their Evangelical counterparts is reasonable. Within 21st century North America, the public health and social justice issues surrounding the impact of trauma are already part of the social consciousness of the progressives who tend to attend Mainline churches (Campbell, 2004; Hermann, 2015). Meanwhile, Evangelical churches are more likely than Mainline churches to be politically and theologically conservative and to be less engaged with social justice issues (Campbell, 2004).

No between-group differences were found in trauma-related attitudes and beliefs (as measured by mean ARTIC-10-HS scores; Baker et al., 2016) when analyzed by race/ethnicity. One possible explanation for this was the lack of representation within the sample from non-White clergy (i.e., only 14.4% non-White). While there were enough respondents from African-American and Hispanic/Latinx clergy to include those groups in the ANOVA, other racial and ethnic minorities (i.e., Asian-American, Middle Eastern, and multiracial) were grouped together into the category of "other." Thus, even though this study had participants that were more racially and ethnically diverse than most clergy-related mental health studies, the sample size may not have been sufficient to find meaningful differences on ARTIC-10-HS scores between racial and ethnic groups.

When comparing whether or not clergy had an advanced degree or certification in the mental health field with their trauma-related attitudes and beliefs, those who did have an advanced degree or certification in counseling (or another mental health field) had higher levels of trauma-related attitudes and beliefs (M =5.37, SD = .71) than those who did not (M = 5.34, SD = .54), a statistically significant difference with moderate effect size, M = .024, 95% CI [-.1913, .1431], $t(233) = .284$, $p = .007$, Cohen's $d = .5948$. The other studies concerning trauma-related

attitudes and beliefs of professional helpers, which were discussed in chapter two, did not report mean scores by education/training; however, mental health training is not as common among clergy as among the social workers, child welfare workers, and other human services professionals considered in the existing literature. Since it is likely that advanced coursework in a mental health field would include some trauma-related content and training, the findings of this study that holding a degree or certification in a mental health related field predicts higher levels of trauma-related attitudes and beliefs for clergy are expected.

Emotional Intelligence (RQ3)

The second exploratory research question for the current study was the following: Are there significant differences in the level of emotional intelligence of clergy based on religious affiliations; race or ethnicity; or having an advanced degree or certification in a counseling-related field? The TEIQue-SF mean total score was 5.49 (*SD* = 0.67) with higher scores indicating a higher degree of trait emotional intelligence. This finding is similar to the results from Carrington (2015), the only other clergy study to use the TEIQue-SF to measure trait emotional intelligence. Carrington (2015) sampled ministers from the United Pentecostal Church (*N* = 81), as part of a larger study on pastoral leadership, and found a mean EI score of 5.40 (*SD* = 0.47).

In a general population study (*N* = 1,119) completed as part of the psychometric analysis of the TEIQue-SF, mean scores were reported by gender: (a) men, *M* = 5.02, *SD* = .73, and (b) women, *M* = 5.18, *SD* = .68 (Cooper & Petrides, 2010). Petrides (2009) completed another study in the general population (*N* = 1,721) utilizing the long form of the TEIQue and also reported mean scores by gender: (a) men, *M* = 4.82, *SD* = .57, and (b) women, *M* = 4.95, *SD* = .61. The mean EI scores found in the current study place clergy above the population average in their

level of trait emotional intelligence. This differs from two previous studies that found that clergy had lower levels of EI than the general population (Francis et al., 2019; Hendron et al., 2014). Francis and colleagues (2019) found that Anglican clergy (N = 364) in Wales had lower levels of EI (as measured by the *Schutte Emotional Intelligence Scale* (EIS; Schutte et al., 1998). The mean score for male clergy was 116.33 (SD = 12.51) as compared to a mean score of 124.78 (SD = 16.52) for men in the general population ($p < .001$), while the mean score for female clergy was 121.79 (SD = 10.55) as compared to a mean score of 130.93 (SD = 15.09) for women in the general population ($p < .001$). Hendron and colleagues (2014) also utilized the EIS (Schutte et al., 1998) to study the EI of clergy in Ireland and Northern Ireland (N = 226), and the mean score for Irish clergy (M =120.19, SD = 13.24) was equivalent to EI scores for prisoners (M = 120.08, SD = 17.71) and individuals in treatment for substance abuse (M = 122.23, SD = 14.08). However, both of these studies utilized a measure of ability EI (EIS, Schutte et al., 1998) rather than trait EI, so it is difficult to make an accurate comparison between their data and the data in the current study.

When considering differences in mean EI scores between demographic groups, no significant differences were found in levels of emotional intelligence (as measured by the *Trait Emotional Intelligence Questionnaire – Short Form* [TEIQue-SF; Cooper & Petrides, 2010]) in the current study. Regarding major denominational groups: (a) Evangelical Protestant, (b) Mainline Protestant and (c) the Roman Catholic Church, the existing research on clergy and EI is limited to studies of clergy from the same denominational tradition (Carrington, 2015; Francis et al., 2019; Hendron et al., 2014; Oney, 2010) so comparisons between denominational groups have not previously been made. In the current study, trait emotional intelligence scores increased from Roman Catholic (M = 5.38, SD = .76), to Evangelical Protestant (M = 5.44, SD = .63), to

Mainline Protestant (M = 5.60, SD = .68), however the differences between groups were not statistically significant, $F(2,227) = 2.073$, $p = .128$). Furthermore, there was no significant difference found in trait emotional intelligence scores between racial and ethnic groups, $F(3,231) = 2.086$, $p = .103$; and, neither was there a significant difference in levels of EI between participants with an advanced degree or certification in a mental health field (M =5.49, SD = .77) compared to those who did not have an advanced degree or certification (M = 5.49, SD = .62), $t(233) = -.020$, $p = .984$. The other existing studies on clergy and EI did not compare mean scores by race or education level.

Trauma Exposure (RQ4)

The third exploratory research question for the current study was the following: What is the prevalence of trauma exposure among clergy? When completing the BTQ (Schnurr et al., 1999), participants were asked to report trauma exposure in various categories over their lifetime. The mean total score for all participants on the BTQ was 3.14 [SD = 1.92] and the range of scores was from 0 to 9 (with higher scores representing more trauma exposure). In terms of total trauma exposure, the median number of items endorsed was three (n = 42, 17.9%) and the mode was two (n = 49, 20.9%). Only 23% of the sample (n = 54) endorsed more than four BTQ items and the maximum number of items endorsed was nine (n = 2, 0.9%).

While it is difficult to make a direct comparison to studies that use different measures of trauma exposure, there are some studies of trauma exposure in other populations of helping professionals. For example, in a study of child welfare professionals, Lee and colleagues (2017) examined trauma exposure using the ACE questionnaire (Felitti et al., 1998) which measures exposure to ten kinds of adverse childhood experiences. Child welfare professionals had significantly higher ACE scores than the general population, with 31% of participants reporting a

score of 4 or higher, which was more than double the rate in the general population (12.5%). Of the child welfare participants, 87.4% had an ACE score of at least one, compared to 55%-60% of general population. In a similar study, Hiles Howard and colleagues (2015) found that human services providers in an urban setting in the southern United States also had double the rate of high ACE scores (defined as 4+) than the general population (25.1% v. 12.5%; $\chi^2 = 17.30$, $p <$ .001.), with 75% of participants reporting at least one ACE. Finally, for a direct comparison with another population that was surveyed using the BTQ (Schnurr et al., 1999), the results of the current study can be compared to a study of trauma exposure among members of the military (N = 253; Whealin et al., 2007). On almost every BTQ item (with the exception being the item related to having served in a war zone/exposure to war related casualties), the current study found that clergy had higher rates of trauma exposure than the members of the military. Of particular note, when considering the potential for complex trauma, are the frequency of the experience of childhood abuse among clergy when compared to the military sample: (a) childhood physical abuse (clergy, 26.3%; military, 21.3%) and (b) sexual assault in childhood or adulthood (clergy, 28.8%; military, 6.7%).

This study is unique in its assessment of the frequency of trauma exposure among clergy. The levels of trauma exposure reported by participants reveal that clergy have a greater likelihood of suffering from trauma-related symptoms and comorbid mental health issues than the general population. When coupled with the relationally demanding nature of pastoral work (Carroll, 2006; DeShon, 2010) and the long hours worked by most clergy (Beck, 1997), the level of trauma exposure among clergy is one that needs attention from seminaries and denominational leadership.

Summary of Findings

In summary, the results of the current research study, which demonstrated that emotional intelligence was the most influential variable in predicting trauma-related attitudes and beliefs, were novel as there have been no previous studies of trauma-related attitudes and beliefs that utilized the same predictor variables. The finding that trauma-related training had a significant role in predicting trauma-related attitudes and beliefs was consistent with other studies in the field of TIC.

Study Limitations

The limitations of this study are explored in the following section in order to provide further context for the results and implications of the current study. Limitations are considered in regard to the (a) research design, (b) sampling methodology, and (c) instrumentation utilized in this study. Suggestions for addressing these limitations in future studies are included.

Research Design

The conclusions that can be drawn from this study are predicated on the internal and external validity of the research design and the appropriate execution of the study. The design of the current study was non-experimental, multivariate, and correlational. Correlational research is useful for understanding the relationships among variables within a specified population (Curtis et al., 2016; Gall et al., 2007) and this design type was selected in order to best answer the research questions which quantitatively investigated the relationships between the identified constructs. In the design of the study, attempts were made to address possible threats to validity. For example, one limitation to the research design was the use of self-report questionnaires (Gall et al., 2007) which can yield distorted results due to the effect of SDRB. The use of the MCSDS-

X1 (Strahan & Gerbasi, 1972) was an attempt to address this threat to validity. Another threat to internal validity was characteristic correlations (Fraenkel et al., 2011) which can be defined as the possibility that the correlation between variables is due to characteristics of individual participants rather than the influence of the specific constructs being studied. The independent variables in this study were chosen based on a review of the literature as likely predictors of the dependent variable but the formation of attitudes and beliefs is a complex process and not all possible predictor variables could be included. While it would be valuable for future research to examine other constructs that may play a role in the formation of trauma-related attitudes and beliefs in Christian clergy, there is evidence that the current study was a valid attempt to investigate an area that had not previously been studied.

Future studies exploring the trauma-related attitudes and beliefs of clergy may benefit from including other variables that may shape a pastor's dispositions related to trauma, particularly (a) theological beliefs related to suffering and (b) cultural values that may interact with attitudes about TIC. Ultimately, in order to implement trauma-informed care (TIC) in religious communities, clergy will need to not only possess attitudes and beliefs that support TIC but also to intentionally develop trauma-informed knowledge, skills, and practices. Thus, the limitations of correlational research design could be addressed in future studies by using an experimental research design to compare the trauma-related attitudes, knowledge, and skills of clergy who have completed TIC training with those who have not.

Sampling Methodology

A representative sample of adequate size is important in order to be able to generalize the findings of this study to the greater population (Tabachnick & Fidell, 2013). The sample utilized in the current study was a proportional, stratified random sample in an attempt to capture data

from a sample that reflected the 20 largest Christian denominations in Florida so that the sample could represent the diversity of clergy in North America. The inclusion criteria for the study were: (a) 18 years old or older, (b) an ordained pastor, priest, minister, or other member of the Christian clergy, and (c) currently work at a church in the State of Florida. Contact information for clergy were primarily collected through a systematic internet search of the websites of churches from each denomination. Efforts were made to find churches within each denomination from varying parts of the state and from communities of different sizes (i.e., urban, suburban, rural). Then invitations to participate were sent, with more being sent to clergy affiliated with the largest denominations (i.e., Roman Catholic, Southern Baptist, United Methodist, etc.) and fewer invitations being sent to clergy affiliated with the smaller denominations.

However, no contact information was found for clergy from two of the targeted denominations: the Church of Jesus Christ of Latter-day Saints (Mormon/LDS) and the Seventh-Day Adventist (SDA) Church. Attempts to make contact with regional church leaders from these denominations were not successful so these denominations were not included in the final sample. Additionally, significantly less information was found online regarding churches from two historically black protestant denominations: (a) the African American Episcopal Church (AME) and (b) the National Baptists of America (NBA), which limited racial diversity within the sample. Nevertheless, the sample in this study was equally or more denominationally and racially diverse than most studies related to clergy and mental health issues (Hodge et al., 2019; Marks, 2013; Miller-Clarkson, 2013; Scott, 2013).

For clergy from LDS, SDA, AME, and NBA churches to be adequately represented in future clergy studies, a culturally contextualized and relationally focused approach to community engagement and clergy recruitment will be needed in order to increase the participation of clergy

from these denominations in future studies. In order to gain access to clergy from these denominations, future researchers may need to spend face-to-face time building relationships with denominational leaders in order to foster trust and communicate how participation in research can directly benefit their communities. For some of these denominations, internet-based surveys may not be the most effective way to engage participants. Cultural dynamics within certain denominations may necessitate the use of paper-based surveys that are distributed in-person at denominational events for clergy, with the endorsement of denominational leaders, in order to increase participation.

Additionally, it is possible that the influence of environmental conditions may have impacted who chose to respond to the study (Johnson & Christensen, 2004). Data collection for the current study took place from March 16, 2021 to April 15, 2021, a period of time that was approximately one year into the COVID-19 pandemic. During the pandemic, churches had to stop meeting in person for long periods of time and pastors had to adapt to unprecedented circumstances for ministry. It is unknown what impact this may have had on how clergy chose to participate in the study. Furthermore, it is unknown how the shared trauma of the pandemic and its cumulative impact on both clergy and their congregants may have influenced the way that participants responded to the survey materials.

Instrumentation

Another limitation to this study was related to the instruments used to collect data, primarily due to the fact that the construct of trauma-related attitudes and beliefs, in the context of trauma-informed care, has only existed in its current form for 20 years (Harris & Fallot, 2001). The *Attitudes Related to Trauma-Informed Care* scale (Baker et al., 2016, Baker et al., 2020) was one of the only measures of trauma-related attitudes and beliefs (that had been studied

for its psychometric properties, was appropriate for a population that may have no previous exposure to TIC and could be used across multiple settings (Champine et al., 2020). Nevertheless, the measure was not designed with clergy or religious communities in mind and wording had to be revised in order to reflect the context of the participants. This may have led to a lower level of internal consistency (α = .653) in this study than in other studies that have used the ARTIC-10-HS (α = .82; Baker et al., 2016).

Furthermore, the study of the attitudes and beliefs of clergy about trauma is complex since views of trauma are deeply intertwined with cultural values and theological beliefs. In her seminal work on trauma, Hermann (1992) wrote, "to study psychological trauma is to come face to face both with human vulnerability in the natural world and with the capacity for evil in human nature" (p. 7). To develop an instrument that can adequately measure the value-laden attitudes and beliefs of helpers about psychological trauma is a daunting task. The ARTIC – Human Services scale (Baker et al., 2016) is an early attempt to assess trauma-related attitudes and beliefs in human services contexts, but the further development of the ARTIC or other measures of trauma-related attitudes and beliefs (and particularly a measure that is developed with religious contexts in mind) could strengthen future research related to the implementation of TIC in churches and other religious communities.

The instruments chosen to measure trauma exposure (*Brief Trauma Questionnaire*, Schnurr et al., 1999) and emotional intelligence (*Trait Emotional Intelligence Questionnaire – Short Form,* Cooper & Petrides, 2010) have each been used frequently in research settings. However, in both cases the choice to use these instruments to the exclusion of other instruments (e.g., the ACE questionnaire [Felitti et al., 1998] and the EQ-I [Bar-On, 1997]) impacted the ease with which this study can be compared to other studies that measured the constructs differently.

This is particularly true in the field of EI research as scholars are divided on how to define and measure emotional intelligence (e.g., ability EI, trait EI, or mixed-model approaches). However, the TEIQue is grounded in trait EI theory and has strong psychometric properties that have been proven over many years of systematic research (Petrides, 2009). Unlike other EI instruments that have been developed primarily for coaching or personal development in business and educational settings (i.e., Bar-On, 1997), the TEIQue was developed with research and clinical applications in mind (Petrides, 2009).

Implications and Recommendations

This study is one of the first to empirically investigate the application of the trauma-informed care model to churches and religious communities. The new and unique findings of this study have pragmatic significance for the implementation of trauma-informed care in church settings. This section will examine the implications of these findings and practical recommendations for (a) clergy, (b) pastoral education, (c) counselors, and (d) counselor education. While the regression model in this study explained approximately 17% of the variance in the trauma-related attitudes and beliefs of Christian clergy, much remains unknown regarding how various aspects of the personal and professional development of clergy may impact trauma-related attitudes and beliefs. In light of this, recommendations for future research are included in each section.

Clergy

For clergy who desire to align their trauma-related attitudes and beliefs with a trauma-informed care model, this study suggests several practical steps. First, the results of this study make it clear that pursuing direct training about trauma and trauma care, as well as other training

related to counseling and mental health, is one simple way to begin investing the necessary time and resources towards increasing trauma-related attitudes and beliefs. The literature review for this study examined the minimal existing requirements of seminaries and denominations in the areas of counseling, pastoral care, and trauma. Until more training is offered and required at the institutional level, it is incumbent upon individual pastors, priests, and ministers to seek out trauma-related training. This may include attending formal courses and training programs but can also include less formal options such as: (a) relational learning from congregants who have personal and professional experience with trauma and (b) articles, books, and podcasts that examine the impact of trauma on individuals, society, and the church.

This study demonstrated that trait emotional intelligence was the most significant predictor of trauma-related attitudes and beliefs for clergy. Clergy need to acknowledge that their emotional intelligence has a profound impact on their ability to effectively lead and pastor their congregation. Furthermore, emotional intelligence is not a static quality, but encompasses a broad domain of skills and traits that can be developed through intentional engagement. Scazzero (2017) argues that the connection between a dynamic Christian spirituality and emotional health are undeniable, and that one way to cultivate emotional health is through contemplative Christian practices. However, since emotional intelligence is revealed in relationship, it is not something that can be developed in isolation. Clergy need to pursue honest feedback from co-workers and congregants about their emotional intelligence and their style of relating. In order to address areas of concern, clergy may find it helpful to seek professional counseling, however significant growth can occur in other settings (e.g., friendships, mentoring relationships, spiritual direction) if the pastor engages these relationships with authenticity and vulnerability.

Finally, several opportunities for future research related to the trauma-related attitudes and beliefs of Christian clergy exist. First, since beliefs about suffering are a core aspect of Christian doctrine that could have a direct impact on views of trauma, future research could build on the current study by theological beliefs about suffering as an additional predictor variable. Another avenue for future research would be to move beyond trauma-related attitudes and beliefs and to assess the trauma-related knowledge and the practical trauma care skills of clergy in order to better understand what types of training would be most beneficial for pastors who desire to implement a TIC model within their churches.

Pastoral Education

Several implications related to the training of clergy emerged from the results of this study. First, the differences in trauma-related attitudes and beliefs between clergy from Evangelical Protestant churches and those from Mainline denominations reveals that Evangelicals are less likely to have the trauma-related attitudes and beliefs needed to lead a trauma-informed congregation. Evangelical pastors may not see trauma care as central to the mission of the church (DeYoung, n.d.), which is traditionally summarized in the "Great Commission" that is found in the final words of Jesus recorded in the Gospel of Matthew: "Go therefore and make disciples of all nations, baptizing them in the name of the Father and of the Son and of the Holy Spirit, teaching them to observe all that I have commanded you" (*English Standard Version*, Matt. 28:18-20). However, some theologians and scholars have made a compelling case that addressing the needs of those impacted by trauma is an essential application of the teachings of the Bible and part of the mission of the church in the world today (Baldwin, 2018; Langberg, 2015). In order to bolster the trauma-related attitudes and beliefs of Evangelical Protestant clergy, Evangelical seminaries and denominations need to include trauma care as part

of pastors' training in practical theology and pastoral care.

Secondly, the importance of trait emotional intelligence in predicting trauma-related attitudes and beliefs in this study should be noted by those involved with pastoral education. By design, the M.Div. is an academic degree that must address the areas of: (a) religious heritage, (b) cultural context, (c) personal and spiritual formation, and (d) religious and public leadership, along with supervised practical ministry experiences (Commission on Accrediting, 2020). No specific coursework in counseling or pastoral care is part of Association of Theological Schools' M.Div. degree requirements. There is nothing that formally requires seminaries or divinity schools to address students' emotional intelligence, which includes the areas such as: (a) the ability to communicate feelings to others, (b) accurate emotional perception, (c) the ability to maintain fulfilling personal relationships, and (d) the ability understand someone else's perspective (Petrides, 2010). Yet, given that each emotional intelligence quality is essential to the relational work of the pastor (Oswald, 2016), it is recommended that programs for pastoral training assess their students for emotional intelligence and find ways of helping those with deficits to grow in their emotional and relational capacities (e.g., through mentoring, counseling, relationship skills training, etc.). In this way, graduates will be better prepared for the relational rigor of the pastorate.

Implications related to the study findings regarding the relationship of (a) trauma-related training and (b) having a degree or advanced certification in counseling or another mental health field with an increase in trauma-related attitudes and beliefs should concern those involved in clergy preparation. Considering the multifaceted helping roles that clergy assume, including many caregiving roles (e.g., grief counseling, crisis intervention, visiting the sick and dying), it is of note that members of the clergy often do not receive sufficient training in mental health

literacy or counseling skills (Vermaas et al., 2017; Wilson, 2004). As such, clergy may be poorly equipped to provide competent care to congregants who turn to them in times of distress related to psychological trauma or other mental health needs. The COVID-19 pandemic provided an illustration of why clergy need to be better equipped in trauma awareness and response. The current study revealed that clergy and their congregations had been significantly impacted by the overwhelming (and potentially traumatic) nature of the pandemic, with many clergy reporting that a close friend or family member had been hospitalized due to COVID-19 (n = 70, 29.8%), while almost a fourth of the participants reported that a close friend or family member had died due to COVID-19 related causes (n = 54, 23%). Over half of the clergy in this study reported that someone in their church congregation had been hospitalized due to COVID-19 (n = 126, 53.6%) and a significant proportion of the sample reported that a member of their church congregation had died due to COVID-19 related causes (n = 102, 43.4%). The individuals affected directly by COVID-19, along with their friends and family, will require ongoing pastoral care and counseling.

In a society that is impacted by trauma on individual, community, and systemic levels, pastoral education programs must begin to incorporate mandatory training related to the principles of trauma-informed ministry. Trauma-informed training for pastors and congregations needs to address multiple areas:

1. Education that raises awareness of the prevalence of trauma, the contexts within which it occurs, and the manifestations of trauma in children, adults, families, and communities (see SAMHSA, 2014).
2. How to establish support systems within church communities that can help address the complex and long-term needs of many trauma survivors (see

Gingrich, 2018).

3. The potential for retraumatization to occur in religious communities and how to avoid this hazard in the diverse ministries of the church (i.e., preaching, teaching, children's and youth ministries, pastoral counseling, community engagement; see Baldwin, 2018; Jones, 2009).

Finally, while trauma training and emotional intelligence were significant predictors of the trauma-related attitudes and beliefs of Christian clergy in this study, the finding that neither previous trauma exposure nor the amount of time spent in counseling-related activities by clergy were significant predictors is also of note. It is possible that how a pastor has processed or healed from previous trauma exposure is more important than the amount or frequency of previous trauma exposure (Deighton et al., 2007). Similarly, an interpretation of the results regarding clergy job role/focus is that even if pastors spend most of their working hours in providing counseling or pastoral care, this does not automatically increase their empathy or understanding regarding the experience of trauma (i.e., trauma-related attitudes and beliefs).

In future research, it would be valuable to explore if how a pastor addresses their personal traumatic experiences (rather than the experiences themselves) significantly predicts the trauma-related attitudes and beliefs of clergy. The high prevalence of trauma exposure reported by clergy warrants attention from those who train and ordain clergy, given the potential impact of the pervasiveness and severity of a person's trauma to impact their mental health and interpersonal relationships. Opportunities and resources for trauma-related psychoeducation and personal counseling need to be made available to pastors-in-training.

Counselors

The *ACA Code of Ethics* (2014) states that ethical counseling practice requires the

counselor to understand that "support networks hold various meanings in the lives of clients and [to] consider enlisting the support, understanding, and involvement of others (e.g., religious/spiritual/community leaders, family members, friends) as positive resources, when appropriate, with client consent" (p. 4). In addition, the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC), a division of the American Counseling Association, has published a set of competencies to guide counselors in addressing spiritual and religious issues with clients (2009). The fifth ASERVIC competency is:

> The professional counselor can identify the limits of his/her understanding of the client's spiritual and/or religious perspective and is acquainted with religious and spiritual resources, including leaders, who can be avenues for consultation and to whom the counselor can refer (ASERVIC, 2009).

And whereas counselors need to be equipped to help clients from various spiritual and religious backgrounds (ASERVIC, 2009), counselors need to be aware that survivors of complex trauma may require the support of a multi-disciplinary team (Barnes & Andrews, 2019; Ko et al., 2008; Murphy, 2010; Stevens et al., 2019), including individuals who can provide spiritually sensitive care (Benson et al., 2016; Callahan, 2013; Canda & Furman, 1999; Hipolito et al., 2014; Streets, 2015). In light of these professional recommendations and given that many trauma survivors have a preference for seeking religious support to address their concerns (Currier et al., 2018; Neergaard et al., 2007), it is important for counselors to network with religious leaders in their communities so that counselors and clergy can refer trauma survivors to one another for assistance when appropriate. Beyond consultation, if counselors work to establish relationships with religious leaders, they may have an important role to play in both providing care for clergy who seek professional counseling and in helping religious leaders grow in both trauma

awareness and emotional intelligence.

Counselor Education

Whereas the current study looked at the trauma-related attitudes and beliefs of clergy members, the results indicate some implications for counselor education as well. Master's level counseling programs are designed to provide broad, foundational knowledge and skills, with the understanding that new counselors will need post-graduate supervision and continuing education in order to develop the necessary competency and expertise in their specific areas of practice. In the past decade, accrediting agencies and licensing boards have acknowledged the need for *all* counselors to have a basic level of trauma-competency upon completing their graduate degrees. CACREP, the accrediting body for graduate programs in counseling, first started requiring that trauma-specific material be covered as part of the core graduate curriculum in 2009 (CACREP, 2009). Most recently, the 2016 accreditation standards (CACREP, 2015) retained this emphasis with requirements that counselor education programs teach all students (regardless of specialty area) about: (a) the "effects of crisis, disasters, and trauma on diverse individuals across the lifespan" (p.10), (b) "crisis intervention, trauma-informed, and community-based strategies, such as Psychological First Aid" (p.11), and (c) "procedures for identifying trauma and abuse and for reporting abuse" (p.11). In addition, for most of the counseling specialties (e.g., clinical mental health counseling, school counseling), there is a mandate that counselors understand the impact of crisis and trauma on the specific populations with whom they work (e.g., individuals with disabilities, college students, couples, and families).

In addition to CACREP, state licensing boards have begun to acknowledge the importance of trauma competency for counselors. A thorough review of licensing board stipulations related to trauma preparation (i.e., the researcher personally reviewed each state's

licensing requirements) revealed that only California and Washington, DC currently require specific trauma-related training for licensed counselors. However, Florida, Iowa, and New York also specified mandatory continuing education in topics related to trauma (crisis, abuse, domestic violence) and four other states (West Virginia, Vermont, Oklahoma, and Maine) suggest coursework in crisis intervention. Consequently, the accreditation standards and the state-specified training needs both acknowledge the importance for trauma-informed counselors and necessitate that counselor education programs be designed to deliver trauma-informed curriculum. Thus, counselor education programs must find ways to both infuse trauma-informed content throughout the core curriculum (rather than relegating the content to a single course) and to provide relevant trauma-specific skills training.

Finally, counselor educators can be important partners for those involved with clergy training and preparation. It would be wise for churches, denominations, and seminaries to include and consult with counselor educators when developing trauma-related training. Counselor educators have the necessary specialized knowledge related to trauma and mental health, as well as expertise and experience in adult learning, to design and implement effective training initiatives. Furthermore, as trauma-informed trainings begin to be created and delivered in the contexts of seminaries and religious congregations, the effectiveness of education in the area of trauma informed care for clergy and congregations needs to be systematically assessed. Counselor educators are well-equipped as researchers and could provide the necessary assistance to facilitate program evaluation of the trauma trainings offered within church and seminary contexts.

Chapter Summary

In this final chapter, the researcher compared the results from this study with existing

research related to clergy, mental health, trauma-informed care, and emotional intelligence. The results of the study revealed that both trauma-related training and trait emotional intelligence are significant predictors of the trauma-related attitudes and beliefs of Christian clergy. Finally, recommendations and implications for pastors, pastoral education, counselors, and counselor education were made.

APPENDIX A: UNIVERSITY OF CENTRAL FLORIDA INSTUTIONAL REVIEW BOARD APPROVAL LETTER

University of Central Florida Institutional Review Board
Office of Research & Commercialization
12201 Research Parkway, Suite 501
Orlando, Florida 32826-3246
Telephone: 407-823-2901 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

Approval of Human Research

From: **UCF Institutional Review Board #1**
FWA00000351, IRB00001138

To: **Elizabeth R. Pennock**:

Date: **September 05, 2018**

Dear Researcher:

On 09/05/2018 the IRB approved the following human participant research until 09/04/2019 inclusive:

Type of Review:	UCF Initial Review Submission Form Expedited Review
Project Title:	Trauma-Informed Clergy: An Investigation of Factors Influencing the Trauma-Related Attitudes of Christian Clergy in Florida
Investigator:	Elizabeth R. Pennock
IRB Number:	SBE-18-13990
Funding Agency:	
Grant Title:	
Research ID:	n/a

The scientific merit of the research was considered during the IRB review. The Continuing Review Application must be submitted 30days prior to the expiration date for studies that were previously expedited, and 60 days prior to the expiration date for research that was previously reviewed at a convened meeting. Do not make changes to the study (i.e., protocol, methodology, consent form, personnel, site, etc.) before obtaining IRB approval. A Modification Form **cannot** be used to extend the approval period of a study. All forms may be completed and submitted online at https://iris.research.ucf.edu .

If continuing review approval is not granted before the expiration date of 09/04/2019, approval of this research expires on that date. When you have completed your research, please submit a Study Closure request in iRIS so that IRB records will be accurate.

Use of the approved, stamped consent document(s) is required. The new form supersedes all previous versions, which are now invalid for further use. Only approved investigators (or other approved key study personnel) may solicit consent for research participation. Participants or their representatives must receive a copy of the consent form(s).

All data, including signed consent forms if applicable, must be retained and secured per protocol for a minimum of five years (six if HIPAA applies) past the completion of this research. Any links to the identification of participants should be maintained and secured per protocol. Additional requirements may be imposed by your funding agency, your department, or other entities. Access to data is limited to authorized individuals listed as key study personnel.

In the conduct of this research, you are responsible to follow the requirements of the Investigator Manual.

This letter is signed by:

Signature applied by Gillian Morien on 09/05/2018 04:05:47 PM EDT

Designated Reviewer

APPENDIX B: PUBLISHER PERMISSION TO USE THE ARTIC SCALE

From: **Christine Greene** christine.greene@klingberg.com
Subject: ARTIC Purchase
Date: September 1, 2017 at 11:42 AM
To: elizabeth.pennock@knights.ucf.edu
Cc: Steve Brown steveb@klingberg.com

CG

Hi Elizabeth,

Please find attached the ARTIC in all its standard versions, along with scoring spreadsheet and instructions. I've also attached a receipt for your records. A separate e-mail will follow with the Qualtrics-compatible version.

We wish you good luck in your work,

Chris Greene
Administrative Assistant
Traumatic Stress Institute
at Klingberg Family Centers
370 Linwood Street
New Britain, CT 06052
tsisupport@klingberg.com
P: 860-832-5562
F: 860-471-8226

Receipt		No. 0057
Payee Name: Klingberg Family Centers Address: 370 Linwood St New Britain, CT 06052 KLINGBERG FAMILY CENTERS	Contact Person: Elizabeth Pennock Licensed to: Department of Child, Family & Community Sciences University of Central Florida PO Box 161250 Orlando, FL 32816-1250	
Date	Description	Amount
	Subtotal	100.00
	Tax	0.00
	Paid in full 9/1/2017 **Approval # 02709C** TOTAL	100.00

APPENDIX C: INFORMED CONSENT

Trauma-Informed Clergy: An Investigation of Factors Influencing the Trauma-Related Attitudes of Christian Clergy in Florida

Informed Consent

Principal Investigator: Elizabeth Pennock, MA
Faculty Advisors: Viki P. Kelchner, PhD and W. Bryce Hagedorn, PhD
Investigational Site: University of Central Florida, College of Community Innovation and Education

Introduction: You are being invited to take part in a dissertation research study being conducted by Elizabeth Pennock, a doctoral candidate in Counselor Education at the University of Central Florida.

You are being invited to participate in this research because you are a pastor, priest, minister, or other member of the Christian clergy.

You may participate in this survey if you are:

1. 18 years old or older,
2. An ordained pastor, priest, minister, or other member of the Christian clergy, and
3. Currently working at a church in the State of Florida.

Purpose of the research study: To better understand what factors influence how clergy from varying backgrounds view both the experience of psychological trauma and their professional role in providing pastoral care or counseling to parishioners who have been through traumatic experiences.

What you will be asked to do in the study: If you choose to participate in the online survey, you will be asked to complete a brief demographic questionnaire along with a series of survey questions related to trauma-related attitudes, theological beliefs, and your personal experiences. Your participation is voluntary and you may stop taking the survey at any time. You may decline to answer any question.

Time required: This survey will take you between 10-15 minutes to complete.

Risks: The risks associated in this study are minimal; however, feelings of discomfort may arise in reading and answering survey questions related to traumatic experiences.

Benefits: We cannot promise any benefits to you or others from your taking part in this research.

Compensation or payment: In order to thank you for your participation, upon completing the survey you will have the opportunity to choose that the researcher make a $1.00 donation on your behalf to one of the following non-profit organizations:

- International Justice Mission (www.ijm.org), or
- The Trauma Healing Institute (http://thi.americanbible.org/).

Donations to IJM and THI will be made once the survey has closed.

Confidentiality: The information collected by this survey will be kept anonymous and confidential. You will not be required to reveal your name or other personally identifying information (for example: address, phone number, email, etc.).

Study contact for questions about the study or to report a problem: If you have questions, concerns, or complaints, contact Elizabeth Pennock at (407)221-4963 or elizabeth.pennock@knights.ucf.edu. This research is being conducted under the supervision of dissertation committee co-chairs who may also be contacted with questions or concerns: • Dr. W. Bryce Hagedorn, University of Central Florida (bryce.hagedorn@ucf.edu) • Dr. Viki Kelchner, University of Central Florida (viki.kelcnher@ucf.edu).

IRB contact about your rights in the study or to report a complaint: Research at the University of Central Florida involving human participants is carried out under the oversight of the Institutional Review Board (UCF IRB). This research has been reviewed and approved by the IRB. For information about the rights of people who take part in research, please contact: Institutional Review Board, University of Central Florida, Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246 or by telephone at (407) 823-2901 or email at irb@ucf.edu.

By clicking the next button below, you are indicating that you have read this consent and agree to participate in this survey.

Next

APPENDIX D: ATTITUDES RELATED TO TRAUMA-INFORMED CARE SCALE

(ARTIC-10-HS)

ARTIC | *Attitudes Related to Trauma-Informed Care Scale*

VERSION: ARTIC-10 HUMAN SERVICES

TRAUMATIC STRESS INSTITUTE

People who work in human services, health care, education, and related fields have a wide variety of beliefs about their clients, their jobs, and themselves. The term "client" is interchangeable with "student," "person," "resident," "patient," or other terms to describe the person being served in a particular setting.

Trauma-informed care is an approach to engaging people with trauma histories in human services, education, and related fields that recognizes and acknowledges the impact of trauma on their lives.

INSTRUCTIONS

For each item, select the circle along the dimension between the two options that best represents your personal belief during the past two months at your job.

Sample

	1	2	3	4	5	6	7	
Ice cream is delicious	○	●	○	○	○	○	○	Ice cream is disgusting.

Note: *In this SAMPLE ITEM, the respondent is reporting that he/she believes that ice cream is much more delicious than disgusting.*

I believe that…

		1	2	3	4	5	6	7	
1	Clients could act better if they really wanted to.	○	○	○	○	○	○	○	Clients are doing the best they can with the skills they have.
2	Focusing on developing healthy, healing relationships is the best approach when working with people with trauma histories.	○	○	○	○	○	○	○	Rules and consequences are the best approach when working with people with trauma histories.
3	If clients say or do disrespectful things to me, it makes me look like a fool in front of others.	○	○	○	○	○	○	○	If clients say or do disrespectful things to me, it doesn't reflect badly on me.
4	The ups and downs are part of the work so I don't take it personally.	○	○	○	○	○	○	○	The unpredictability and intensity of work makes me think I'm not fit for this job.
5	It's best not to tell others if I have strong feelings about the work because they will think I am not cut out for this job.	○	○	○	○	○	○	○	It's best if I talk with others about my strong feelings about the work so I don't have to hold it alone.
6	Clients do the right thing one day but not the next. This shows that they are doing the best they can at any particular time.	○	○	○	○	○	○	○	Clients do the right thing one day but not the next. This shows that they could control their behavior if they really wanted to.
7	Clients need to experience real life consequences in order to function in the real world.	○	○	○	○	○	○	○	Clients need to experience healing relationships in order to function in the real world.
8	I realize that clients may not be able to apologize to me after they act out.	○	○	○	○	○	○	○	If clients don't apologize to me after they act out, I look like a fool in front of others.
9	I feel able to do my best each day to help my clients.	○	○	○	○	○	○	○	I'm just not up to helping my clients anymore.
10	The most effective helpers find ways to toughen up – to screen out the pain – and not care so much about the work.	○	○	○	○	○	○	○	The most effective helpers allow themselves to be affected by the work – to feel and manage the pain – and to keep caring about the work.

Thank you for your participation.

KLINGBERG FAMILY CENTERS

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APPENDIX E: BRIEF TRAUMA QUESTIONNAIRE

Brief Trauma Questionnaire

The following questions ask about events that may be extraordinarily stressful or disturbing for almost everyone. Please circle "Yes" or "No" to report what has happened to you.

If you answer "Yes" for an event, please answer any additional questions that are listed on the right side of the page to report: (1) whether you thought your life was in danger or you might be seriously injured; and (2) whether you were seriously injured.

If you answer "No" for an event, go on to the next event.

Event	Has this ever happened to you?	If the event happened, did you think your life was in danger or you might be seriously injured?	If the event happened, were you seriously injured?
1. Have you ever served in a war zone, or have you ever served in a noncombat job that exposed you to war-related casualties (for example, as a medic or on graves registration duty?)	No Yes	No Yes	No Yes
2. Have you ever been in a serious car accident, or a serious accident at work or somewhere else?	No Yes	No Yes	No Yes
3. Have you ever been in a major natural or technological disaster, such as a fire, tornado, hurricane, flood, earthquake, or chemical spill?	No Yes	No Yes	No Yes
4. Have you ever had a life-threatening illness such as cancer, a heart attack, leukemia, AIDS, multiple sclerosis, etc.?	No Yes	No Yes	*N/A*
5. Before age 18, were you ever physically punished or beaten by a parent, caretaker, or teacher so that: you were very frightened; or you thought you would be injured; or you received bruises, cuts, welts, lumps or other injuries?	No Yes	No Yes	No Yes
6. Not including any punishments or beatings you already reported in Question 5, have you ever been attacked, beaten, or mugged by anyone, including friends, family members or strangers?	No Yes	No Yes	No Yes
7. Has anyone ever made or pressured you into having some type of unwanted sexual contact? Note: By sexual contact we mean any contact between someone else and your private parts or between you and some else's private parts	No Yes	No Yes	No Yes
8. Have you ever been in any other situation in which you were seriously injured, or have you ever been in any other situation in which you feared you might be seriously injured or killed?	No Yes	*N/A*	No Yes
9. Has a close family member or friend died violently, for example, in a serious car crash, mugging, or attack?	No Yes	*N/A*	No Yes
10. Have you ever witnessed a situation in which someone was seriously injured or killed, or have you ever witnessed a situation in which you feared someone would be seriously injured or killed? Note: Do not answer "yes" for any event you already reported in Questions 1-9	No Yes	*N/A*	*N/A*

APPENDIX F: TRAIT EMOTIONAL INTELLIGENCE QUESTIONNAIRE – SHORT FORM

TEIQue-Short Form

Instructions: Please answer each statement below by putting a circle around the number that best reflects your degree of agreement or disagreement with that statement. Do not think too long about the exact meaning of the statements. Work quickly and try to answer as accurately as possible. There are no right or wrong answers. There are seven possible responses to each statement ranging from 'Completely Disagree' (number 1) to 'Completely Agree' (number 7).

1 . . . . . 2 . . . . . 3 . . . . . 4 . . . . . 5 . . . . . 6 7

Completely Disagree **Completely Agree**

1. Expressing my emotions with words is not a problem for me.	1	2	3	4	5	6	7
2. I often find it difficult to see things from another person's viewpoint.	1	2	3	4	5	6	7
3. On the whole, I'm a highly motivated person.	1	2	3	4	5	6	7
4. I usually find it difficult to regulate my emotions.	1	2	3	4	5	6	7
5. I generally don't find life enjoyable.	1	2	3	4	5	6	7
6. I can deal effectively with people.	1	2	3	4	5	6	7
7. I tend to change my mind frequently.	1	2	3	4	5	6	7
8. Many times, I can't figure out what emotion I'm feeling.	1	2	3	4	5	6	7
9. I feel that I have a number of good qualities.	1	2	3	4	5	6	7
10. I often find it difficult to stand up for my rights.	1	2	3	4	5	6	7
11. I'm usually able to influence the way other people feel.	1	2	3	4	5	6	7
12. On the whole, I have a gloomy perspective on most things.	1	2	3	4	5	6	7
13. Those close to me often complain that I don't treat them right.	1	2	3	4	5	6	7
14. I often find it difficult to adjust my life according to the circumstances.	1	2	3	4	5	6	7
15. On the whole, I'm able to deal with stress.	1	2	3	4	5	6	7
16. I often find it difficult to show my affection to those close to me.	1	2	3	4	5	6	7
17. I'm normally able to "get into someone's shoes" and experience their emotions.	1	2	3	4	5	6	7
18. I normally find it difficult to keep myself motivated.	1	2	3	4	5	6	7

19. I'm usually able to find ways to control my emotions when I want to.	1	2	3	4	5	6	7
20. On the whole, I'm pleased with my life.	1	2	3	4	5	6	7
21. I would describe myself as a good negotiator.	1	2	3	4	5	6	7
22. I tend to get involved in things I later wish I could get out of.	1	2	3	4	5	6	7
23. I often pause and think about my feelings.	1	2	3	4	5	6	7
24. I believe I'm full of personal strengths.	1	2	3	4	5	6	7
25. I tend to "back down" even if I know I'm right.	1	2	3	4	5	6	7
26. I don't seem to have any power at all over other people's feelings.	1	2	3	4	5	6	7
27. I generally believe that things will work out fine in my life.	1	2	3	4	5	6	7
28. I find it difficult to bond well even with those close to me.	1	2	3	4	5	6	7
29. Generally, I'm able to adapt to new environments.	1	2	3	4	5	6	7
30. Others admire me for being relaxed.	1	2	3	4	5	6	7

APPENDIX G: MARLOWE-CROWNE SOCIAL DESIRABILITY SCALE – SHORT FORM X1

MCSDS-X1

Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is true or false as it pertains to you.

Scoring Key: ***True (T)*** indicates socially desirable response (= score of 1) for items from 1 to 5. **False (F)** indicates socially desirable response for items from 6 to 10.

1. I'm always willing to admit it when I make a mistake (T)
2. I always try to practice what I preach (T)
3. I never resent being asked to return a favor (T)
4. I have never been irked when people expressed ideas very different from my own (T)
5. I have never deliberately said something that hurt someone's feelings (T)
6. I like to gossip at times (F)
7. There have been occasions when I took advantages of someone (F)
8. I sometimes try to get even rather than forgive and forget (F)
9. At times I have really insisted on having things on my own way (F)
10. There have been occasions when I felt like smashing things (F)

APPENDIX H: DEMOGRAPHIC QUESTIONNAIRE

UNIVERSITY OF CENTRAL FLORIDA

Clergy Trauma Care Survey // University of Central Florida

Please answer the following demographic questions.

1. Denomination: Of what church denomination are you a leader? (*Examples: Southern Baptist, Catholic, Non-denominational*)

2. In your ministry role, how many hours per week do you spend in activities related to providing pastoral care or counseling? (*estimate average number of hours, numerical values only*)

3. Trauma-Specific Training: Have you received any training specifically about caring for individuals and communities who have experienced trauma?

- No
- Yes (please briefly describe)

4. How many years have you worked in pastoral ministry? (*Numerical values only.*)

Next

Clergy Trauma Care Survey // University of Central Florida

5. Education: What degrees do you hold? *(check all that apply)*

- [ ] Associate's Degree
- [ ] Bachelor's Degree
- [ ] Master of Divinity
- [ ] Master of Counseling
- [ ] Master of Marriage and Family Therapy
- [ ] Master of Pastoral Counseling
- [ ] Doctorate of Ministry
- [ ] PhD in

_____

- [ ] Other

_____

6. Licensure / Certification: What counseling-related licenses or certifications do you hold, if any?

- [ ] Licensed Master's-level Mental Health Professional (counselor, marriage and family therapist, social work, etc.)
- [ ] Licensed Psychologist
- [ ] Certified Pastoral Counselor
- [ ] Clinical Pastoral Education (for chaplains)
- [ ] Other

Certified Pastoral Counselor

Clinical Pastoral Education (for chaplains)

Other

None

7. Do you currently work in ministry full-time or part-time?

Part-time (less than 30 hours per week)

Full-time (30 hours per week or more)

8. Church Size: Approximately how many members and regular attenders are part of the congregation where you are a leader?

less than 100

100-250

250-500

500-1000

Over 1000

Next

9. Gender

- Male
- Female
- Other

10. Race / Ethnicity *(select all that apply)*

- White
- Hispanic / Latino/a
- Black or African American
- Asian or Asian American
- American Indian or Alaska Native
- Middle Eastern or North African
- Native Hawaiian or Pacific Islander
- Other

11. Do you know personally know someone who has been hospitalized with or died from COVID-19? *(This question will be used to inform future research around the church, trauma response, and COVID-19.)*

Please select all that apply.

11. Do you know personally know someone who has been hospitalized with or died from COVID-19? *(This question will be used to inform future research around the church, trauma response, and COVID-19.)*

Please select all that apply.

- Someone in my family or a close friend has been hospitalized due to COVID-19.
- Someone in my family or a close friend has died due to COVID-19 related reasons.
- Someone in the congregation that I lead has been hospitalized due to COVID-19.
- Someone in the congregation that I lead has died due to COVID-19 related reasons.
- I have been personally hospitalized for reasons related to COVID-19.

Next

Clergy Trauma Care Survey // University of Central Florida

APPENDIX I: COUNSELING RESOURCES FOR PARTICIPANTS

Thank you for participating in this research study. It is possible that responding to questions related to your personal experiences of trauma may have caused discomfort or brought up distressing memories. If you would like help working through these experiences, you are invited to make use of any of the following resources:

Online resources for trauma survivors:

- *PTSD Alliance* http://www.ptsdalliance.org/
- *Unites States Department of Veteran Affairs: National Center for PTSD* https://www.ptsd.va.gov/
- *Sidran Institute* https://www.sidran.org/

Telephone hotlines:

- *National Sexual Assault Telephone Hotline:* 800.656.HOPE (4673)
- *Crisis Text Line:* Text HOME to 741741. (This free, 24/7 support service provides access to trained crisis counselors via text message).
- *National Suicide Prevention Lifeline*: 800-273-8255

How to find a counselor in your area:
The following online resources may help you find a mental health provider in your area:

- *Substance Abuse and Mental Health Services Administration (SAMHSA) National Helpline:* 1-800-662-HELP (4357) SAMHSA's hotline can help you locate mental health facilities in your area. This free national hotline is available 24/7 and can also direct you to local support groups, community-based organizations, and other mental health resources. You can also visit their online treatment locator. https://findtreatment.samhsa.gov/
- *Psychology Today*: Search for treatment providers by location and specialty. https://www.psychologytoday.com/us/therapists/florida
- *Christian Counselor's Network*: https://www.focusonthefamily.com/lifechallenges/christian-counselors-network

Next

APPENDIX J: DONATION RECEIPT FOR THE TRAUMA HEALING NETWORK OF THE AMERICAN BIBLE SOCIETY

Gmail

Elizabeth P <epennock2@gmail.com>

Thank you for your gift to American Bible Society
1 message

American Bible Society <OnMission@americanbible.org>
Reply-To: donorcare@americanbible.org
To: epennock2@gmail.com

Sun, May 9, 2021 at 1:48 PM

AMERICAN BIBLE SOCIETY

Dear Elizabeth,

Thank you for your gift of $100.00 to American Bible Society.

Your generosity is touching and changing lives with God's Word. Like you, we know that "the Word of God is alive and active.... It judges the desires and thoughts of the heart" (Hebrews 4:12, GNT).

We will faithfully use your gift to share the peace, comfort, and hope of Christ found in the Bible with more waiting hands and open hearts. You will have an eternal impact!

Thank you for your partnership in sharing the Good News!

Yours in Christ,

Robert L. Briggs
President and CEO
American Bible Society

"How wonderful it is to see a messenger coming across the mountains, bringing good news, the news of peace!" Isaiah 52:7 (GNT)

GIFT RECEIPT BELOW

Ms. Elizabeth Pennock

578 Pinebranch Cir

Winter Springs FL 32708

Thank you for your contribution of $100.00 that American Bible Society received on 05-09-2021.

APPENDIX K: DONATION RECEIPT FOR INTERNATIONAL JUSTICE MISSION

Gmail

Elizabeth P <epennock2@gmail.com>

You just made an incredible impact - thank you!

1 message

International Justice Mission <giving@ijm.org>
Reply-To: giving@ijm.org
To: epennock2@gmail.com

Sun, May 9, 2021 at 1:40 PM

Dear Elizabeth,

Thank you for partnering with IJM. Your contribution will truly make a difference in the lives of children, women and men around the world.

Your gift of $150.00 has been received. View your receipts in Your Portal.

Donating in honor of someone you love? Click here to send them an eCard.

Because of you, we're able to rescue victims of violence, bring their offenders to justice and provide much-needed aftercare to survivors.

If you have any questions about your giving, please contact us at giving@ijm.org or 703-465-5495.

On behalf of those we serve — thank you.

Gratefully,

The IJM Team

P.S. Did you know that you may be able to double the gift you just made? Check to see if your company will match your gift!

Transaction Receipt:

Please print or save a copy of this receipt for your records.

Donor Information:

Name:	Elizabeth Pennock
Street:	578 Pinebranch Cir
City:	Winter Springs
State:	FL
Zip:	32708
Country:	US
Email:	epennock2@gmail.com

Transaction Information:

Payment Date:	05/09/2021
Payment Type:	Card
Amount:	$150.00
Tax-Deductible Amount:	$150.00

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