Beyond the Pulpit: A Quantitative Analysis of Midwest Church Leaders' Confidence and Competence in Addressing Sexual Trauma

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A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

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Abstract

This quantitative study investigates the interconnectedness of confidence and competence within the context of Midwest church leaders in addressing survivors of sexual trauma. Sexual Trauma encompasses crimes like sexual assault, rape, and sexual abuse, and it presents complex challenges within faith communities. This research employs an ordinal logistic regression, combining a survey instrument to assess leaders' confidence, known as the *Readiness to Work with Trauma-Exposed Patients* (RTEPS), and a comprehensive tool to measure competence, referred to as the *Trauma-Informed Care Questionnaire* (TICQ). Additionally, demographic factors, including race, age, gender, denomination, previous trauma training, and years of ministry experience, are analyzed to understand their influence on church leaders' confidence and competence in addressing sexual trauma. Participants included Midwest church leaders who had at least one experience with a survivor of sexual trauma. Results found no significant relationship between the competence and confidence levels of Midwest church leaders in addressing sexual trauma. However, age, denomination, and previous trauma training significantly impact leaders' confidence. While age, gender, and denomination significantly impact leaders' competence. This study informs future research and equips church leaders with valuable insights to effectively serve survivors of sexual trauma. This aligns with the growing body of research on trauma-informed institutions, advancing the understanding of how church leaders perceive and respond to trauma survivors.

Key Words: sexual trauma, trauma-informed institution, Midwest church leaders, confidence, competence

Copyright Page

Dedication

To my loving husband, Nicholas, whose unwavering support and encouragement sustained me through this challenging journey. To our precious Eleanor, who brought joy and inspiration during her arrival amidst the writing process. This dissertation is dedicated to both of you, my sources of strength and motivation.

Acknowledgments

I want to emphasize that this journey has been a collective effort, and I am profoundly grateful to each person who has played a part, no matter how small, in bringing this dissertation to fruition. Your presence in my life has made all the difference.

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A heartfelt thank you to Professor Schoonover for imparting the invaluable lesson of always questioning authority. Your teachings have enriched my academic journey and instilled in me a lifelong commitment to critical thinking and intellectual exploration.

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Chapter 1: Introduction

This study was designed to look at the confidence and competence of church leaders as they address sexual trauma within their church. Over time, the role of church leaders has shifted to include mental health care. Therefore, research regarding trauma-informed care and church leaders needs to be conducted to better understand the experiences and ability of church leaders to handle this new role. Given the substantial influence of spirituality in individuals' lives and the common occurrence of traumatic experiences, it is essential for churches to adopt trauma-informed practices in order to provide effective support to their members. This chapter delves into the background of this topic, reviews the gap in the literature, sets the stage for the layout of the study, and presents the importance of the study.

Background

Throughout history, sexual trauma has been viewed and addressed differently. As society gains more insight into the experiences, impacts, and needs of survivors of sexual trauma, clinicians are focusing more effort on the healing and recovery process. Individuals seeking guidance both spiritually and for their mental health often come from a background that includes trauma. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) defines trauma as an event or circumstance that includes physical, emotional, or life-threatening harm. There is a recognition that social services must target trauma recovery and be attuned to the needs of those with a traumatic history (Sweeney et al., 2018). Henceforth, social institutions such as schools, medical facilities, and legal systems are being challenged to become trauma-informed so that they are ready to serve survivors best (Holland & Barnes, 2019). As social institutions begin to adopt trauma-informed practices, the social institution of the church is being

called upon to consider their policies and practices regarding trauma response (Crosby et al., 2021).

Spirituality is vital to many people's lives (Williams et al., 2014). When trauma is experienced, the church is often a safe haven for support. Therefore, church leaders are tasked with addressing the spiritual, physical, and emotional needs of survivors of sexual trauma. With this, there is a need for research to be conducted on the confidence of church leaders' ability to address sexual trauma. As church leaders are tasked with more responsibility, their subjective experience of working with survivors of sexual trauma is critical.

Since church leaders are entering a new domain, their competence in addressing sexual trauma needs to be addressed. Results will help inform clinicians and researchers on how to best partner with churches in educating and training them to serve this population. The focus of this research study was to evaluate the confidence that church leaders have when addressing survivors of sexual trauma. Additionally, the competence of their trauma response was evaluated to understand better the subjective and objective reality of Midwest church leaders' response to sexual trauma. To do so, one must understand intersubjectivity, the church's role, the impact of sexual trauma, current trauma-informed practices, and the research surrounding these topics.

Problem Statement

There is a dearth of quantitative research concerning the gap between what church leaders provide and their training and readiness to address survivors of sexual violence (Crosby et al., 2021; Fortune, 2002; Hill & Yancey, 2022). Without adequate training and response, survivors may experience heightened symptoms of PTSD (Ahrens & Aldana, 2012; Brenner & Ben-Amitay, 2015; SAMHSA, 2014). Ideally, the church should be a place of healing and

restoration. Therefore, providing trauma-informed care is just one way church leaders can ensure they carry out the mission of the church.

While the existing body of literature has focused on the experiences that church leaders have when counseling survivors, there is yet to be data regarding the confidence and competence of church leaders in providing care to survivors of sexual trauma. Many qualitative studies have been conducted concerning how church leaders respond and what they experience when counseling survivors (Munro-Kramer et al., 2017; Payne & Hays, 2016; Rudolfsson et al., 2012; Streets, 2015). In addition, extensive research has been conducted to evaluate what survivors are seeking and what they need to mitigate PTSD symptoms (Holland & Barnes, 2019; Munro-Kramer et al., 2017). The problem revolves around the absence of quantitative data concerning the confidence and competence levels of church leaders in their response to sexual trauma in their congregation. Consequently, the level of care provided to survivors who turn to these church leaders for support remains uncertain.

Purpose Statement

The purpose of this study was to fill the existing gap in quantitative research by understanding the interconnectedness of confidence and competence levels of Midwest church leaders in their responses to survivors of sexual trauma. The research participants were comprised of individuals who hold positions of authority within Midwest churches, including head pastors, children and youth service directors, and music leaders, and who are actively involved in their respective ministries. These church leaders must also possess prior experience in assisting at least one survivor of sexual trauma within their congregations. This current research assessed the impact of church leaders' competence, as measured by the *Trauma-*

Informed Care Questionnaire (TICQ), on their confidence in addressing sexual trauma, as measured by the *Readiness to Work with Trauma-Exposed Patients (RTEPS) survey.*

Additionally, this study analyzed the influence of demographic variables, including race, age, gender, denomination, and years of ministry experience, on church leaders' confidence and competence in addressing sexual trauma within their congregation. The study employed a survey-based approach, where participants were contacted through church associations and online channels, ensuring a diverse and representative sample. Once informed consent was obtained, participants were directed to a Google Form-based survey, segmented into three sections: the demographic questionnaire, the RTEPS, and the TICQ. This approach allows for the systematic collection and analysis of data to comprehensively examine the interplay between competence, confidence, and demographic variables among church leaders in addressing sexual trauma. This research seeks to provide valuable insight that can help guide future training and support for church leaders to better equip them to serve the complex needs of trauma survivors.

Significance Of Study

Sexual trauma is a complex issue, and survivors of sexual trauma need trauma-informed care in order to prevent additional harm (Ahrens & Aldana, 2012; Brenner & Ben-Amitay, 2015; SAMHSA, 2014). When survivors turn to church leaders for support, the leaders are confronted with the task of addressing the mental health needs of this group in a manner that fosters healing rather than causing further harm. Many church leaders lack education about trauma-informed care (Lasair, 2020; Rudolfsson & Tidefors, 2013; Streets, 2015). With this knowledge, it is important to get a clear picture of the confidence and competence of church leaders in responding to sexual trauma so that proper support and training can be formulated.

First, this study can increase the data regarding trauma-informed care within the church setting. Churches have become a common place for survivors to turn to, and therefore, creating a trauma-informed environment is an essential goal (Hall & Gjesfjeld, 2013; Iheanacho et al., 2021; Sualp et al., 2021). Second, this data is aimed to provide a foundation for understanding the readiness of church leaders to address sexual trauma so that one can evaluate the impact that churches have on survivors who seek support from church leaders. Third, this study seeks to inform future trainings aimed at church leaders developing trauma-informed responses within the church. Fourth, the cultural and demographic data is designed to provide a multicultural approach to better understand the impact of one's background on one's readiness to work with trauma survivors. Last, the data can be utilized to guide future research.

Providing compassion and support to survivors is not just an aspiration but a key tenet of Christianity. Galatians 6:2 *(New International Bible, 1978/2011,* Gal. 6:2) states, “Bear one another’s burdens, and so fulfill the law of Christ.” In this Biblical context, it is imperative that church leaders can bear the burdens of survivors. This is foundational to the Christian faith and is a moral obligation of church leaders. Overall, this study contributes to the understanding of church leaders' effectiveness in providing care to survivors, considering both their confidence and competence.

Research Questions

RQ1: What is the relationship between the competence level of Midwest church leaders, as measured by the *Trauma-Informed Care Questionnaire* (TICQ), and their confidence in addressing sexual trauma, as measured by the *Readiness to Work with Trauma-Exposed Patients* (RTEPS)?

RQ2: To what extent do demographic factors such as race, age, gender, denomination, and years of ministry experience impact the confidence and competence levels of Midwest church leaders in addressing sexual trauma?

Definitions

Church Leaders: Those who have authority within the church, receive payment from the church for their service, and are expected to provide spiritual guidance to congregation members (Strunk et al., 2017).

Competence- The ability, knowledge, and skills in a specific area (SAMHSA, 2014).

Confidence: One's readiness to work in a specific area (Kazlauskas et al., 2022).

Readiness to Work with Trauma-Exposed Patients (RTEPS): self-report survey to assess confidence.

Sexual Trauma: an all-encompassing, non-legal term that refers to crimes like sexual assault, rape, and sexual abuse (Block & Maxfield, 2019).

Trauma-Informed Competence Questionnaire (TICQ): 18-item questionnaire to assess trauma competency.

Summary

This chapter serves as an outline of this vital research, which focuses on church leaders' confidence and competence in responding to sexual trauma survivors. This study addresses the lack of quantitative research on the topic by utilizing the RTEPS and TICQ surveys to quantify confidence and competence. Furthermore, demographic factors were considered to get a clearer picture of the impact demographics have on the church leaders' readiness to address sexual trauma. In conclusion, this study is critical in laying the groundwork for future efforts. It serves as a guide for providing training to church leaders regarding trauma-informed care. Additionally,

future research can utilize this data to expand on the ideas presented in this dissertation. Lastly, this research aims to increase the quality-of-care survivors receive from church leaders by providing an overview of church leaders' preparedness and capacity to inform future initiatives.

Chapter 2: Literature Review

Understanding the literature regarding leadership in the church, mental health awareness in churches, trauma-informed care, sexual trauma, and church response to sexual trauma is foundational to building this study. This chapter presents the extensive body of research in these areas and focuses on the critical role that church leaders have in responding to survivors of sexual trauma in a trauma-informed manner. Additionally, this chapter aims to provide an understanding of the unique challenges that survivors, institutions, and church leaders face when working together and lay the foundation for what necessary skills and knowledge are needed to serve survivors of sexual trauma.

Theoretical Framework

To establish the significance of a study, it is essential that it is grounded within an established theoretical framework. This study is grounded in the theory of intersubjectivity, which allows the findings to be placed within a broader context. The theory of intersubjectivity asserts that individuals' experiences are mutual and impact others (Husserl, 1999). When individuals interact with one another, there is an exchange of meanings that is more complex than the experiences of a single individual (Harrison & Tronick, 2022). Additionally, as interactions occur with one another, shared experiences are developed. All humans are interconnected through shared experiences and shared meanings (Zlatev et al., 2008). The term "intersubjectivity" was originally coined by Edmund Husserl (1999) and was defined as the "interchange of thought and feelings, both conscious and unconscious, between two persons or subjects, as facilitated by empathy" (p. 38-39). While the idea of intersubjectivity was explored by earlier individuals such as Max Scheler, Edith Stein, or Maurice Merleau-Ponty, the work of

Husserl on the theory of intersubjectivity is foundational and the launching point for increased popularity and expanded research (Tavory, 2022).

The theory of intersubjectivity emphasizes that one's social reality and interpretations of experiences are influenced by the shared knowledge, experiences, and meanings within society (Husserl, 1999). Therefore, no one is completely independent of others. Additionally, mutual meaning is made when an interaction occurs, and the individuals leave the interaction with a complex understanding and perception of the interaction. Husserl (1999) states that there are three main characteristics of human interaction. First is dialogue, which includes the talking, listening to, and discussing that happens between the individuals. The second is empathy, which refers to shared emotions. Lastly is availability. This is the willingness of each individual to be present for another. These three characteristics build upon one another to develop an intersubjectivity where each person leaves the interaction with a complex understanding of the human relationship. After an interaction, intersubjectivity states that the individuals finish with a divergence of subjective meaning. Therefore, each person has a subjective view of the interaction, which will inform their thoughts, feelings, values, and meanings that are unique from the others in the experience but not separate (Cooper-White, 2014).

Research regarding the neurological processes involved in intersubjectivity shows that the posterior right temporoparietal system is the critical component in the synchronization of nonverbal communications (Schore, 2021). In early development, this system is tasked with forming a core self, which leads to the ability to enter intersubjective interactions with another human in adulthood. As this develops, nonverbal cues are developed and recognized. Therefore, intersubjectivity focuses beneath the content, or words, that are being shared and looks at the nonverbal interactions to develop meaning.

Research on intersubjectivity has brought forth many significant findings. In a study by De Jaegher et al. (2017), intersubjectivity was directly linked to research regarding the meaning-making of experiences. Intersubjectivity is a complex study area due to the vastly different meanings that people can develop based on identical experiences. To complicate this more, populations such as those with autism or schizophrenia may struggle with intersubjectivity due to the altered understanding of their social environment (Fuchs, 2015). Fuchs' research suggests that individuals with a restricted understanding of the social environment may make assumptions that lack context. This causes a deficit in the interaction and, therefore, impacts the intersubjectivity.

In the current study, the idea of intersubjectivity is intertwined in the meaning-making that happens when a survivor of sexual trauma reports their trauma to a church leader. Not only does the survivor walk away with a unique understanding of the interaction, but the church leader also has a unique perspective of the experience. Previous research has explored the responses that survivors have received from social institutions such as medical facilities, legal systems, and churches (Campbell, 2013; Cole, 2018; DeCandia et al., 2014; Holland & Barnes, 2019; Mihelicova et al., 2018). Minimal research has looked at the subjective experiences of church leaders after interacting with a survivor of sexual trauma. Intersubjectivity theory asserts that these interactions impact church leaders in a unique way that is separate but interconnected (Konstantinidou, 2018). The experiences of church leaders after working with survivors of sexual trauma need to be evaluated. While their experience is separate from that of the survivor, there is an interconnected piece that can influence how the church leader makes meaning after the interaction.

Overview of Leadership Roles

Leaders within the church are vital to the success of the institution. Church leadership can be dynamic, with individuals holding diverse roles and responsibilities to assist in the success of the church (Grudem, 2020). The senior or head pastor is the overall leader and is responsible for the spiritual leadership and guiding the vision and mission of the church (Getz, 2003). Oftentimes, churches will have an assistant pastor who works alongside the head pastor in carrying out pastoral duties, counseling, and managing various ministries within the church (Grudem, 2020).

Additionally, Getz (2003) describes that each of the various ministries of the church typically have a leader. The youth director focuses on the youth ministry, the children's director focuses on the children's ministry, and the music director focuses on the music ministry. Lastly, some serve in informal leadership roles within the church, such as Sunday school leaders, youth helpers, and deacons (Grudem, 2020; Thorn, 2017). These roles help carry out the mission of the church but are typically unpaid positions. This hierarchical structure is led by the pastor, followed by assistant pastors, department directors, and informal leaders.

Leaders in the church are foundational in carrying out the vision and mission of the institution. In the study by Strunk et al. (2017), the impact of pastors was studied and showed that deficiencies in pastoral leadership can lead to a deficit of church vitality. Additionally, further research showed that pastoral leadership training and education are crucial to the success and vitality of the church (Burns et al., 2013). The roles of church leadership tend to be fluid and impacted by the needs of the church, the current demands of society, and the unique place of employment.

Responsibilities and Expectations of Church Leaders

In the American church, leaders are pulled in many different directions and tend to experience tension. This tension is called role strain and occurs when more responsibility and expectations are placed upon a person, causing tension in their life and work (Goode, 1960). Historically, church leaders have been responsible for their congregants' spiritual well-being and overseeing the institution's administrative needs. However, in recent times, church leaders have become increasingly influenced by congregants, resulting in heightened expectations placed upon them, including the expectation to counsel their congregants (Fulton, 2016). In a study involving 367 church leaders, 80% reported that they had provided counseling to their church members (Hedman, 2014).

Edwards (2014) describes the role strain that church leaders are experiencing by breaking down the expectations into three main categories: micro-level, meso-level, and macro-level. Micro-level refers to congregants' expectations of the pastor, such as unlocking the door before service, holding office hours, or visiting the sick. Meso-level alludes to the expectations of the denomination or religious network within which the institution is situated, including specific teachings, training, or traditions. The third level is the macro-level, which concerns societal expectations that are often evolving and may include responses to social concerns, community presence, or social services. The expectation for church leaders to provide counseling is being pushed from all three levels.

With these heightened expectations, church leaders may experience role strain. The expectations from the community, congregants, and themselves may begin to conflict with one another, exceed their training or capabilities, and lead to disappointment. Recent interviews with church leaders showed that stress and burnout were high due to the role strain they were

experiencing (Clarke et al., 2023). Participants identified that their workload, expectations, isolation, and personal challenges led to strain in their roles. This points to the wide-reaching expectations placed on church leaders and highlights the need to prepare them to balance the many roles they are expected to fill, including trauma-informed practices.

Research has shown that burnout occurs when one experiences role strain (Clarke et al., 2023; Edwards, 2014; Wells, 2013b). Individuals working in the helping fields are at high risk for burnout (Kaschka et al., 2011). Therefore, church leaders tasked with helping people spiritually and in many other ways must be vigilant to prevent burnout in their work. Hildenbrand (2016) emphasized the importance of work-life balance and found that supervisors with family-supportive characteristics and organizations with family-friendly policies were positively related to life satisfaction and health. While church leaders have a high responsibility for their work, emphasizing balance in their lives is critical to their well-being. According to role strain theory, individuals have limited energy and capabilities, and too much strain can negatively impact their effectiveness and overall well-being (Marks, 1977).

The stress that church leaders experience can be categorized into two primary sources: work-related stress and boundary-related stress (Wells et al., 2012). The job duties of a church leader naturally cause stress, but their personal character and ability to set boundaries can significantly impact their stress levels. Further research has found that the stress experienced by church leaders has different health effects (Wells, 2013a). Church leaders can experience an impact on their emotional health when stress becomes overwhelming. Moreover, their physical health can deteriorate when stress and burnout are left untreated, but higher levels of perceived support can lessen the adverse effects of stress on the church leaders' overall emotional and physical health (Wells, 2013b). The impact of stress and burnout on church leaders' emotional

and physical well-being clearly poses a challenge to the modern church. Additionally, the expectations of church leaders have expanded to care not only for the spiritual needs of congregants but also for their physical and mental well-being.

Leadership Challenges in Modern Churches

In recent years, more pressure has been placed on churches and church leaders to fill the health and wellness gap, including physical and mental wellness. The focus on wellness pushes for the development of healthy habits, resulting in a better quality of life. This transition to focusing on physical and mental wellness has been a slow one that many church leaders have gone through unprepared without any guidelines to follow (Houston-Kolnik & Todd, 2016; Tedder & Smith, 2018). Therefore, church leaders are expected to provide health guidance and counseling to promote wellness in their congregants.

Caring for the wellness of congregants is not a new idea. For the past couple of decades, churches have begun offering health programs targeted at physical wellness (Bopp et al., 2013; Hankerson & Weissman, 2012). Hankerson and Weissman identified these programs to include group fitness, walking challenges, health coaching, and health-related Bible studies. Implementation of such programs is greatly impacted by the attitudes of the leaders. Baruth et al. (2015) found that church leaders cited chronic health conditions, an aging population, poor health behaviors, and the inability to access healthcare services as the most common health challenges facing their congregations. Additionally, the church leaders stated they felt a responsibility to be role models for their congregants regarding physical health and wellness. Moreover, Bopp et al. assert that churches have a responsibility toward physical well-being due to their widespread reach within the population. In fact, research on megachurches shows that

religious organizations can reach a diverse population that traditional health services may not be able to reach (Bopp & Webb, 2012). A significant factor in offering health and wellness programs within a church setting is dependent on resources and congregant interest (Bopp & Webb, 2013). The beliefs regarding the integration of physical and spiritual health vary among church leaders regardless of denomination (Webb et al., 2013). Nevertheless, many church leaders made mention of some health-related activities that were taking place at their church (Baruth et al., 2015). As the acceptance of health-related activities became more popular in churches, a pathway for mental health programming was made.

Similarly, to the research showing that churches can reach more people regarding physical health, Hall and Gjesfjeld (2013) assert that rural churches have a key role in filling the mental health gap. In rural areas, there is a lack of services, and many individuals and families cannot afford formal mental health services. Therefore, church leaders are often consulted by congregants seeking mental health guidance. Given churches' vital role in bridging the mental health gap, it becomes imperative to understand the spectrum of services they provide to this population.

Mental Health Awareness in Churches

Since churches have become more accepting of health and wellness programming, expectations towards addressing mental health are becoming more prevalent. Trauma-informed churches are institutions in which leaders in faith communities have a basic understanding of trauma and its complex impact on individuals. Additionally, trauma-informed churches are equipped to respond to individuals who have experienced trauma in a way that prevents revictimization and encourages healing. Research into the role of church leadership regarding

trauma response has been growing in recent years (Hill & Yancey, 2022; Rudolfsson & Tidefors, 2009; Streets, 2015). The findings point to a need for church leaders to understand trauma and have a plan for how to address it.

The Relationship Between Mental Health and Churches

While wellness programs have been accepted within churches, the partnership between counselors and church leaders still faces many obstacles. The gap between these two parties exists due to differences in their approach and goals (Chaddock & McMinn, 1999; Hodge et al., 2020). Counselors tend to come from a more liberal perspective, and therefore, church leaders may have reservations about partnering with them due to conflicting values (Inbar & Lammers, 2012). In a study by Hodge et al., the attitudes of religious leaders toward integrating psychology into church ministry were researched. The findings showed a significant split between what church leaders believe regarding the role of psychology in the church. More conservative churches had religious leaders who viewed psychology and church ministry as less compatible due to the liberal leanings and social justice concerns within psychology. Additionally, clinicians had more difficulty reaching out to church leaders than the reverse (Milstein et al., 2017). Therefore, the expectation of church leaders to initiate collaboration is high.

The attitudes that clergy hold regarding mental health are on a continuum of beliefs (Payne & Hays, 2016). These beliefs ranged from strictly spiritual viewpoints to those that integrate medical and psychological principles into their attitudes. There is a vast range of views that church leaders hold regarding mental health and counseling. Therefore, there is a range of responses and actions that churches are taking in this realm.

Initiatives and Programs for Mental Health Support in Churches

As churches have evolved to meet the needs of society, many programs and services have been added to address the mental health of individuals. Church mental health programs have been developed and effectiveness assessed (Berkley-Patton et al., 2021; Hankerson &Weissman, 2012; Laverne et al., 2014). The research found that African Americans underutilize traditional mental health services but tend to be more open to spiritual options. Church-based programs help with racial disparities regarding accessing mental health services (Hankerson & Weissman, 2012).

Church leaders have a powerful role in providing mental health service accessibility to minority populations (Sualp et al., 2021) Research shows that Black sexual assault survivors oftentimes experience fear and intimidation when receiving services at community-based mental health facilities (Bryant-Davis et al., 2015). Therefore, the church can stand in the gap by providing these services (Coombs et al., 2022; Hays, 2015). Additionally, Iheanacho et al. (2021) conducted a study with women experiencing depression and found that the majority preferred to receive therapy from trained clergy, followed by a psychiatrist and psychologist.

The implementation of a mental health committee within the church an option for bringing mental health awareness into the church (Williams et al., 2014). The mental health committee will serve to bridge the gap between the church and the congregants by identifying and addressing mental health needs. In order for the committee to be successful a relationship with the head pastor will need to be built. The lead pastor has the most authority over the implementation of such a program. The head pastor will oftentimes seek advice and approval from other church leaders within their congregation before implementing something new.

Therefore, the study showed that oftentimes, building a relationship with the head pastor is best done through other leaders in the church who have more influence on the lead pastor. Secondly, a community partnership needs to be built where the resources of the community and the church are partnering to serve the congregants best. This can only be done when trusting relationships are built between clinicians and church leaders. Third, the training and programming need to be flexible. Many different factors can alter the timing, needs, and participation. Therefore, having a flexible system allows for broader usage and acceptance by the church and its members. To provide adequate care for those seeking mental health services, one must clearly understand trauma-informed care, the experiences of individuals seeking services, and their unique needs. Additional options include equipping church leaders to respond, providing group support, and including psychoeducation within sermons (Coombs et al., 2022; Grudem, 2020; Hays, 2015).

Trauma and Trauma-Informed Care

Trauma-informed care is the idea that an institution seeks to realize and understand the impact of trauma and recovery, recognize the signs and symptoms of trauma, integrate knowledge about trauma into policies, procedures, and practices, and avoid re-traumatization (Trauma-Informed Care Implementation Resource Center, 2021). Though trauma-informed institutions are becoming a significant conversation in the professional realm, much growth and research is still to be done. According to Berger and Quiros (2014), an organization that desires to be trauma-informed must have a well-developed system of care. This system must be aware of the complexities of trauma and have research-backed approaches to addressing trauma within the organizational framework. This traumatic event or circumstance has lasting adverse effects on the individual. Trauma can occur to anyone despite their background and has an array of effects on their emotional, physical, mental, social, or spiritual well-being. Individuals with severe

mental health concerns are also at higher risk of traumatization. Therefore, institutions that address mental health concerns must be aware of best practices regarding responding to individuals with trauma (Mihelicova et al., 2018).

This current research is grounded in the trauma-informed approach provided by the Substance Abuse and Mental Health Services Administration (2014), which serves as the foundation for our understanding of trauma-informed response. SAMHSA emphasizes that a trauma-informed approach is cognizant of the context in which trauma is being addressed. Therefore, trauma-informed care must have broader implications than simply clinical interventions. Trauma-informed care will infiltrate the institutions' policies, practices, and culture (DeCandia et al., 2014). SAMHSA offers the four "R's" that build the foundation for training an institution in trauma-informed practices: realizes, recognizes, responds, and resists re-traumatization. First, an institution must realize the impact of trauma. Second, the institution can learn to recognize the signs and symptoms of trauma within individuals. Third, the institution responds to this knowledge by implementing trauma-informed policies, procedures, and practices. Fourth, the institution strives to resist re-traumatization, therefore providing a safe, healing environment for individuals within their church congregation (SAMHSA, 2014).

For churches to be trauma-informed, specific training must be developed (Crosby et al., 2021). Churches need to be equipped with the knowledge of how to recognize and respond to individuals who are traumatized. This training cannot be limited to only church leaders; it should extend to all working roles, such as administration, children's workers, and security, so that the church environment is infused with confident and competent workers who can address an individual experiencing trauma without causing re-traumatization (Crosby et al., 2021). Each worker within the church is commissioned as a representative of the church. Therefore, they are

tasked with the duty to provide a safe environment for traumatized individuals within the church (Streets, 2015).

The Need for Trauma-Informed Approaches in Churches

As churches begin to consider new ways to address individuals with mental health concerns, their practices must be educated and led by research-backed practices. It is essential that introductory training in trauma-informed care precedes implementation within an organization. While some churches are beginning to consider mental health as an essential part of spiritual well-being, many churches have not yet been educated on the need.

Trauma-informed organizational environments significantly improve self-awareness, outlook, coping ability, self-worth, and self-determination (Shier & Turpin, 2022, Sweaney et al., 2018; Unick et al., 2019). Moreover, a significant reduction in concurrent disorder behavior, such as substance abuse and criminal activities, has been reported by Mihelicova et al. (2015) and Shier and Turpin (2022). The overarching goal of becoming a trauma-informed institution lies in taking basic knowledge and putting it into action within the institution's daily culture (DeCandia et al., 2014; SAMHSA, 2014). Utilizing this framework of trauma-informed care, this study aims to evaluate Midwest churches in their trauma-informed practices.

Spirituality is a significant part of many individuals' lives (Palmer et al., 2020). Additionally, research asserts that all individuals are exposed to at least one traumatic experience within their lifetime (López-Zerón & Blow, 2017; U.S. Department of Justice., 2013). Therefore, churches need to have trauma-informed practices in place to best support individuals within the faith community. Streets (2015) describes trauma-informed care within churches as one that actively seeks a basic understanding of trauma and uses that to guide and reflect upon religious

practices. Trauma-informed care within churches should extend to preaching, Bible study, prayer, worship, and all other religious practices.

Key Principles for Implementing Trauma-Informed Practices in Churches

Unick et al. (2019) concluded that for an organization to be trauma-informed, several things must occur first. The organization must demonstrate cultural changes through leadership, policies, practices, and daily interactions. Secondly, survivors need to be involved in the implementation at all levels, ensuring their experiences are heard and accurate ideas of how the support is going are known. Third, the organization needs to remove power differentials. Lastly, ongoing training is necessary and needs to include an experiential aspect to help in the understanding and application of trauma-informed practices. Churches can utilize these principles to begin building a trauma-informed environment.

Another option for churches who wish to implement a trauma-informed approach is the SAMHSA (2014) structure, which includes realizing, recognizing, responding, and resisting re-traumatization. Similarly, Blaustein (2018) identified the ARC approach, which includes attachment, regulation, and competency. Attachment is described as the basic human need for connection. Regulation focuses on the ability to manage experiences emotionally, cognitively, physiologically, and behaviorally. Lastly, Blaustein defines competency in four parts: intrapersonal, interpersonal, cognitive, and regulatory competence. Each of these focuses on different areas of understanding and achievement.

The diverse perspectives of church leaders on mental health and counseling directly influence the responses and actions taken by church leaders. However, due to the significant role of spirituality in people's lives and the prevalence of traumatic experiences, churches must

embrace trauma-informed practices to support their congregants effectively. When considering different trauma-informed approaches, churches begin by acknowledging and comprehending the complex nature and impact of trauma. This study centers on this aspect, emphasizing the importance of church leaders' competence in comprehending trauma.

Attitudes and Perceptions for Implementing Trauma-Informed Care.

The organization's and its leaders' attitudes regarding the implementation can significantly impact the success and sustainability of trauma-informed policies and practices. Therefore, the ARTIC-45 scale was developed to evaluate the attitudes related to trauma-informed care (TIC) (Baker et al., 2016). ARTIC stands for attitudes related to TIC. This is a 45-item scale that has seven subscales: underlying causes of problem behavior and symptoms, responses to problem behavior and symptoms, on-the-job behavior, self-efficacy at work, reactions to the work, personal support of TIC, and system-wide support for TIC. This tool can help evaluate the obstacles that an organization may encounter when trying to implement trauma-informed care. Ideally, after trauma-informed training, the scoring will show more positive attitudes from the leaders.

Additionally, the TICS-10 was developed to identify the staff member's perceptions of the service environment after implementing trauma-informed practices (Hales et al., 2019). TICS refers to The Trauma Informed Climate Scale (TICS). These scales help identify obstacles before implementation and problems occurring in carrying out new trauma-informed practices or sustaining them.

Sexual Trauma and Church Response

When looking at the church's trauma-informed response to mental health and survivors of sexual trauma, it is essential to recognize the complex nature of sexual trauma. Additionally, without understanding the experiences of this population, one cannot fully be equipped to handle the challenges that may arise in counseling. There is a critical intersection of sexual trauma and the response of churches. This complex topic requires a thoughtful exploration of both the nature of sexual trauma and the unique role that churches play in responding to survivors. Within this context, churches have a crucial role to play in providing support, guidance, and healing to survivors of sexual trauma. Judith Herman (2021), a world-renowned trauma researcher, calls for action in her seminal work Trauma and Recovery.

> It is very tempting to take the side of the perpetrator. All the perpetrator asks is that the bystander do nothing. He appeals to the universal desire to see, hear, and speak no evil. The victim, on the contrary, asks the bystander to share the burden of pain. The victim demands action, engagement, and remembering. (p.7-8)

Understanding Sexual Trauma and Its Prevalence

The term "sexual violence" is an all-encompassing, non-legal term that refers to crimes like sexual assault, rape, and sexual abuse (Block & Maxfield, 2019). Additionally, intimate partner violence is often correlated with sexual violence (Merrick et al., 2018). On average, Merrick et al. estimate that there are 356,000 victims of rape and sexual assault each year in the United States. This statistic points to a large population of individuals who are dealing with sexual trauma. Additionally, according to Addington (2022), one in four women and one in nine

men will be raped at some point in their lives. This is a widespread issue that impacts men and women.

Challenges Faced by Survivors of Sexual Trauma

Most survivors experience short-term impacts from the traumatic experience, such as nightmares, hypervigilance, mood changes, and relationship alterations, which can be categorized under Acute Stress Disorder (U.S. Department of Justice, 2013). Additionally, 1 in 3 individuals were injured during the assault, creating long-term or lifelong impacts. This can include long-term alterations in mood, trust issues, inability to move forward, depression, and anxiety. Research has shown that for survivors of sexual trauma, 1 in 7 contracted a sexually transmitted infection, 2 in 3 were concerned for their safety and experienced fear, and 1 in 7 women survivors became pregnant (Merrick et al., 2018). Overall, these impacts have lasting physical and emotional effects on the survivor, who needs excellent care from a trained professional.

A traumatic event that occurs not only affects the current state of an individual but can have long-term effects on them mentally, emotionally, and physically and even cause them to be at more risk of revictimization (Perry & Winfrey, 2021). Perry and Winfrey describe these painful experiences as an ache that grows into a deep longing to feel needed and loved. This desire to be validated will often develop into the individual not setting standards for what they deserve, and in turn, they face self-sabotage, promiscuity, violence, and addiction. Dr. Harris (2018) summed up the impact of trauma by explaining the DNA shift that occurs after trauma.

> Twenty years of medical research has shown that childhood adversity literally gets under our skin, changing people in ways that can endure in their bodies for decades. It can tip a

> child's developmental trajectory and affect physiology. It can trigger chronic inflammation and hormonal changes that can last a lifetime. It can alter the way DNA is read and how cells replicate, and it can dramatically increase the risk for heart disease, stroke, cancer, diabetes—even Alzheimer's. (P. XV)

The Psychological Effects and Stigma of Sexual Trauma

Dr. van der Kolk (2019) intimately describes the bodily experience that many survivors experience after a traumatic event.

> Traumatized people chronically feel unsafe inside their bodies: The past is alive in the form of gnawing interior discomfort. Their bodies are constantly bombarded by visceral warning signs, and in an attempt to control these processes, they often become experts at ignoring their gut feelings and numbing awareness of what is playing out inside. They learn to hide from their selves. (p. 97)

This interior discomfort that is described can cause survivors to experience anxiety, depression, and many other psychological disorders. Van der Kolk continues by saying that being able to feel safe with other people is the key to mental health. It is through safe connections that people can grow, heal, and live meaningful and satisfying lives (van der Kolk, 2019).

Despite sexual trauma being a common occurrence in society, there is still often a stigma and shame connected to those who are victims of sexual trauma. There are many reasons for this. First, in general, sex is seen as a private matter, and therefore, crimes involving it hold extra shame and secrecy (Schmallenger, 2016). Secondly, victim blaming often causes the victim to look worse than the perpetrator. Reasons for victim blaming often are based on what the victim

was wearing, where the victim was, or the intoxication levels of the victim. Lastly, sex crimes are committed based on power and control, leaving the victim feeling powerless and weak (U.S. Department of Justice, 2013). These feelings can last long after the event occurred and even contribute to their decision to report what occurred or not. When a survivor overcomes all these obstacles and discloses their trauma, the community needs to be equipped to respond to them in a way that is helpful to their recovery.

Survivors Experiences with Seeking Help

Once survivors reach out for help, they desire a great deal of support to begin healing. After a crisis, getting the victim the necessary resources, interviews, and information for their healing journey is an excellent place to start. The goal is to give the victim and their family peace, power, hope, and control back in this challenging situation. After one is out of the crisis, counseling benefits both the survivor and the non-perpetrator family members.

While the impacts on survivors of sexual assault can be widespread, research showing the help-seeking behaviors of survivors shows there is also variation in the behaviors of men and women when they are seeking help (Young et al., 2018). When women reached out for help, there was more emphasis on receiving referral resources for further help. Contrarily, men often sought to share their experiences due to a perceived lack of personal support in their lives. Knowing this, the responses and services need to be aware of gender differences.

Qualitative analysis by Ahrens and Aldana (2012) showed that survivors' perceptions of the reactions they receive after disclosing sexual trauma directly impact the relationship. Similarly, Brenner and Ben-Amitay (2015) conducted a multifaceted study that examined the response to sexual abuse disclosure and found that revictimization rates in adulthood were

correlated with negative responses from earlier disclosures. In fact, revictimization rates were higher when women received negative responses to their disclosure than those who did not disclose their experience at all (Brenner & Ben-Amitay, 2015). Overall, the research points to a need for knowledge that leads to the prevention of revictimization during the disclosure process (Ahrens & Aldana, 2012; Brenner & Ben-Amitay, 2015; SAMHSA, 2014).

Impact of Institutional Response to Sexual Trauma

Social institutions need to be cognizant of their responses to sexual trauma disclosures. Women who reported institutional betrayal surrounding their unwanted sexual experience reported increased levels of anxiety (Smith & Freyd, 2013). Additionally, they reported increased trauma-specific sexual symptoms, dissociation, and problematic sexual functioning. Institutional betrayal can occur when a survivor does not receive the desired response to a trauma disclosure. Survivors desire a culture of caring, a one-stop-shop for receiving care, validation, control, agency within the service, and confidentiality (Munro-Kramer et al., 2017; Ranjbar & Speer, 2013). This helps break down the shame that many survivors feel.

Additionally, the participants stated that they wanted to feel free from guilt, shame, fear, and other negative emotions. 94% of women who experience sexual trauma have post-traumatic stress disorder symptoms following rape (U.S. Department of Justice, 2013). These findings were reiterated by Powell and Cauchi (2013), who found that when survivors were heard and taken seriously, they were more likely to speak up about the case. Therefore, the simple act of being heard and seen when disclosing sexual trauma can profoundly impact one's mental health and recovery.

When researching the trauma-informed practices and approaches of institutions, one must consider the experiences survivors of sexual trauma endure. When individuals decide to disclose their traumatic experience, a great deal of shame and fear is involved. Mahon (2022) suggested that trauma-informed practices are beginning to be implemented within human services at the state and city levels. These implementations can help lessen the shame and fear that survivors feel about approaching institutions for help.

The Need for Trauma-Informed Institutions.

Overall, sexual trauma is a widespread societal concern that has lasting impacts on individuals, families, and churches. Consequently, our society needs to move towards trauma-informed institutions to provide safety to victims and prevent re-victimization. Dr. van der Kolk (2019) stresses the profound effects of trauma on the whole person and their livelihood.

> We have learned that trauma is not just an event that occurred sometime in the past; it is also the imprint left by that experience on the mind, brain, and body. This imprint has ongoing consequences for how the human organism manages to survive in the present. Trauma results in a fundamental reorganization of the way the mind and brain manage perceptions. It changes not only how we think and what we think about but also our very capacity to think. (p. 8)

Trauma-Informed Response to Sexual Trauma

As society begins to evaluate how to best respond to survivors of sexual trauma, systems and standards are being built. Sexual assault response teams (SARTS) provide services to survivors and connected care (Cole, 2018). SARTS are a community-level intervention to help survivors and their families navigate the criminal justice system. For years, survivors struggled

to gain advocacy within the legal system, which left them lost and hurt. With the implementation of SARTS, more communities are finding a more collaborative approach between survivors and resources within the community. Twenty-nine percent of SARTS are located in the Midwest (Greeson & Campbell, 2015). This is just one system that has been developed to better the care for survivors of sexual trauma. Although SARTS has had success within the legal system, there is still a need for trauma-informed systems within other institutions.

Trauma-informed care and Practice (TICP) is a response model for sexual trauma survivors that integrates multiple evidence-based theories to serve survivors best. TICP contains many strengths-based principles and considers the impact of trauma on the survivor as foundational to the approach. It outlines how to respond to survivors in a way that encourages physical, psychological, and emotional safety (Berger & Quiros, 2014; BlueKnot Foundation, 2019; SAMHSA, 2014). This approach is centered around several core principles, each essential in providing comprehensive support to survivors. Safety is paramount, ensuring both physical and emotional safety for survivors. Trust is fostered and maintained as a foundation for healing. Respecting survivors' choices is emphasized, giving them control over their recovery. Collaboration, empowerment, and the nurturing of healing relationships play pivotal roles in the process. TICP promotes cultural sensitivity, recognizing diversity, and the need for knowledge about trauma's impact. Additionally, the model underscores the importance of staff well-being and self-care. Overall, these principles are at the forefront of how one should address sexual trauma and are common themes throughout the research.

Additionally, Dr. Herman (2022) shares how the power of a group is essential in the healing of sexual trauma. It is only through connection that one can begin to accept their story and put the pieces of their life together. Herman shares the contrast that trauma is degrading

while the group exalts the victim. Additionally, trauma is dehumanizing while the group restores the victim. Due to the complex nature of trauma, evidence-based clinical treatment is also highly suggested for those recovering, such as Contextual Therapy, Cognitive Behavioral Therapy (CBT), Contextual Behavior Trauma Therapy (CBTT), Emotion-Focused Therapy (EFT), or Sensorimotor Therapy (Holowka & Marx, 2010).

Church Leaders' Roles and Experiences in Responding to Sexual Trauma

Spirituality and mental health are tethered together in a profound way. Survivors of sexual trauma report a wavering relationship with God, emotional distance from the congregation, and feeling betrayed and abandoned by God (Rudolfsson & Tidefors, 2014). Additionally, survivors struggle to bring up the topic to church leaders, experiencing that their feelings and needs were not recognized (Rudolfsson & Tidefors, 2015). The survivors expressed a need for an open space to express spiritual doubts and emotions without being rushed toward forgiveness. Lastly, they desire their church leaders to acknowledge when they have reached their limits and refer them to an expert when necessary (Fortune, 2002; Rudolfsson & Tidefors, 2015). While the church may be in the early stages of acknowledging the tie between mental health and spirituality, the research is showing a connection that is undeniable.

While it is crucial for church leaders to provide trauma-informed care to their congregants, it is also important that their own experiences be heard and acknowledged. A major challenge for church leaders in helping survivors was seeing survivors blame themselves for the violence and choose to stay in violent situations (Zust et al., 2017). Church leaders overwhelmingly expressed sadness for the survivors, wanted them to leave violent situations, and felt that they were not experts in being able to help the survivors (Zust et al., 2017). Additionally,

an emphasis on ethical standards when helping congregants needs to be incorporated into clinical pastoral education (Fleenor et al., 2022). Without a clear standard, church leaders are left feeling unequipped to handle trauma within their church despite it being a common thing they encounter.

Despite there being a clear need for churches to be prepared to respond to sexual trauma, the well-being of church leaders needs to be considered as well. In a study regarding the secondary traumatization of church leaders (Hendron et al., 2012), the results of a Burnout Inventory were similar to those reported by counselors and other mental health professionals. Additionally, 57% of church leaders scored in the moderate to high range for emotional exhaustion.

The stress from addressing trauma can result in physical, cognitive, and behavioral effects on the church member and the people the pastor relies on for support, such as family members and friends (Hendron et al., 2014). Findings indicate that this is a challenging aspect of the ministry and one that can result in physical, cognitive, and behavioral effects not only on those who provide the initial support but also, in turn, upon their informal support networks. Additionally, church leaders expressed insecurity and a perceived lack of psychological competencies as a significant setback in them providing trauma-informed care to their congregants despite their desire to best serve them (Rudolfsson & Tidefors, 2013). As church leaders become more knowledgeable about trauma, they also need to be aware of self-care practices and how to stay healthy in order to provide for their congregants.

Frequency Of Church Leaders Addressing Trauma

In a study by Rudolfsson et al. (2012), church leaders were surveyed about the prevalence of sexual trauma in their congregations. Results found that women leaders reported higher estimates than men. Additionally, women church leaders were more prepared to address it within their congregations. Further research by Rhee et al. (2003) found that fifty percent of participants in their study have seen child abuse and neglect among their church members. However, most who have witnessed child abuse prefer to provide pastoral counseling to the abused family instead of reporting the case to a child protective agency. In a domestic violence study of church leaders' response by Houston-Kolnik et al. (2019), results showed that some participants only felt comfortable intervening when violence became physical (Houston-Kolnik et al., 2019). This reflection on how child abuse and domestic violence, which have been more heavily researched, are handled in the church, points to the response given to survivors of sexual trauma. Additionally, it emphasizes the need to explore how church leaders grapple with these issues, especially within the context of the prevalence of sexual trauma.

Due to the incidence of sexual trauma being higher for women than men, women who are church leaders experience sexual trauma disclosures differently than men. In a phenomenological study aimed at describing the experiences of female church leaders who provide counseling to survivors of sexual trauma, it was found that the church leaders tended to become more emotionally involved (Van Wyk, 2018). Moreover, their status as females made them more approachable to survivors. The experiences of church leaders differ based on their backgrounds, gender, age, belief systems, and race. Therefore, it is crucial that any study regarding the experiences of church leaders considers these factors throughout the study.

Intimate partner violence is a phenomenon within the area of sexual trauma that has been heavily researched. In a study by Tedder and Smith (2018), results found a need for clergy to receive training in the area of intimate partner violence. None of the clergy in this study acknowledged previous extensive training in intimate partner violence, and all of the participants indicated a desire to develop such competency. Nevertheless, it is common for church leaders to provide counseling for individuals and families struggling with this. In their study, Rudolfsson and Tidefors (2009) found that 77% of church leaders had met with victims of sexual abuse. Similarly, Kassas et al. (2022) conducted research on how often clergy respond to domestic violence and other mental health concerns within their communities. All of their participants stated they were involved in counseling within their community. This is a reflection of how involved church leaders find themselves in counseling-type activities.

Overall, being an institution that is aware of the impact of trauma and has a system that is trauma-informed is critical in serving those who have survived sexual trauma. This can only come through adequate training and policies that are system-specific and sustainable for the given institution (Guevara et al., 2021). Nevertheless, the research regarding how this looks for churches is slim, making it difficult to create sustainable trauma-informed practices.

The Confidence and Competence of Church Leaders Responding to Sexual Trauma

As more and more systems are being developed or updated to better support survivors of sexual trauma, the spotlight is turning toward churches and religious institutions. Most accredited theological seminaries in the USA have not adequately prepared church leaders to respond (Houston-Kolnik & Todd, 2016). Additionally, religious leaders acknowledged their need for greater training and connections to service providers (Houston-Kolnik & Todd, 2016). Regarding

abuse, 53% of church leaders felt at least somewhat prepared to have those conversations (Hill & Yancey, 2022).

There has been substantial research showing where church leaders respond with minimization, blaming, and shaming (Rhee et al., 2003; Rudolfsson et al., 2012; Rudolfsson & Tidefors, 2014; Rudolfsson & Tidefors, 2015; Smietana, 2014; Streets, 2015; Zust et al., 2021). Consequently, this highlights that individuals recovering from a traumatic experience turn to the church for comfort but wind up feeling deeply disappointed by the response of the church. The church's response can impact an individual's spiritual beliefs and their ability to process the traumatic experience (SAMHSA, 2014; Streets, 2015).

Research regarding trauma response within the church points to a lack of knowledge and education regarding realizing, recognizing, responding, and resisting revictimization (Lasair, 2020; Rudolfsson & Tidefors, 2013; Streets, 2015). Despite this lack of training, church leaders strongly agreed that local churches are responsible for providing resources and support to individuals with mental illness (Iheanacho et al., 2021; Smietana, 2014). Matthew 11:28 (*New International Bible, 1978/2011*) encourages the broken and weary to find rest in Christ. Therefore, as churches proclaim this, they are held to a higher standard of effectively addressing those with trauma who come to their church for comfort. In 2020, Lasair evaluated the purpose of spiritual counseling and the need to equip church leaders with clinical knowledge. Throughout this research, results showed that trauma-informed guidance for church leaders needs to be led by trained clinicians. SAMHSA (2014) also emphasizes the need for collaboration between mental health services and churches to provide trauma-informed care. Recent research showed that church members desire their church leaders to be more educated in mental health topics and demonstrate that when preaching (Zust et al., 2021). This chapter underscores the pressing need

for church leaders to be confident and competent in addressing sexual trauma, yet research is yet to be done in this area.

Summary

The study highlights the critical need to address sexual trauma within church communities, mainly focusing on the scarcity of research on church leaders' confidence and competence in supporting survivors of sexual trauma. The exploration of church leaders' diverse roles in addressing sexual trauma, along with their experiences in navigating the internal challenges they encounter while supporting survivors, has shown signs of role strain.

Additionally, one can draw upon the research and see that churches play a pivotal role in the care and well-being of survivors of sexual trauma. Nevertheless, the complexity of addressing sexual trauma requires trauma-informed knowledge and guidance alongside adequate training. Lack of such may lead church leaders to feel unequipped and lack confidence in their abilities to provide services to this population. Still, the research points to churches playing a vital role in the service gap for survivors of sexual trauma, predominantly minority populations (Hall & Gjesfjeld, 2013; Iheanacho et al., 2021; Sualp et al., 2021). Further research must be conducted in order to have a clear understanding of the response that church leaders provide when addressing survivors of sexual trauma.

Therefore, in this study, confidence was evaluated to gain deeper insight into the unique experiences of church leaders as they face the role strain and increasing pressures of addressing mental health concerns. Additionally, the competence of church leaders in providing trauma-informed care to congregants was evaluated. Without both confidence and competence, church leaders will not be able to handle the new demands placed upon them adequately. Therefore,

knowing where church leaders stand now can help inform one on how to best support churches and, as a result, serve survivors.

Chapter 3: Methods

The competence and confidence of church leaders is an area of research that still needed to be studied. Additionally, these variables need to be considered within a multicultural perspective. Building upon the foundation built in Chapter 2, this chapter will lay out the methods used to learn more about the confidence and competence of church leaders in addressing sexual trauma. This research adopts a quantitative framework to thoroughly evaluate the interconnectedness of confidence and competence in the context of church leaders addressing sexual trauma in their congregants. Additionally, this chapter provides a guide for how the research process was carried out and how data was analyzed. Overall, this chapter will focus on the current study's design, the research questions and hypotheses, the specific requirements for participation in the study, and the data collection and analysis procedure.

Design

This study uses a survey research design to gather data and insights regarding the current state of Midwest church leaders. This quantitative research study was correlational in nature, aiming to provide an in-depth understanding of specific aspects related to Midwest church leaders and their levels of confidence in addressing sexual trauma. Additionally, the research utilized a well-established trauma-informed quiz (TICQ) as a measurement tool to assess the competence of this particular population (Kenny et al., 2017).

The primary focus of this research is to examine the demographic characteristics of Midwest church leaders and their responses to assessments measuring confidence and competence in addressing sexual trauma within their congregations. Through the systematic collection and analysis of data, the study presented an overview and utilized regression analysis to evaluate the connections between the variables being examined (Creswell & Creswell, 2017).

This allowed for an exploration of how confidence and competence levels in handling sexual trauma may be linked within this specific context. Furthermore, a regression analysis was utilized to examine demographic variables, which are an integral part of this study, providing valuable insights into the influence of various demographic factors, including age, gender, race, denomination, and years of ministry experience, on the church leaders' confidence and competence. This comprehensive approach contributes to a deeper understanding of the research topic (Weathington et al., 2017).

Employing a quantitative research design in this study allows for valuable insights into the complex dynamics of trauma response within the church environment (Weathington et al., 2017). While existing research has delved into the subjective experiences of church leaders involved in assisting trauma survivors, a notable gap exists regarding objective data in this domain (Kassas et al., 2022; Van Wyk, 2018; Zust et al., 2017). By quantifying church leaders' confidence and competence levels, this research contributes to a foundation of empirical data that can significantly benefit future studies. Additionally, this data can enhance church readiness and implementation of trauma-informed practices within the church. This quantitative approach allows for a more in-depth examination of the interrelationship between confidence and competence, allowing for an exploration of how these factors may interact and influence one another. Additionally, a quantitative design allows for a multicultural perspective where variations across diverse demographics are acknowledged. Overall, this design method allows for a clearer understanding of the research topic and the diverse population.

Research Questions

RQ1: What is the relationship between the competence level of Midwest church leaders, as measured by the *Trauma-Informed Care Questionnaire* (TICQ), and their confidence in

addressing sexual trauma, as measured by the *Readiness to Work with Trauma-Exposed Patients* (RTEPS)?

RQ2: To what extent do the demographic factors of race, age, gender, denomination, and years of ministry experience impact the confidence or competence levels of Midwest church leaders in addressing sexual trauma?

Hypotheses

For RQ1 (Relationship between Competency Level and Confidence):

Null Hypothesis (H0): There is no significant relationship between the competency level of Midwest church leaders, as measured by the *Trauma-Informed Care Questionnaire* (TICQ), and their confidence in addressing sexual trauma, as measured by the *Readiness to Work with Trauma-Exposed Patients Survey* (RTEPS).

Alternative Hypothesis (H1): As measured by the Trauma-Informed Care Questionnaire (TICQ), church leaders competency will be related to their confidence, as measured by the *Readiness to Work with Trauma-Exposed Patients Survey* (RTEPS).

For RQ2 (Impact of Demographic Factors):

Null Hypothesis 1 (H0): Race does not significantly impact the confidence (a) and competence (b) levels of Midwest church leaders in addressing sexual trauma.

Alternative Hypothesis 1 (H1): Race significantly impacts confidence (a) and competence (b).

Null Hypothesis 2 (H0): Age does not significantly impact the confidence (a) and competence (b) levels of Midwest church leaders in addressing sexual trauma.

Alternative Hypothesis 2 (H1): Age significantly impacts confidence (a) and competence (b).

Null Hypothesis 3 (H0): Gender does not significantly impact the confidence (a) and competence (b) levels of Midwest church leaders in addressing sexual trauma.

Alternative Hypothesis 3 (H1): Gender significantly impacts confidence (a) and competence (b).

Null Hypothesis 4 (H0): Denomination does not significantly impact the confidence (a) and competence (b) levels of Midwest church leaders in addressing sexual trauma.

Alternative Hypothesis 4 (H1): Denomination significantly impacts confidence (a) and competence (b).

Null Hypothesis 5 (H0): Previous trauma training does not significantly impact the confidence (a) and competence (b) levels of Midwest church leaders in addressing sexual trauma.

Alternative Hypothesis 5 (H1): Previous trauma training significantly impacts confidence (a) and competence (b).

Null Hypothesis 6 (H0): One's years of ministry leadership experience does not significantly impact the confidence (a) and competence (b) levels of Midwest church leaders in addressing sexual trauma.

Alternative Hypothesis 6 (H1): One's years of ministry leadership experience significantly impacts confidence (a) and competence (b).

Participants and Setting

Understanding the characteristics and backgrounds of the individuals participating in the study is essential to maintaining the integrity of the study. For this study, purposive sampling was utilized to select participants who meet specific criteria relevant to the current research study.

Inclusion Criteria

1) **Church Leadership Roles:** To be eligible for participation in this study, individuals must meet the criteria for church leaders defined explicitly in this research. This group comprises individuals holding top positions of authority within their department in the church, receiving compensation from the church, and having primary responsibility for providing spiritual guidance to members of their congregations.
2) **Geographic Location:** The study focused on churches in the United States' Midwest region. This study utilized the U.S. Census definition of the Midwest (Miles, n.d.). Therefore, The Midwest region includes the East North Central division: Illinois, Indiana, Michigan, Ohio, and Wisconsin; and the West North Central division: Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota (Mills, n.d.).
3) **Active Service:** To capture participants' current experiences and perspectives effectively, eligible participants must be actively serving in their leadership roles at the time of the study. This criterion ensures that the data collected reflects church leaders' current experiences and challenges.
4) **Experience with Trauma Cases:** Eligible participants should have experience working with at least one congregant who has encountered trauma. This criterion ensures that participants have exposure to the topic aligned with the current research focus.

Exclusion Criteria

1) **Exclusion of Non-Leadership Roles:** Paid positions within the church, including janitors and secretaries, who do not hold roles as spiritual mentors, were explicitly excluded from participation in this study.
2) **Exclusion of Unpaid Roles:** Church leaders who are not compensated or serve in a voluntary capacity were excluded from participation in this study.

Sample

For this study, the sample consisted of 213 participants. According to Faul et al. (2007), 213 participants is the required minimum for a medium effect size with statistical power of .8 at the .05 alpha. This sample was acquired throughout the Midwest region through Facebook solicitations, direct invites to church leaders listed in the Gospel Coalition Directory, and a formal advertisement to the small-town pastors meeting. These methods are designed to reach a wide range of demographics for the sample. The snowball sampling method was adopted for participant recruitment in this study. This non-probability sampling approach is deemed suitable for accessing specific, hard-to-reach populations such as church leaders. It involves selecting initial participants, who then refer the researcher to other potential participants within their network (Creswell & Creswell, 2017). The sample included 127 males and 86 females. The majority of participants were White (84.50%), followed by Black (14.10%) and Asian (1.40%). Participants represented various denominations, and their ages ranged from 21 to 81 years. Years of ministry experience ranged from 1 to 56 years, and the church leaders reported trauma training hours ranged from 0 to 340 hours.

Setting

This study utilized Google Forms for data collection. Utilizing an online setting allows for efficiency in data collection, accessibility to diverse populations, and the ability to maintain participant anonymity. A multi-faceted approach to survey distribution was employed to reach potential participants who meet the study's inclusion criteria.

1) The Small-Town Pastors Meeting was contacted to distribute the survey. This allowed for a direct connection with the target population.
2) Online advertisement was utilized, which included Facebook. Specifically, Facebook groups that target Church leaders were contacted. This includes Women in Youth Ministry, Download Youth Ministry, Pastors Helping Pastors, Worship Pastors Cohort, Children's Pastors and Children's Ministries Leaders, Ask The Pastors of Facebook, and Small Town Pastors. This method was used in order to allow for convenient access to the survey and a sense of safety in answering honestly.
3) Direct email invitations were sent to church leaders identified by The Gospel Coalition directory as serving in a Midwest Church.

Instrumentation

This research study includes a demographics questionnaire, a self-assessment of trauma confidence, and a competency test. Each of these measures were administered online and entirely anonymously.

Demographic Questionnaire

Participant information, including age, gender, cultural background, job title, marital status, educational background, length of time in their current church leadership role, number of

trauma survivors they have worked with, type of church denomination or affiliation, congregation size, and geographic location, was included in the demographic survey. Additionally, this questionnaire asked about education level, trauma training, and other certifications they may hold to supplement the individual's history of working with trauma collected by the competency measure. Lastly, the questionnaire asked about their experience working with individuals with trauma within their congregation. Individuals who have not worked with any congregants with trauma were not included in the study due to their inability to answer many of the necessary questions. Additionally, participants must be actively serving in head leadership at their church, and the church must be located in the Midwest. The Demographic Questionnaire can be found in Appendix A.

Trauma Confidence Survey

In this study, participants completed a 10-item measure of confidence regarding working with clients who have trauma called *The Readiness to Work with Trauma-Exposed Patients* (RTEPS) (Kazlauskas et al., 2022). This is a simple self-report scale used to evaluate the individuals' perceived readiness to work with trauma clients. This measurement can serve as an indicator of how self-confident an individual is in trauma-informed care. Additionally, this evaluates their willingness to recognize and address trauma in their practice. The complete list of items included in this measurement is included in Appendix A.

Three Ph.D.-level mental health professionals with extensive experience in trauma-informed treatment, research, and clinical practice created the RTEPS items (Kazlauskas et al., 2022). Following the development of the initial list of items during the expert discussions, items from all three domains were chosen and revised. Furthermore, RTEPS items were finalized

following input and discussion with several clinicians who commented on the RTEPS items. The final RTEPS scale had ten items in three domains as a result of the development process: assessment (three items), treatment (three items), and affect tolerance (four items) (Kazlauskas et al., 2022). This allowed the researcher to identify how the individual personally evaluates their skills.

Additionally, the affect management section identifies how the experience impacts them (Kazlauskas et al., 2022). Each item is rated on a 5-point scale (0 = completely disagree; 1 = disagree, 2 = neither agree nor disagree, 3 = agree, 4 = completely agree). Kazlauskas et al. reports that the RTEPS scale's final score is the sum of all items ranging from 0 to 40. A higher scale score indicates a greater perceived readiness to work with trauma-exposed patients.

Kazlauskas et al. (2022) evaluated the validity of the RTEPS scale. This study performed several statistical procedures. First, evidence of validity based on the internal structure was gathered through exploratory structural equation modeling (ESEM) of the RTEPS with the robust maximum likelihood estimator and geomin rotation. This study tested single-factor, two-factor, three-factor, and four-factor models to identify the best factor structure of the RTEPS. In addition, they performed a two-way analysis of covariance (ANCOVA) with two covariates to collect evidence of validity based on relationships to other variables. A two-way ANCOVA was used to test the interaction effect of two independent variables on a continuous dependent variable by controlling for one or more continuous covariates. The overall scale had good internal consistency as measured by Cronbach's alpha (.80), and the assessment, treatment, and affect tolerance subscales had alphas of .67, .79, and .75, respectively.

Research regarding this instrument found that the average score of the total RTEPS scale was 21.21 (SD = 4.70), ranging from 2 to 33 (Kazlauskas et al., 2022). Therefore, for this study,

a score of 16.51 to 25.91 was considered moderate confidence. Any score resulting lower than 16.51 was categorized as low confidence, and any score above 25.91 was considered high confidence. Participants were categorized based on this score for statistical analysis purposes.

Trauma Competency Quiz

The next step in this study is evaluating how the individual typically responds to trauma within their clients. The goal of this is to evaluate their trauma-informed care to see if their actions match trauma-informed competencies. For this study, the TICQ was utilized to measure trauma competency. The TICQ was developed to help measure the trauma-informed understanding that staff members possess. This instrument was created by an expert in child welfare and evaluated by other experts with both research and clinical experience (Kenny et al., 2017). The TICQ was originally developed due to there being no existing measure for the construct of trauma-informed competency. This questionnaire contains 18 items and is in a multiple-choice format. Test-retest reliability was found to be 0.71 (N = 59). Items include: "What are some Essential Elements of trauma-informed care?" and "What are some ways helping professionals can address the impact of trauma?". Additionally, Kenny et al. reports that this questionnaire is designed with experience information on participants, such as their position, years of experience, and prior training. Participants can score between 0 and 18. The TICQ has a mean of 10.81 and a standard deviation of 2.17. For this study, alterations to this instrument were made to exclude the Child Advocacy Center, which was the original setting of the study. Additionally, collaboration with the original author permitted wording changes to the study. The Original format is provided in Appendix B. The TICQ Measure utilized can be found in

Appendix A, which only includes Part 2 of the instrument. The permission to utilize this tool and uphold the alterations is in Appendix C.

Data from the TICQ was analyzed using T-tests to analyze the increase of competency after training to ensure the validity of the test and one-way analysis of variance (ANOVAs) were used to consider the demographic characteristics (Kenny et al., 2017). The founding study for TICQ found that White/ Caucasian participants had higher pretest scores than Black and Hispanic, and participants with bachelor's and graduate degrees had higher scores than those with only high school diplomas. Additionally, Kenny et al. reports that those with 10-20 years or more than 20 years of work experience had significantly lower scores than other participant groups. While the research on trauma-informed competency is limited, the TICQ can be utilized to gain baseline data on one's trauma-informed competency (Kenny et al., 2017).

Procedures

The study began with submitting a research proposal to the Institutional Review Board (IRB) for ethical approval (Appendix F). Following the IRB's approval, the research proceeded with participant recruitment. Participants were recruited through announcements to the Small-Town Pastor Meeting, Facebook Group Solicitations, and sending direct email invites to church leaders listed in The Gospel Coalition directory (Appendix E). Church leaders received detailed information about the research's purpose and informed consent for the study (Appendix D). Participants were provided with a link to access and complete the survey.

To ensure a representative sample, announcements about the anonymous survey were disseminated through the channels outlined above. Although no formal controls were implemented to prevent participant collaboration during survey completion, data integrity was maintained through rigorous statistical analyses.

The survey was offered through online methods to reach a diverse population. A Google form was used to collect the three measures in this study. This is designed to streamline the data collection process. It was structured into three distinct sections, each corresponding to one of the three measures utilized in this study.

When participants accessed the survey, they were given the informed consent form outlining the study's purpose and procedures. They then proceeded to the survey sections once they had reviewed and agreed to participate. The first section focuses on gathering demographic information about the participants. Importantly, if a participant's demographic profile does not align with the study's criteria, the form was automatically submitted after this section, excluding them from further participation and data analysis.

The second section of the survey contained the RTEPS, which assesses participants' self-reported confidence levels in addressing sexual trauma. The responses from this section were scored to categorize participants into one of three confidence levels: low, moderate, or high. This categorization was crucial for subsequent data analysis.

The final section presented participants with the TICQ, a tool designed to measure their competence in addressing sexual trauma. This section was scored automatically by the Google Form platform, and a total number was provided for analysis.

Upon completing all survey sections, participants' responses were securely entered into SPSS, which was specifically established for data analysis purposes. Using an online data collection platform, the survey was kept anonymous, and the participants' identities were never collected. This structured survey process ensures efficient data collection and a clear connection to the data analysis.

Variables

This research aims to examine how variations in competence level influence or impact the confidence of Midwest church leaders in addressing sexual trauma.

Independent Variables

1) **Demographic Variables**

a. **Race:** Race is a categorical independent variable representing the racial background of the church leader. Numerical values are assigned to different racial categories (e.g., 1 for White, 2 for Black, 3 for Hispanic, etc.).

b. **Gender:** Gender is a binary independent variable indicating the gender of the church leader (e.g., 0 for Male, 1 for Female).

c. **Age:** Age is a continuous independent variable representing the age of the church leader.

d. **Denomination:** Denomination is a categorical independent variable denoting the church denomination or affiliation of the leader. Numerical values are assigned to different denominational categories (e.g., 1 for Baptist, 2 for Methodist, 3 for Presbyterian, etc.).

e. **Years of Ministry Experience**: Years of Ministry Experience is a continuous independent variable representing the number of years the church leader has been engaged in ministry roles.

f. **Hours of Training/Education:** The number of hours in a continuous variable represents the number of hours that church leaders have regarding trauma.

Dependent Variables

1) **Church Leader's Confidence in Addressing Sexual Trauma**: This dependent variable assesses the church leader's self-reported confidence level in addressing sexual trauma within the congregation. It is measured using the *Readiness to Work with Trauma-Exposed Patients Survey* (RTEPS).

2) **Church Leader's Competence in Addressing Sexual Trauma:** This dependent variable evaluates the church leader's competence in addressing sexual trauma among congregation members. It is measured using the *Trauma-Informed Competence Questionnaire* (TICQ).

Data Analysis

An ordinal logistic regression was used to analyze the data for this research study. Ordinal logistic regression allows one to assess how changes in the continuous variable (competence level) are associated with changes in the ordinal variable (confidence level) while considering the ordinal nature of the dependent variable. Utilizing this statistical analysis allowed the researcher to determine whether there is a statistically significant relationship between competence level and confidence level, assess the direction and strength of the relationship, and obtain odds ratios that quantify how much the odds of being in a higher category of the ordinal variable change for a one-unit change in the continuous independent variable. The ordinal logistic regression has the following assumptions, as Warner (2021) outlined.

1) Proportional Odds Assumption: In ordinal logistic regression, one is interested in modeling the odds of an observation falling into or above a particular category of the

ordinal dependent variable. The model examines how the independent variables influence these cumulative odds. Therefore, the impact of the independent variables on moving up one category versus staying in the current category should be the same, regardless of where you are on the ordinal scale.

2) Independence of Observations: This assumes that the observations are independent of each other. For this study, the independent competence variable does not influence the score received to measure confidence.

3) Linearity of the Log-Odds: This assumption is checked utilizing the Box-Tidwell procedure to determine if the relationship between the independent variables and the natural logarithm of the odds of being in a higher category is linear.

4) No Perfect Multicollinearity: Perfect multicollinearity occurs when one independent variable can be precisely predicted from another, making it impossible to estimate the unique contribution of each variable.

5) No Endogeneity: This assumes that the error term does not influence the independent variables in the model.

6) Sample Size: A large sample size is essential to ensure the reliability of the estimates. This study calculated a sample size of N=213 using G*Power software.

7) Ordinality of the Dependent Variable: The dependent variable in this study is an ordinal variable with three meaningful categories: low, moderate, and high confidence.

When analyzing data with a statistical analysis method, it is essential to ensure that the assumptions are met. If the assumptions are unmet, the researcher can consider using multinomial logistic regression, multivariate analysis of variance, or nonparametric tests.

In addition to the planned ordinal logistic regression analysis to explore the relationship between competence and confidence levels among Midwest church leaders in addressing sexual trauma, supplementary statistical analyses were employed to delve deeper into the influence of demographic factors on these levels. The study encompassed a multivariant analysis of covariance (MANCOVA) to investigate potential variations in confidence and competence scores across distinct demographic groups. This comprehensive statistical approach allowed for the assessment of disparities in preparedness to address sexual trauma among church leaders, considering factors such as age, gender, race, years of ministry experience, and denomination. Through the MANCOVA, the study aims to uncover any statistically significant differences in confidence and competence levels, providing a more nuanced understanding of how these demographic variables potentially impact the church leaders' readiness to support survivors of sexual trauma.

Type 1 and 2 errors are controlled by the significance level (α). As part of this analysis, the researcher uses $\alpha = 0.05$. The sample size was determined using the significance level of $\alpha = 0.05$, a desired statistical power of 80% or higher, considering three categories in the ordinal variable and understanding the population's practical constraints. To calculate the sample size required to achieve the desired power level, G*Power, a widely used statistical software, was employed (Faul et al., 2007). The input for this was based on the significance level of $\alpha = 0.05$, a desired statistical power of 80%, and consideration of the variables. G*Power determined the necessary sample size (N) needed to achieve statistical significance. According to the calculations, it was determined that a sample size of 213 participants was required to achieve a statistical power of approximately 80% (Faul et al., 2007).

Internal and external validity are a vital part of research. Internal validity regards the accuracy of the inferences made within the study. External validity considers the extent to which the findings can be generalized beyond the given context. The data collection procedures and data analysis methods laid out are set to ensure the internal validity of these findings. Additionally, the population and context limit the external validity of church leaders in the Midwest. Nevertheless, this study lays the groundwork for further research to be conducted with other populations.

Overall, this study aims to develop solid quantitative research regarding the competence and confidence of church leaders in the Midwest. This study investigated the relationship using sampling procedures and ordinal logistic regression. Additionally, the final MANCOVA analysis determined any patterns based on the gender, age, race, and denomination of the participants. Overall, the methods of this study are detailed to help guide this study and future research in this field.

Chapter 4: Findings

This study focuses on the competence and confidence of church leaders in addressing sexual trauma. The research seeks to answer the question of what is the relationship between the competence level of Midwest church leaders, as measured by the *Trauma-Informed Care Questionnaire* (TICQ) developed by Kenny et al. (2017), and their confidence in addressing sexual trauma, as measured by the *Readiness to Work with Trauma-Exposed Patients* (RTEPS) developed by Kazlauskas et al. (2022). Additionally, to what extent do the demographic factors of race, age, gender, denomination, and years of ministry experience impact the confidence or competence levels of Midwest church leaders in addressing sexual trauma? In this chapter, the research utilized a multiple regression analysis and Pearson correlation coefficient to analyze the research questions. The following sections describe the outcomes derived from these data analyses.

Data Screening

Data was imported from Google Forms into the Statistical Package of the Social Sciences (SPSS) to create an electronic data set. Before testing the assumptions, the researcher sorted the data, and all categorical variables were coded for use in SPSS. The data was inspected visually for inconsistencies in each variable by proofreading survey questions completed by participants. No data errors or inconsistencies were identified. A priori power analysis was conducted using G*Power software to determine the minimum sample size required to achieve a desired statistical power of 80% (Faul et al., 2007). The analysis was based on a significance level of $\alpha = 0.05$ and considered the specific variables of interest in the study. Based on these parameters, GPower determined that a sample size of 213 participants was necessary to achieve the desired level of statistical power. Of the original 254 potential participants, 213 fit the inclusion criteria

and were included in the SPSS analysis. Incomplete surveys and surveys with inconsistent screening questions were removed from analysis before any screenings, reducing cases from 254 to 213.

Descriptive Statistics

The sample included 127 males (59.60%) and 86 females (40.40%). Most participants were White (84.50%), followed by Black (14.10%) and Asian (1.40%). When looking at the variable of denomination, the study included the following denomination representation: Baptist (N=100), Assembly of God (N=3), Catholic (N=2), Christian Church (N=13), Episcopal (N=5), Evangelical Free (N=4), Methodist (N=18), Non-Denominational (N=36), Pentecostal (N=4), Presbyterian (N=26). Two respondents did not include their denomination (Table 1). The age of participants ranged from 21 to 81, with a mean of 45.52 (SD = 14.26). The years of ministry experience ranged from 1 to 56, with a mean of 18.57 (SD = 12.62). The hours of training ranged from 0 to 340, with a mean of 22.98 (SD = 47.83) (Table 2).

Table 1
Sociodemographic Characteristics of Participants

Characteristic	*n*	%
Gender		
Male	127	59.60
Female	86	40.40
Race		
White	180	84.50
Black	30	14.10
Asian	3	1.40
Denomination		
Assembly of God	3	1.40
Baptist	100	47.40
Catholic	2	.90
Christian Church	13	6.20
Episcopal	5	2.40
Evangelical Free Church	4	1.90
Methodist	18	8.50
Non-Denominational	36	17.10
Pentecostal	4	1.90
Presbyterian	26	12.30

Note. $N = 213$ (for denomination $N = 211$).

Table 2
Means and Standard Deviations for Study Variables

Characteristic	*n*	*M*	*SD*
Age	212	45.52	14.26
Years of Ministry experience	211	18.57	12.62
Hours of training	213	22.98	47.83

The church leader's competence in addressing sexual trauma ranged from 5 to 13, with a mean of 9.63 (SD = 1.49). The church leader's confidence in addressing sexual trauma ranged from 9 to 36, with a mean of 22.52 (SD = 5.94) (Table 3). Out of 213 participants, 16.00% show low-level church leaders' confidence in addressing sexual trauma, 51.10% moderate level, and 31.90% high-level church leaders' confidence in addressing sexual trauma (Figure 1).

Table 3

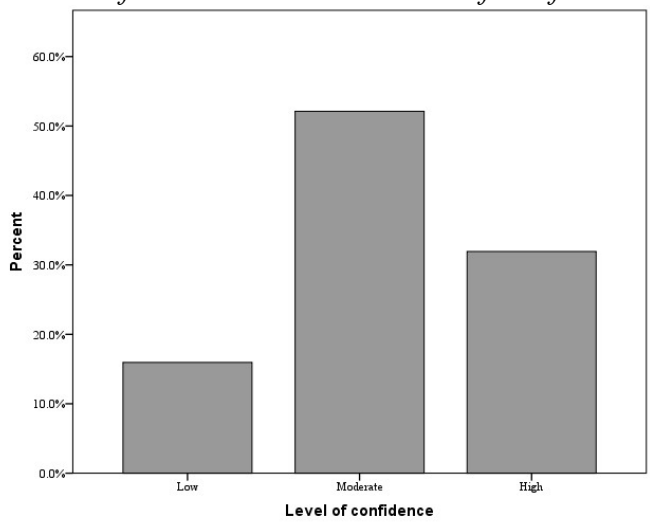
Means and Standard Deviations for Church Leader's Competence and Confidence in Addressing Sexual Trauma

Characteristic	*M*	*SD*
Church leader's competence in addressing sexual trauma	9.63	1.49
Church leader's confidence in addressing sexual trauma	22.52	5.94

Note. $N = 213$

Figure 1

Bar chart for Church Leader's Level of Confidence in Addressing Sexual Trauma



Note. The graph shows the church leader's level of confidence in addressing sexual trauma. The x-axis shows level of confidence (low, moderate, high), while the y-axis shows percent of participants.

Relationship between Competency Level and Confidence

Null hypothesis (*H0*): There is no significant relationship between the competency level of Midwest church leaders, as measured by the TICQ, and their confidence in addressing sexual trauma, as measured by the RTEPS.

Tests of Assumptions

In the context of the present dissertation's regression analysis, several fundamental assumptions have been rigorously evaluated. Kolmogorov-Smirnov test of normality results was

conducted to determine whether a church leader's competence in addressing sexual trauma is normally distributed. The results are non-significant (p=.001) (Appendix G, Table 10). According to the central limit theorem, if the sample size exceeds 30, the data will follow a normal distribution (n = 213) (LaMorte, 2016). Therefore, the Pearson correlation coefficient parametric test was utilized to test the relationship between variables.

Results

Alternative hypothesis (*H1*): As measured by the *Trauma-Informed Care Questionnaire* (TICQ), church leaders' competency will be related to their confidence, as measured by the *Readiness to Work with Trauma-Exposed Patients Survey* (RTEPS).

The Pearson correlation coefficient was computed to determine the relationship between a church leader's competence and a church leader's confidence in addressing sexual trauma. The results indicate a non-significant positive, very weak relationship, r (213) = .004, p = .955 (Table 4). Therefore, the researcher fails to reject the null hypothesis and concludes that there is no significant relationship between the competency level of Midwest church leaders, as measured by the TICQ, and their confidence in addressing sexual trauma, as measured by the RTEPS.

Table 4
Relationship between Competency Level and Confidence

	1	**2**
1. Church Leader's Competence in Addressing Sexual Trauma	1	
2. Church Leader's Confidence in Addressing Sexual Trauma	.004	1

Note. $N = 213$.

Impact of Demographic Factors

Building upon the initial investigation of the relationship between confidence and competence in addressing sexual trauma among Midwest church leaders, this section further explores the potential influence of demographic and professional characteristics. This analysis seeks to examine whether six specific factors - race, age, gender, denomination, previous trauma training, and years of ministry leadership experience - significantly impact both confidence and competence levels. Additionally, a multivariate analysis of covariance (MANCOVA) was conducted to determine the effect of age, years of ministry experience, hours of training, race, gender, and denomination on church leader's competence in addressing sexual trauma and church leaders' confidence in addressing sexual trauma. This section aims to identify potential demographic or professional correlates of confidence and competence variations, offering a more nuanced understanding of this complex relationship within the context of Midwest church leaders.

Tests of Assumptions

This section meticulously examines and validates critical assumptions inherent to the data analyses conducted. Proper adherence to the tests of assumptions helps in ensuring the validity of the study. For this research question, to what extent do demographic factors such as race, age, gender, denomination, and years of ministry experience impact the confidence and competence levels of Midwest church leaders in addressing sexual trauma, multiple regression analysis, and multivariate analysis of covariance (MANCOVA) was conducted to analyze the data.

Regression Analysis

The first test run for this research question was a regression analysis. Maximum Cook's distance is .16<1, so the assumption that there are no significant outliers has been met. The variance inflation factor (VIF) for all variables is less than five, so the assumption that there is no multicollinearity has been met. The normal P-P plot of regression standardized residuals shows that points slightly deviate from the line, so the assumption that residuals are approximately normally distributed has been met (Appendix G, Figure 2). Furthermore, the central limit theorem states that if the sample size exceeds 30, the data will follow a normal distribution (n = 213) (LaMorte, 2016).

Individual Impact of Demographic Factor on Confidence Levels

Regression analysis was conducted to determine whether race, gender, age, years of ministry experience, and denomination predict a church leader's confidence in addressing sexual trauma. The multiple regression model statistically significantly predicted the church leaders' confidence in addressing sexual trauma, $F(15, 193) = 2.382$, $p = .004$, adj. $R^2 = .156$. While the model was significant overall, not all variables added statistically significantly to the prediction ($p < .05$). Regression coefficients and standard errors can be found in Table 5.

Table 5

Regression Analysis: Confidence Levels and Demographic Factors

Effect	Estimate	*SE*	95% CI		*p*
			LL	*UL*	
Constant	27.38	1.98	23.47	31.29	< .001
Race					
White	.65	1.25	-1.82	3.11	.606
Asian	-1.49	3.60	-8.59	5.61	.679
Gender					
Female	-1.09	.87	-2.81	.64	.215
Age	-.09	.03	-.14	-.03	.004
Years of Ministry Experience	-.03	.04	-.10	.04	.348
Hours of Training	.03	.01	.01	.04	.002
Denomination					
Assembly of God	8.13	3.47	1.28	14.98	.020
Baptist	-1.05	1.22	-3.45	1.35	.390
Catholic	-3.61	4.25	-11.99	4.76	.396
Christian Church	.43	1.97	-3.46	4.32	.828
Episcopal	-3.80	2.82	-9.37	1.76	.180
Evangelical Free Church	-2.29	3.10	-8.41	3.83	.461
Methodist	-.74	1.70	-4.09	2.61	.663
Pentecostal	.19	3.11	-5.94	6.32	.950
Presbyterian	-3.60	1.55	-6.65	-.55	.021

Note. N = 213. CI = confidence interval; *LL* = lower limit; *UL* = upper limit. Dependent variable: Church Leader's Confidence in Addressing Sexual Trauma

Null hypothesis 1a (*H0*): Race does not significantly impact the confidence levels of Midwest church leaders in addressing sexual trauma.

In the current analysis, consistent with data analysis guidelines, dummy coding was utilized for categorical variables to facilitate interpretation (Hair et al., 2020). For the race variable, blacks served as the reference group, allowing for comparisons between other racial groups against this baseline.

If a participant is of White race, it is a positive, non-significant predictor of the church leader's competence in addressing sexual trauma ($B = .65$, $p = .606$). If a participant is of Asian

race, it is a negative, non-significant predictor of the church leader's competence in addressing sexual trauma (B = -1.49, p = .679). Therefore, we fail to reject the null hypothesis 1a that race does not significantly impact the confidence levels of Midwest church leaders in addressing sexual trauma.

Null hypothesis 2a (*H0*): Age does not significantly impact the confidence levels of Midwest church leaders in addressing sexual trauma.

Age is a significant negative predictor of church leaders' confidence in addressing sexual trauma (B = -.09, p = .004). This suggests that younger church leaders may express greater confidence in handling situations of sexual trauma compared to their more experienced counterparts. Therefore, we reject the null hypothesis 2a and conclude that age significantly impacts the confidence levels of Midwest church leaders in addressing sexual trauma.

Null hypothesis 3a (*H0*): Gender does not significantly impact the confidence levels of Midwest church leaders in addressing sexual trauma.

For the gender variable, males served as the reference group, allowing for comparisons for the female group against this baseline. If a participant is female, it is a negative, non-significant predictor of the church leader's confidence in addressing sexual trauma (B = -1.09, p = .215). Therefore, we fail to reject the null hypothesis 3a that gender does not significantly impact the confidence levels of Midwest church leaders in addressing sexual trauma.

Null hypothesis 4a (*H0*): Denomination does not significantly impact the confidence levels of Midwest church leaders in addressing sexual trauma.

For this variable, Non-Denominational served as the dummy variable. If a participant is Assembly of God, it is a positive, significant predictor of a church leader's confidence in addressing sexual trauma (B = 8.13, p = .020). If a participant is Assembly of God, it will

increase the church leader's confidence in addressing sexual trauma. If a participant is Baptist (B = -1.05, p = .390), Catholic (B = -3.61, p = .396), Episcopal (B = -3.80, p = .180), Evangelical Free Church (B = -2.29, p = .461) or Methodist (B = -.74, p = .663), it is negative, non-significant predictor of a church leader's confidence in addressing sexual trauma. If a participant is Christian Church (B = .43, p = .828) or Pentecostal (B = .19, p = .950), it is a positive, non-significant predictor of church leader's confidence in addressing sexual trauma. If a participant is Presbyterian, it is a negative, significant predictor of a church leader's confidence in addressing sexual trauma (B = -3.60, p = .021). If a participant is Presbyterian, it will decrease a church leader's confidence in addressing sexual trauma. Therefore, we reject the null hypothesis 4a that denomination significantly impacts the confidence levels of Midwest church leaders in addressing sexual trauma.

Null hypothesis 5a (*H0*): Previous trauma training does not significantly impact the confidence levels of Midwest church leaders in addressing sexual trauma.

Hours of training is a significant positive predictor of a church leader's confidence in addressing sexual trauma (B = .03, p = .002). Therefore, we reject the null hypothesis 5a and conclude that previous trauma training significantly impacts the confidence levels of Midwest church leaders in addressing sexual trauma (Table 5).

Table 5

Regression Analysis: Confidence Levels and Demographic Factors

Effect	Estimate	*SE*	95% CI		*p*
			LL	*UL*	
Constant	27.38	1.98	23.47	31.29	< .001
Race					
White	.65	1.25	-1.82	3.11	.606
Asian	-1.49	3.60	-8.59	5.61	.679
Gender					
Female	-1.09	.87	-2.81	.64	.215
Age	-.09	.03	-.14	-.03	.004
Years of Ministry Experience	-.03	.04	-.10	.04	.348
Hours of Training	.03	.01	.01	.04	.002
Denomination					
Assembly of God	8.13	3.47	1.28	14.98	.020
Baptist	-1.05	1.22	-3.45	1.35	.390
Catholic	-3.61	4.25	-11.99	4.76	.396
Christian Church	.43	1.97	-3.46	4.32	.828
Episcopal	-3.80	2.82	-9.37	1.76	.180
Evangelical Free Church	-2.29	3.10	-8.41	3.83	.461
Methodist	-.74	1.70	-4.09	2.61	.663
Pentecostal	.19	3.11	-5.94	6.32	.950
Presbyterian	-3.60	1.55	-6.65	-.55	.021

Note. N = 213. CI = confidence interval; *LL* = lower limit; *UL* = upper limit. Dependent variable: Church Leader's Confidence in Addressing Sexual Trauma

Null hypothesis 6a (*H0*): One's Number of years of ministry leadership experience does not significantly impact the confidence levels of Midwest church leaders in addressing sexual trauma.

Years of Ministry experience is a non-significant negative predictor of a church leader's confidence in addressing sexual trauma (B = -.03, p = .348). Therefore, we fail to reject the null hypothesis 6a that one's years of ministry leadership experience does not significantly impact the confidence levels of Midwest church leaders in addressing sexual trauma.

Impact of Demographic Factor on Competence Levels

Regression analysis was conducted to determine whether race, gender, age, years of ministry experience, and denomination predict a church leader's competence in addressing sexual trauma. R^2 = .244, indicating that 24.40% of the variance in church leader's competence in addressing sexual trauma is explained by race, gender, age, years of ministry experience, and denomination.

Null hypothesis 1b (*H0*): Race does not significantly impact the competence levels of Midwest church leaders in addressing sexual trauma.

For this variable, the black group served as the baseline. If a participant is of White race, it is a positive, non-significant predictor of a church leader's competence in addressing sexual trauma (B = .31, p = .294). If a participant is of Asian race, it is a positive, non-significant predictor of a church leader's competence in addressing sexual trauma (B = .54, p = .530). Therefore, we fail to reject the null hypothesis 1b that race does not significantly impact the competence levels of Midwest church leaders in addressing sexual trauma.

Null hypothesis 2b (*H0*): Age does not significantly impact the competence levels of Midwest church leaders in addressing sexual trauma.

Age is a significant, negative predictor of a church leader's competence in addressing sexual trauma (B = -.02, p = .003). This suggests that younger church leaders may express greater confidence in handling situations of sexual trauma compared to their more experienced counterparts. Therefore, we reject the null hypothesis 2b and conclude that age significantly impacts the competence levels of Midwest church leaders in addressing sexual trauma.

Null hypothesis 3b (*H0*): Gender does not significantly impact the competence levels of Midwest church leaders in addressing sexual trauma.

Males served as the baseline for this analysis. If a participant is female, it is a positive significant predictor of a church leader's competence in addressing sexual trauma ($B = .62$, $p = .004$). Therefore, we reject the null hypothesis 3b and conclude that gender significantly impacts the competence levels of Midwest church leaders in addressing sexual trauma.

Null hypothesis 4b (*H0*): Denomination does not significantly impact the competence levels of Midwest church leaders in addressing sexual trauma.

Non-denominational served as the baseline variable for this analysis. If a participant is Assembly of God (B = 1.41, p = .090), Catholic (B = .94, p = .358), Christian Church ($B = .35$, $p = .464$), or Episcopal ($B = .67$, $p = .324$), it is a non-significant, positive predictor of church leader's competence in addressing sexual trauma. If participant is Baptist ($B = -.35$, $p = .226$), Methodist ($B = -.63$, $p = .124$), or Presbyterian ($B = -.12$, $p = .749$), it is a non-significant negative predictor of a church leader's competence in addressing sexual trauma. If a participant is Evangelical Free Church, it is a significant positive predictor of a church leader's competence in addressing sexual trauma ($B = 1.50$, $p = .044$). If the participant is Pentecostal, it is a significant negative predictor of a church leader's competence in addressing sexual trauma ($B = -1.53$, $p = .040$). Therefore, we fail to reject the null hypothesis 4b that denomination does not significantly impact the competence levels of Midwest church leaders in addressing sexual trauma.

Null hypothesis 5b (*H0*): Previous trauma training does not significantly impact the competence levels of Midwest church leaders in addressing sexual trauma.

Hours of training is a non-significant negative predictor of a church leader's competence in addressing sexual trauma ($B = -.001$, $p = .759$). Therefore, we fail to reject the null hypothesis

5a that previous trauma training significantly impacts the competence levels of Midwest church leaders in addressing sexual trauma.

Null hypothesis 6b (*H0*): One's years of ministry leadership experience does not significantly impact the competence levels of Midwest church leaders in addressing sexual trauma.

Years of Ministry experience is a non-significant negative predictor of a church leader's competence in addressing sexual trauma (B = -.02, p = .3759). Therefore, we fail to reject the null hypothesis 6a that one's years of ministry leadership experience does not significantly impact the competence levels of Midwest church leaders in addressing sexual trauma (Table 6).

Table 6
Regression Analysis: Competence Levels and Demographic Factors

Effect	Estimate	*SE*	95% CI		*p*
			LL	*UL*	
Constant	10.54	.47	9.61	11.47	< .001
Race					
White	.31	.29	-.28	.90	.294
Asian	.54	.86	-1.15	2.24	.530
Gender					
Female	.62	.21	.21	1.03	.004
Age	-.02	.01	-.04	-.01	.003
Years of Ministry Experience	-.02	.01	-.03	.001	.065
Hours of Training	-.001	.002	-.01	.003	.759
Denomination					
Assembly of God	1.41	.83	-.22	3.05	.090
Baptist	-.35	.29	-.93	.22	.226
Catholic	.94	1.01	-1.06	2.93	.358
Christian Church	.35	.47	-.58	1.27	.464
Episcopal	.67	.67	-.66	1.99	.324
Evangelical Free Church	1.51	.74	.04	2.96	.044
Methodist	-.63	.41	-1.43	.17	.124
Pentecostal	-1.53	.74	-2.99	-.07	.040
Presbyterian	-.12	.37	-.85	.61	.749

Note. N = 213. CI = confidence interval; *LL* = lower limit; *UL* = upper limit. Dependent variable: Church Leader's Competence in Addressing Sexual Trauma

Further Analysis using MANCOVA

Prior to conducting statistical analyses, certain assumptions were assessed to ensure the analyses could be used appropriately (Gall et al., 2007; Kazdin, 2003; Rovai et al., 2014; Warner, 2013). These assumptions included the independence of observations, no significant outliers, normality, linearity, homogeneity of variances, homoscedasticity, and homogeneity of regression slopes. Assumptions relevant to the multivariate analysis of covariance (MANCOVA) were evaluated to ensure the integrity of the results. The dataset included two continuous dependent variables: church leaders' confidence and competence in addressing sexual trauma. Furthermore, three categorical independent variables—race, gender, and denomination—were incorporated into the analysis. Covariates, including age, years of ministry experience, and hours of training, were also considered. Preliminary assessments confirmed the assumption of independence, with each group within the independent variables comprising distinct participants and no individual appearing in more than one group. Additionally, examination of the homogeneity of variances and covariances revealed adherence to this assumption, supported by a significant F-value ($F(42, 3368.52) = 2.87$, $p < .001$) and Box's M value of 141.75. These findings fulfill the prerequisites for MANCOVA, thereby fortifying the validity of the following analyses.

Test of Main Effects in the MANCOVA Model

A MANCOVA was conducted to examine the independent and combined effects of age, years of ministry experience, hours of training, race, gender, and denomination on church leaders' competence and confidence in addressing sexual trauma. Additionally, each dependent

variable (competence and confidence) was analyzed separately due to their distinct nature in the individual effects sections found later in this chapter.

The MANCOVA revealed several key findings (Table 8). Age displayed a significant main effect ($F(2, 180) = 6.28$, $p = .002$, Wilks' Lambda = .93, partial $\eta^2 = .06$), indicating that age differences were associated with variations in church leaders' combined competence and confidence (Figure 3).

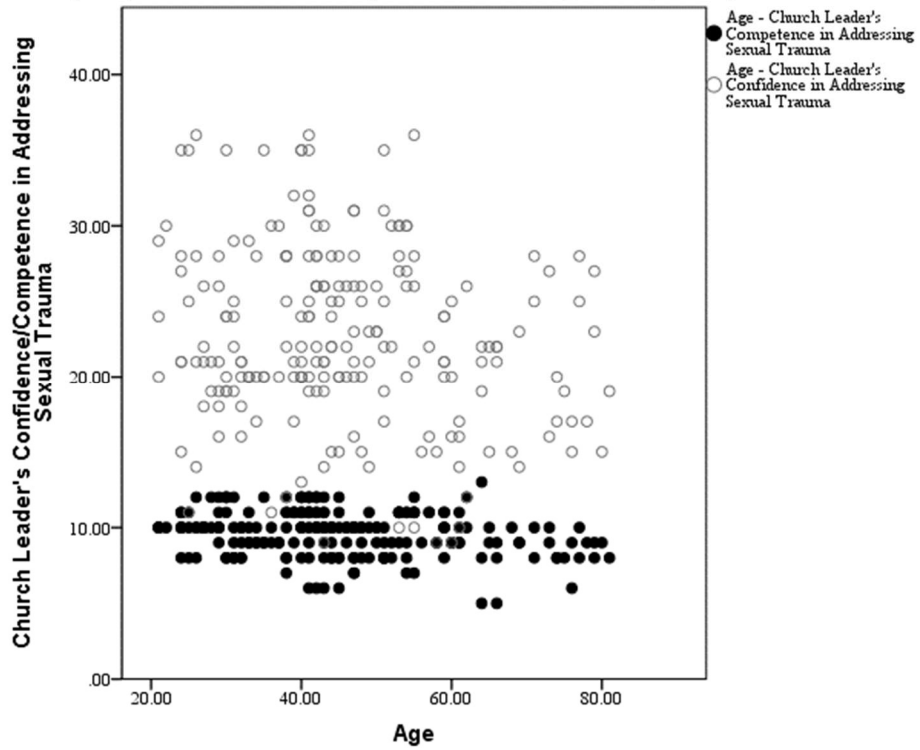
Table 8
Multivariate Analysis of Covariance (MANCOVA)

Effect	Wilks' Lambda	*F*	Hypothesis df	Error df	*p*	Partial η^2
Intercept	.14	514.57	2.00	180.00	< .001	.85
Age	.93	6.28	2.00	180.00	.002	.06
Years of ministry experience	.97	1.93	2.00	180.00	.147	.02
Hours of training	.94	5.27	2.00	180.00	.006	.05
Race	.99	.17	4.00	360.00	.951	.00
Gender	.96	3.45	2.00	180.00	.034	.03
Denomination	.77	2.78	18.00	36000	< .001	.12
Race * Gender	.98	1.40	2.00	180.00	.248	.01
Race * Denomination	.92	2.51	6.00	360.00	.022	.04
Gender * Denomination	.88	2.30	10.00	360.00	.012	.05
Race * Gender * Denomination	.93	2.10	6.00	360.00	.052	.03

Note. Dependent variables: Church leader's competence in addressing sexual trauma and church leader's confidence in addressing sexual trauma.

Figure 3

Scatterplot for the Relationship between Competency, Confidence, and Age

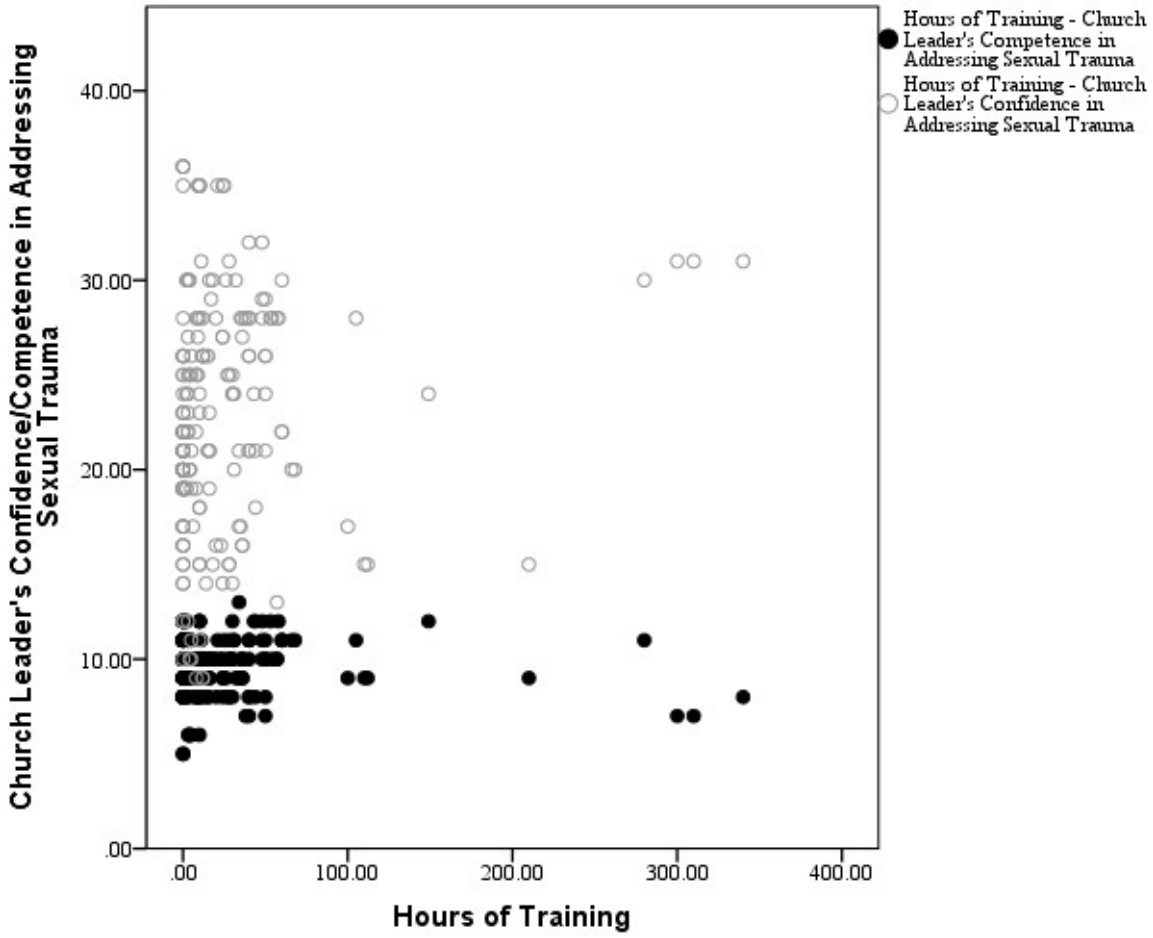


Note. The graph shows the relationship between competency, confidence, and age. The x-axis shows age, while the y-axis shows church leader's confidence and competence in addressing sexual trauma.

However, years of ministry experience ($F(2, 180) = 1.93$, $p = .147$, Wilks' Lambda = .97, partial $\eta^2 = .02$) and race ($F(2, 180) = .17$, $p = .951$, Wilks' Lambda = .99, partial $\eta^2 = .00$) did not have statistically significant independent effects. Furthermore, hours of training ($F(2, 180) = 5.27$, $p = .006$, Wilks' Lambda = .94, partial $\eta^2 = .05$) and gender ($F(2, 180) = 3.45$, $p = .034$, Wilks' Lambda = .96, partial $\eta^2 = .03$) emerged as significant main effects (Figure 4 and 5).

Figure 4

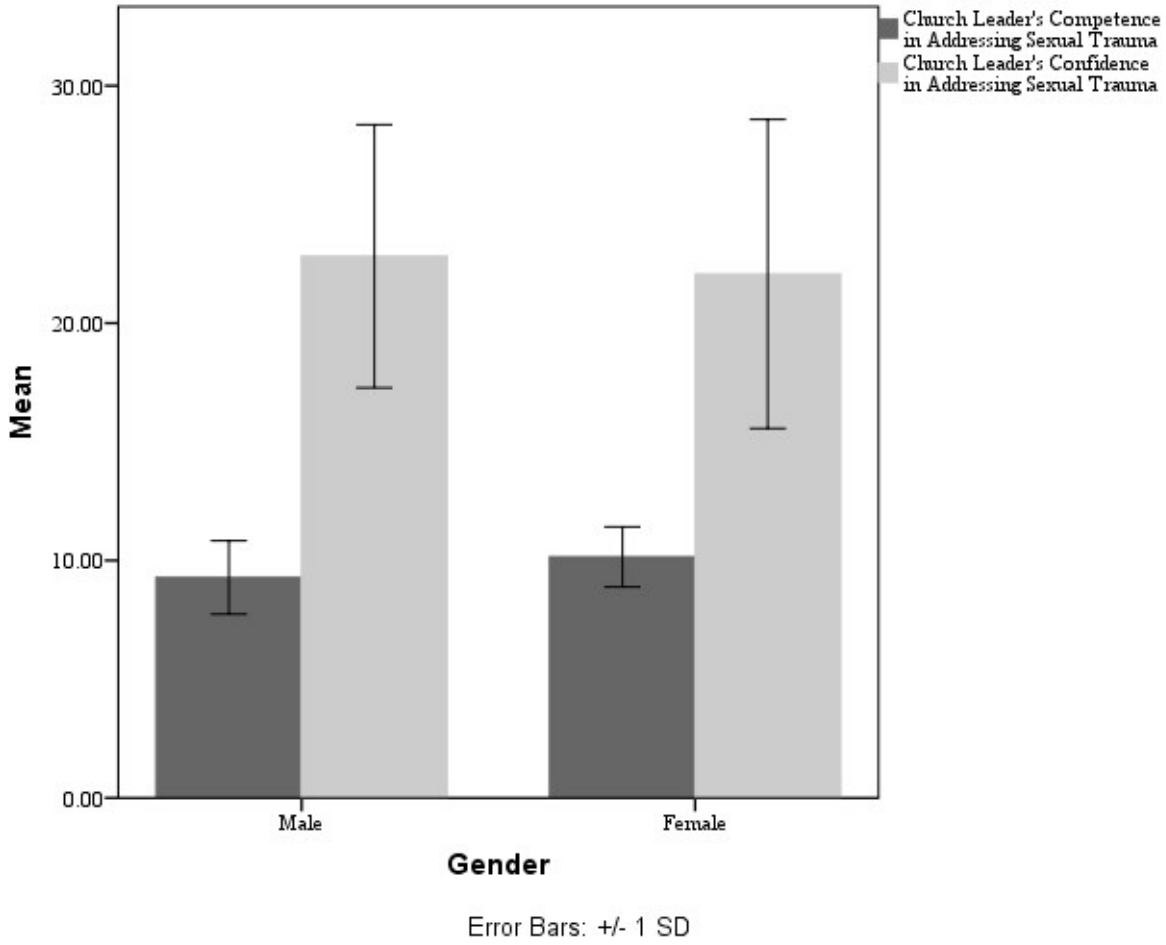
Scatterplot for the Relationship between Competency, Confidence, and Hours of Training



Note. The graph shows the relationship between competency, confidence, and hours of training. The x-axis shows hours of training, while the y-axis shows church leader's confidence and competence in addressing sexual trauma.

Figure 5

Bar chart for Competency and Confidence by Gender

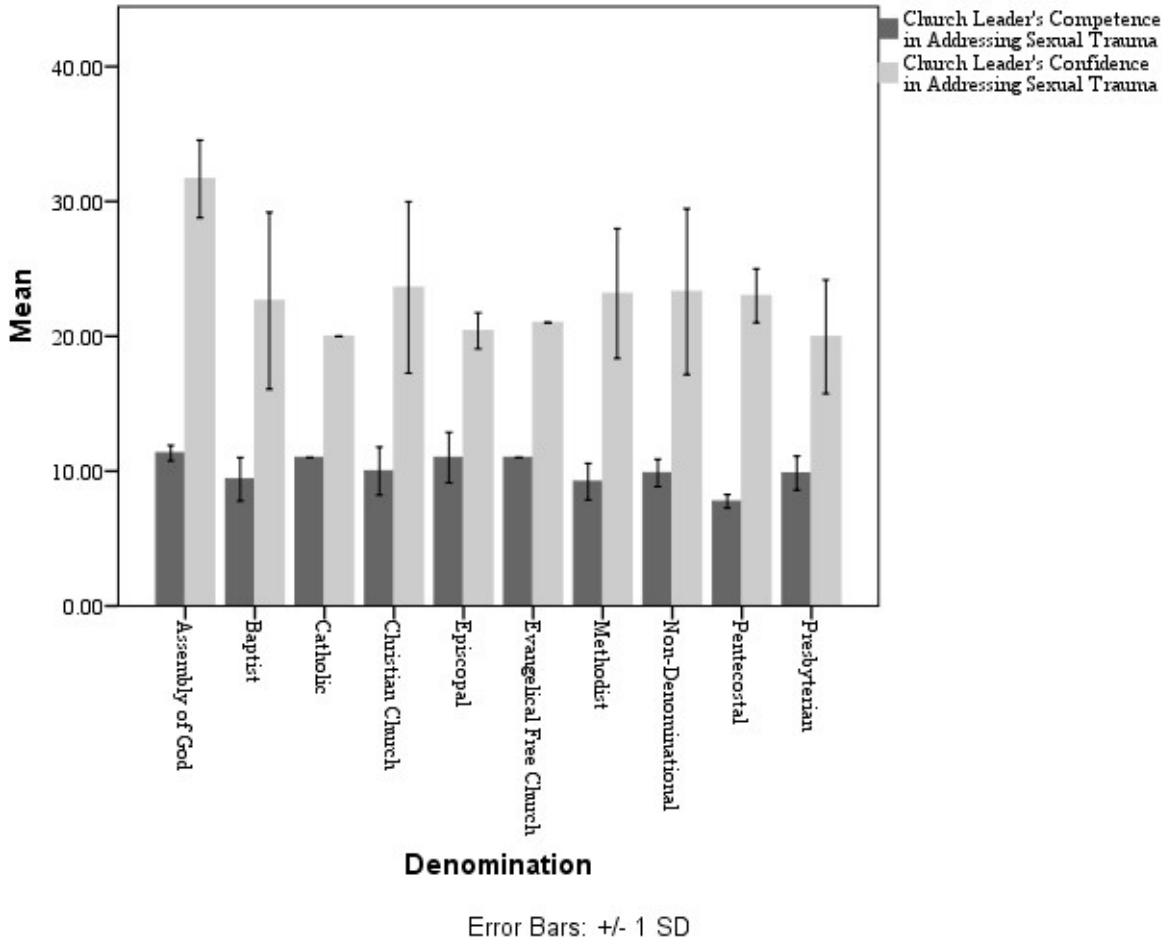


Note. The graph shows church leader's confidence and competence in addressing sexual trauma by gender. The x-axis shows gender (male or female). The y-axis shows mean church leader's confidence and competence in addressing sexual trauma. Error bars show +/- 1 standard deviation.

This suggests that differences in training hours and gender were associated with varying levels of competence and confidence. Additionally, denomination ($F(2, 180) = 2.78$, $p < .001$, Wilks' Lambda = .77, partial $\eta^2 = .12$) had a significant main effect, suggesting its influence on church leaders' combined competence and confidence (Figure 6).

Figure 6

Bar chart for Competency and Confidence by Denomination



Note. The graph shows church leader's confidence and competence in addressing sexual trauma by gender. The x-axis shows denomination. The y-axis shows mean church leader's confidence and competence in addressing sexual trauma. Error bars show +/- 1 standard deviation.

Interaction Effects

Further analyses explored interaction effects, revealing no significant interaction between race and gender ($F(2, 180) = 1.40$, $p = .248$, Wilks' Lambda = .98, partial $\eta^2 = .01$). However, significant interactions emerged between both race and denomination ($F(6, 360) = 2.51$, $p = .022$, Wilks' Lambda = .92, partial $\eta^2 = .04$) and gender and denomination ($F(10, 360) = 2.30$, $p = .012$, Wilks' Lambda = .88, partial $\eta^2 = .05$). These findings suggest that the relationships between

individual characteristics (race and gender) and church leaders' preparedness may vary depending on their specific denomination affiliation.

Individual Effects on Confidence

In an earlier analysis, it was determined that there is a significant effect of age, hours of training, gender, and denomination on a church leader's competence in addressing sexual trauma and church leader's confidence in addressing sexual trauma, we further examine the effects of these variables on each dependent variable.

The MANCOVA revealed several key findings regarding church leaders' confidence in addressing sexual trauma. First, age had a significant main effect ($F(1, 181) = 4.96$, $p = .027$, partial $\eta^2 = .02$), suggesting that older church leaders reported slightly higher confidence levels compared to younger colleagues. Second, hours of training emerged as a significant factor ($F(1, 181) = 10.59$, $p = .001$, partial $\eta^2 = .05$), indicating that increased training is associated with greater confidence. Third, gender did not have a statistically significant main effect ($F(1, 181) = .37$, $p = .542$, partial $\eta^2 = .002$). Fourth, the denomination displayed a significant main effect ($F(1, 181) = 3.28$, $p = .001$, partial $\eta^2 = .014$). Post-hoc Bonferroni comparisons revealed significant differences between the Assembly of God denomination ($M = 31.67$, $SD = 2.89$) and both the Baptist denomination ($M = 22.63$, $SD = 6.57$, $p = .016$) and Presbyterian denomination ($M = 19.96$, $SD = 4.22$, $p = .038$), with church leaders in the Assembly of God reporting higher confidence levels. These findings offer a comprehensive view of the different factors influencing church leaders' confidence in addressing sexual trauma (Table 9).

Table 9

Multivariate Analysis of Covariance (MANCOVA) – Tests of between Subjects Effects

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	*F*	*p*	Partial η^2
Corrected Model	Church Leader's Confidence in Addressing Sexual Trauma	2083.94	27	77.18	2.61	< .001	.28
	Church Leader's Competence in Addressing Sexual Trauma	137.40	27	5.08	2.75	< .001	.29
Intercept	Church Leader's Confidence in Addressing Sexual Trauma	7611.83	1	7611.83	257.68	< .001	.58
	Church Leader's Competence in Addressing Sexual Trauma	1353.04	1	1353.04	731.13	< .001	.80
Age	Church Leader's Confidence in Addressing Sexual Trauma	146.75	1	146.75	4.96	.027	.02
	Church Leader's Competence in Addressing Sexual Trauma	13.05	1	13.05	7.05	.009	.03
Hours of training	Church Leader's Confidence in Addressing Sexual Trauma	312.86	1	312.86	10.59	.001	.05
	Church Leader's Competence in Addressing Sexual Trauma	.13	1	.13	.07	.786	.002
Gender	Church Leader's Confidence in Addressing Sexual Trauma	11.02	1	11.01	.37	.542	.002
	Church Leader's Competence in Addressing Sexual Trauma	11.83	1	11.83	6.39	.012	.03
Denomination	Church Leader's Confidence in Addressing Sexual Trauma	872.35	9	96.92	3.28	.001	.14
	Church Leader's Competence in Addressing Sexual Trauma	37.76	9	4.19	2.27	.020	.10
Error	Church Leader's Confidence in Addressing Sexual Trauma	5346.67	181	29.54			
	Church Leader's Competence in Addressing Sexual Trauma	334.96	181	1.85			

Individual Effects on Competence

The MANCOVA further explored factors influencing church leaders' competence in addressing sexual trauma. Contrary to regression analysis, hours of training did not have a statistically significant main effect ($F(1, 181) = .07$, $p = .786$, partial $\eta^2 = .002$), suggesting that the amount of training might not directly translate to church leaders' competence. Additionally, a significant main effect emerged for gender ($F(1, 181) = 6.39$, $p = .012$, partial $\eta^2 = .03$). Post-hoc Bonferroni comparisons revealed that female church leaders reported significantly higher perceived competence ($M = 10.15$, $SD = 1.27$) compared to their male counterparts ($M = 9.28$, $SD = 1.54$). Additionally, the denomination displayed a significant main effect ($F(1, 181) = 2.27$, $p = .020$, partial $\eta^2 = .010$) (refer to Table 9 for detailed results). These findings, as shown in Table 9 above, suggest that both gender and denominational affiliation may be associated with variations in church leaders' perceived competence in addressing sexual trauma.

Summary

Chapter 4 provides a comprehensive presentation of the descriptive data gathered in the current study and outlines the methodologies employed to address the research questions and associated hypotheses. The assessment of church leaders' competence and confidence in addressing sexual trauma is collected through the *Trauma-Informed Care Questionnaire* (TICQ) developed by Kenny et al. (2017) and the *Readiness to Work with Trauma-Exposed Patients* (RTEPS) developed by Kazlauskas et al. (2022). Both instruments contribute to the criterion variables, representing the focus of this investigation. A total of six predictor variables, encompassing demographic and professional aspects, including gender, age, race, denomination, trauma training, and years of ministry experience, are examined.

Multiple regression analyses revealed some interplay between demographic characteristics and church leaders' competence and confidence regarding sexual trauma. Although the null hypothesis for the first research question failed to be rejected due to the absence of statistically significant relationships, several noteworthy associations emerged for the second question. Older leaders reported lower confidence and competence in addressing sexual trauma, while female leaders demonstrated higher perceived competence. Additionally, increased hours of trauma-related training corresponded with heightened confidence levels (Table 7). These findings underscore the need for further exploration of this complex relationship. While certain demographic factors appear to play a role, the lack of significant associations in other areas highlights the multifaceted nature of this phenomenon and the potential for additional contributing factors yet to be identified.

Additionally, this study employed MANCOVA to further investigate the factors influencing church leaders' preparedness to address sexual trauma. Age, hours of training, gender, and denomination emerged as significant main effects on the combined measures of competence and confidence. While age and denomination consistently influenced both competence and confidence, the effect of training was specific to confidence, and gender displayed a significant effect only on perceived competence. Furthermore, post-hoc comparisons revealed that female church leaders reported higher perceived competence than their male counterparts. Significant interaction effects were found between race and denomination and gender and denomination, suggesting that the influence of individual characteristics on preparedness may vary depending on denominational affiliation. Combining the insights from the regression analysis and the MANCOVA leads to a more comprehensive understanding of the research questions.

Table 7
Summary Results and Hypotheses

	DV: Confidence level		DV: Competence level	
Independent variable	**Hypothesis**	**Impact**	**Hypothesis**	**Impact**
Race	Null hypothesis 1a: not rejected	0	Null hypothesis 1a: not rejected	0
Age	**Null hypothesis 2a: rejected**	-	**Null hypothesis 2a: rejected**	-
Gender	Null hypothesis 3a: not rejected	0	**Null hypothesis 3a: rejected**	+
Denomination	**Null hypothesis 4a: rejected**	±	**Null hypothesis 4a: rejected**	±
Hours of training	**Null hypothesis 5a: rejected**	+	Null hypothesis 5a: not rejected	0
Years of ministry experience	Null hypothesis 6a: not rejected	0	Null hypothesis 6a: not rejected	0

Note. 0: non-significant; -: statistically significant negative; +: statistically significant positive. ±: mixed results (both positive and negative impacts reported)

Chapter 5: Conclusions

This final chapter is a culmination of the research into Midwest church leaders' confidence and competence in addressing sexual trauma within their churches. This chapter contains the implications of the research findings, suggestions for training developments, and considerations for future research. Additionally, this chapter highlights the value of the research conducted and situates the research in the broader context of trauma-informed care within religious settings.

Discussion

The purpose of this study was to fill the research gap in quantitative research by understanding the interconnectedness of confidence and competence levels of Midwest church leaders in their ability to address survivors of sexual trauma. The participants in this study were individuals who held a position of authority within Midwest churches. This included head pastors, children's leaders, youth pastors, and music leaders. All participants were actively involved in their respective ministries. The participants utilized the *Trauma-Informed Care Questionnaire* (TICQ), developed by Kenny et al. (2017), to measure their competence and the *Readiness to Work With Trauma Exposed Patients* (RTEPS) survey, developed by Kazlauskas et al (2022), to measure their confidence. In addition to the correlation between confidence and competence, this study also explored the influence of demographic variables, including race, age, gender, denomination, and years of ministry experience, on church leader's confidence and competence in addressing sexual trauma within their churches.

RQ1: Relationship Between Competency Level and Confidence

Question 1 of this study posed, "What is the relationship between the competence level of Midwest church leaders, as measured by the Trauma-Informed Care Questionnaire (TICQ), and their confidence in addressing sexual trauma, as measured by the Readiness to Work with Trauma-Exposed Patients (RTEPS)." The nuances of a religious setting adds complexity to the discussion of trauma-informed care within institutions. Therefore, this current study builds upon previous research to better understand the complexities of this setting.

Previous research by Houston-Kolnik and Todd (2016) highlights a significant gap in the training and education that religious leaders receive regarding trauma response. Additionally, they call for enhanced training on responding to abuse due to this lack of preparedness among church leaders. Furthermore, Lasair (2020) and Rudolfson (2013) continually echo the deficit in trauma-informed knowledge and education within the church setting. In the current research, the participants reported a mean of 22.98 hours of dedicated trauma training. Many of these hours were obtained through mandated reporter training, foster care (STARS) licensure training, and grief training, none of which give clear guidelines or tools for dealing with sexual trauma within a religious setting. Additionally, very few participants received trauma training during their formal education which aligns with Houston-Kolnik and Todd, who suggest that the majority of accredited theological seminaries within the USA inadequately prepare church leaders to address survivors of trauma.

Research has shown that low trauma competence may lead church leaders to respond to survivors with minimization, blaming, and shaming (Rhee et al., 2003; Streets, 2015; Zust et al., 2021). The current study revealed that the competence of church leaders in addressing sexual

trauma ranged from 5 to 13, with a mean of 9.63 (SD = 1.49). The TICQ has a standardized mean of 10.81; therefore, the average participant scored lower than the mean on the TICQ scale. Ongoing research in this area may give a clearer picture of the competency of church leaders as frontline responders in addressing sexual trauma. Fleenor et al. (2022) emphasized the need for standard guidelines for trauma-informed care. 66% of participants in this study reported having low to moderate confidence in their ability to handle trauma, aligning with the notion of feeling unprepared found in Fleenor's research.

A Pearson correlation coefficient analysis revealed a non-significant and very weak relationship ($r(213) = .004$, $p = .955$) between measured competence in trauma-informed care and confidence in addressing sexual trauma. While the research does align with past research regarding the deficit of confidence and competence in Midwest church leaders when addressing sexual trauma, this finding indicates that there is no significant relationship between these variables, within the given sample. The absence of significance points to greater complexity that is yet to be understood regarding the needs within the church setting and the changes that would need to occur regarding the training and education of church leaders.

Expounding on the results, many varying factors may have led to a weak relationship. First, one’s personal experiences with trauma, both directly and when supporting a survivor, may play a role in shaping one's confidence of competence. For example, a leader who has personally experienced trauma may have a deeper compassion and understanding for survivors, which in turn may boost their confidence in dealing with this situation. On the other hand, someone who has dealt with survivors previously may experience burnout or secondary traumatization which decreases their confidence. Another explanation for the weak relationship may be attributed to the theological beliefs that the church or individual hold regarding sexuality and victims. Leaders

that ascribe to more conservative views may experience internal conflicts regarding their faith and the realities of sexual trauma. These theological beliefs may greatly impact the confidence or competence of church leaders. Additionally, individual factors such as self-efficacy, emotional intelligence, and spiritual well-being could also make an impact on the church leader's confidence and competence. High self-efficacy may enhance the leader's ability to manage challenging situations, despite their lack of training or familiarity with the subject-matter. Emotional intelligence allows leaders to display empathy and compassion in the face of sensitive situations, leading to increased trust from the survivor and better outcomes. Therefore, these better outcomes may give them a confidence boost in their ability to handle future situations. Lastly, spiritual well-being could play a significant role in the confidence of church leaders by providing a foundation and purpose when they are handling challenges. By analyzing the multifaceted aspects of confidence and competence, one can better understand the complexities of the given research.

Furthermore, the limitations of the measures utilized may impact the weak relationship found in the research. The TICQ was standardized for measuring trauma competence; however, this scale may not fully capture the specific knowledge and skills that are critical within a faith-based setting. Addressing sexual trauma in these settings requires an understanding of the unique dynamics such as theological considerations, the integration of spiritual practices, and the navigation of the tension between religious beliefs and the reality of trauma. Due to the measure not being built for religious settings, there may be pieces that are missing that could give the researcher a deeper understanding within the given setting. Additionally, the self-report style of the RTEPS may be skewed by participants reporting that they feel more confident than they really are. This is suggested by the social desirability bias which shows that people tend to report

themselves more positively than reality, therefore inflating their confidence scores (Weathington et al., 2017). Additionally, both measures utilized in this study lack granularity which would aid in narrowing down to minute relationships that may be present between confidence and competence. Overall, the measures utilized play a large part in the findings and shifts in these measures could produce a deeper understanding of the relationships at play.

While the measures used in this study play a large role in the outcome, the context of the population also plays an important role. Midwestern church leaders may have a different worldview and context than church leaders in other parts of the nation or world. Joyce (2012) outlines that the Midwest is characterized by indirect communication, which has a higher potential for confusion and misunderstandings. Additionally, the Midwest is known as an area where the communities are close-knit and social cohesion is valued. Therefore, church leaders that serve in the Midwest may be influenced by these values. This could show up in the study by church leaders being less likely to express their doubts in the self-report confidence measure because they are supposed to be a support to those around them.

RQ2: Impact of Demographic Factors

The second question posed in this study was "to what extent do demographic factors such as race, age, gender, denomination, and years of ministry experience impact the confidence and competence levels of Midwest church leaders in addressing sexual trauma."

Impact of Demographic Factors on Confidence Levels

The current study found that age was a significant demographic factor affecting confidence levels in church leaders. Older church leaders reported lower confidence in

addressing sexual trauma which aligns with the findings of Hendron et al. (2012), which found that secondary traumatization over time may impact one's confidence. This suggests that the emotional toll that one feels from addressing trauma repeatedly could cause one to develop feelings of burnout and reduced self-efficacy, particularly in older church leaders who have more experience dealing with these types of situations. On the other hand, the increase in confidence among younger church leaders could be attributed to their heightened awareness and openness in discussing trauma. Younger generations, particularly Millennials and Gen Z, are often characterized by their willingness to engage in conversations about mental health which reduces long standing stigmas (Twenge, 2023). This increase in conversations may lead to higher comfortability and confidence surrounding this complicated situation.

This study also revealed interesting insights into the role of denominational influence in regards to church leaders' confidence. Leaders identifying as Assembly of God reported higher confidence, while those identifying as Presbyterian reported lower confidence. These findings highlight the potential influence of denominational beliefs on the leader's approach to addressing sexual trauma. While future research is needed to better understand the complexity of denominational influence, there are a few considerations that may help one better understand the results of the given study. Importantly, the degree of theological conservatism within a denomination could play a role in the findings. Assembly of God churches are comprised of some of the youngest and most diverse churchgoers in America (Carter, 2021). In fact, 53% of the membership within the Assembly of God denomination are individuals under the age of 35. Therefore, since findings show that younger generations of church leaders were more confident, it aligns that a denomination filled with young members would appear as a forerunner in confidence. Conversely, Presbyterian churches were found to be a negative significant predictor

of confidence in addressing sexual trauma. Previous research by Milstein et al. (2017) found that more conservative churches had church leaders that felt that psychology and church ministry are less compatible. Henceforth, leaders within these more conservative churches may approach issues regarding trauma or mental health with hesitancy.

Lastly, the current study found that previous trauma training was positively associated with confidence levels. This echoes the research put out by Fleenor et al. (2022) and Tedder and Smith (2018), who emphasized the importance of comprehensive training that equip church leaders with the knowledge and skills required to effectively address sexual trauma within their congregations. These training can increase the confidence of church leaders to do the work set forth in front of them and handle survivors of sexual trauma in a trauma-informed manner.

Impact of Demographic Factors of Competence Levels

In addition to looking at the impact of demographic factors on confidence, a thorough analysis of the demographic factors impact on competence levels was completed. Similarly, to confidence, age was found to be a significant factor impacting competence levels. Similarly, to the previous findings, older leaders showed lower competence while younger leaders had higher competence. This aligns with the broader literature on the development of expertise, which suggests that continuous learning is crucial for maintaining competence in any given field (Ericson, 2008). Although older leaders have many more years of experience, the lack of exposure to updated trauma-informed care trainings could explain the lower competence scores found within this age group. Additionally, many older leaders may rely on their past experiences or traditional ways of handling situations which are not up to date with the current best practices in the field of trauma response. Younger generations have many advantages that older church

leaders may not have had. Particularly, younger generations have the opportunity to learn best practice in trauma-informed care through their recent education, which has updated trauma practices, compared to older generations who received outdated training (Hickman & Ault, 2020). Additionally, as discussed before, their increased willingness to discuss topics surrounding mental health and trauma can equate to a higher level of sensitivity and empathetic support for survivors (Twenge, 2023). Younger generations also have easier access to technology and resources that gives them the ability to stay up to date on the current research, best practices, and support networks, therefore aiding in their understanding and response to trauma (Lenhard, 2010). Nevertheless, one should be careful to make sweeping statements regarding the advantages, rather acknowledging that it is not universal nor exclusive to younger generations. Ultimately, individual variations in training, experience, and ongoing learning significantly contribute to the competence of church leaders when addressing challenging situations like survivors of sexual trauma (Smith et al., 2021).

Contrary to the findings of demographics and confidence, gender played a significant role in competence with female leaders demonstrating higher competence than male leaders. This finding contradicts previous research by Rudolfsson and Tidefors (2024) and Van Wyk (2018), that suggested that female leaders could become more emotionally involved when working with survivors of sexual trauma. On the contrary, it is possible that female church leaders recognize this potential for emotional involvement and seek out training and resources to better equip themselves for these situations. This would explain the findings of females showing higher competence and may cause females to be able to provide more effective support to survivors of sexual trauma while maintaining their emotional state and professional boundaries. Furthermore, many women are more familiar with sexual trauma due to the high prevalence of female

survivors. According to the National Sexual Violence Resource Center (2015), one in five women and one in seventy-one men will be raped at some point in their lives. This stark difference in victimization rates could impact the competence of church leaders addressing sexual trauma, leading to higher female competence.

Denomination once again emerged as a significant factor in addressing competence. However, the denominations that surfaced as significant were not the same as those that surfaced for confidence. First, the Evangelical Free Church was identified as a significant positive predictor of church leaders' competence in addressing sexual trauma. When evaluating the possible explanations of this result, the vast number of resources for mental health issues, including human trafficking, crisis response, and trauma developed and dispersed by the Evangelical Free Church of America may have played a significant role. As church leaders in this denomination are hearing from their superiors about these topics, their awareness and understanding is increased. Additionally, this denomination provides educational opportunities, training and real-life stories that can be utilized for helping leaders and church members become more competent in addressing sexual trauma. On the other hand, Pentecostal denomination was found to be a significant negative predictor of church leaders' competence in addressing sexual trauma. This finding could be credited to their belief that sickness, suffering, and oppression are manifestations of sin and/or demonic activity which guides their mission to heal and deliver them from that sin and/or demon (Allison, 2020). These beliefs may cause revictimization as survivors are met with spiritualized trauma beliefs and individuals that reject typical trauma-informed practices.

The present study's findings point to a disconnect between the confidence and competence of church leaders in addressing sexual trauma. This disconnect is a concerning

finding as inadequate training and response from church leaders can have long-lasting, detrimental effects on survivors. Research continually supports the notion that without proper support, survivors experience heightened symptoms of Post Traumatic Stress Disorder (PTSD) (Ahrens & Aldana, 2012; Brenner & Ben-Amitay, 2015; Substance Abuse and Mental Health Services Administration, 2014). Therefore, the mission of equipping church leaders with the necessary knowledge and skills to effectively support survivors of sexual trauma is paramount and enhances the support the church provides within their communities.

Implications

This research into the confidence and competence of Midwest church leaders in addressing survivors of sexual trauma holds wide implications for counseling, ministry, and trauma-informed response. First is the prevalent call for Christians to care for the hurting and the broken as outlined in Galatians 6:2 (New International Bible, 1978/2011). The research also highlights the vital role that churches play as community care providers. This role is especially important for supporting minority populations that may underutilize traditional mental health services but are open to religious leaders (Allen et al., 2010; Coombs et al., 2022; Derose & Rodriguez, 2020; Hankerson & Weissman, 2012; Hays, 2015). The church is situated as a key community support that can provide for survivors of sexual trauma, specifically those who turn to religious settings for support over traditional settings. First, the church is a place where one can experience connection, community, and shared values. This connection can increase trust and allow for individuals who feel unsafe opening up to counselors or community services, to be comfortable asking for help in their church setting. Second, churches are a place of diversity and therefore, individuals can find a church that meets their needs and has people that they can relate

to. Third, churches are a hub that people can find suitable referrals throughout the community and through the connections made with other members.

In addition to providing services to those who are hesitant to use traditional avenues of support, churches have a powerful role in providing mental health services to minority populations (Sualp et al., 2021). Research shows that Black sexual assault survivors often experience fear and intimidation when receiving services at community-based mental health facilities (Allen et al., 2010; Bryant-Davis et al., 2015). For minority populations that tend to be more religious, such as Latino populations, the church can become a safe setting where they can bring up their past traumas and receive the care and support they need (Derose & Rodriguez, 2020). Furthermore, Iheanacho et al. (2021) found that females who are experiencing depression prefer to receive therapy from trained clergy which echoes the need for church-based mental health programming. Overall, the church can stand in the gap by providing safe services to those who are hesitant or minorities in need of support (Allen et al., 2010; Bryant-Davis et al., 2015; Coombs et al.; Derose & Rodriguez, 2020; 2022; Sualp et al., 2021; Hays, 2015; Iheanacho et al., 2021). Church leaders have continually evolved to meet the needs of their congregation; from the pulpit, to physical health concerns, and now to mental health concerns. As churches continue to meet the needs of society, many programs and services have been built to fill the gap. Church mental health programs have been developed and their effectiveness assessed, demonstrating positive outcomes (Berkley-Patton et al., 2021; Hankerson & Weissman, 2012; Laverne et al., 2014). Additionally, church-based programs can help bridge racial disparities regarding accessing mental health services (Hankerson & Weissman, 2012).

The current study highlights the potential for increased collaboration between church leaders and mental health professionals in order to bridge the care gap between pastoral care and

trauma-informed counseling. These collaborations could encompass a robust referral process, joint training programs, and the development of support networks that allow for more comprehensive care for survivors within the church context. The implementation of a mental health committee within the church is an option for delegating individuals who are responsible for addressing mental health awareness and programming into the congregation (Williams et al., 2014). This committee can help leaders in bridging the gap between the church and its congregants by identifying and addressing mental health needs.

This research positions itself in the field of traumatology, specifically advocating for high standards within the institutions that are directly working with survivors of sexual trauma. Trauma-informed organizational environments significantly improve various aspects of well-being while also decreasing concurrent disorder behaviors (Mihelicova et al., 2015; Shier & Turpin, 2022; Sweaney et al., 2018; Unick et al., 2019). As institutions, like churches, become trauma-informed, the support provided to survivors can be more positively impactful. This shift to trauma-informed institutions includes not only a knowledge of trauma but also action that transforms the organizational culture (DeCandia et al., 2014; SAMHSA, 2014). Research, like the current study, regarding the trauma-informed practices of institutions allows for targeted support in order to increase the response of institutional trauma informed care. The existing research on churches and trauma-informed care is limited and therefore, this research adds to the discussion on trauma-informed practices within religious settings, advocating for an informed approach to supporting survivors no matter the setting they are in. As evidenced in this study, trauma-informed care is complicated to implement and doing so in unique institutions, like churches, poses many more challenges. Careful considerations must be made to fully understand the nuances of these institutions, build relationships that allow for a transformation to trauma-

informed practices, and develop policies and procedures that are reflective of the values of the institution while incorporating trauma-informed care.

Trauma Training

The significant positive impact of trauma training on leaders' confidence underscores the importance of continuous education and the integration of specialized trauma care training within theological education and ministry preparation programs. This aligns with previous research indicating the benefits of trauma-informed care training in improving outcomes for trauma survivors (Chaddock & McMinn, 1999; Hodge et al., 2020). Having church leaders that are confident to handle trauma when approached is foundational to providing care. Therefore, adequate trauma-informed training needs to be available for church leaders (Crosby et al., 2021). When church leaders are not adequately equipped, survivors are harmed (Ahrens & Aldana, 2012; Brenner & Ben-Amitay, 2015; Smith & Freyd, 2013). Therefore, it is essential that churches have a basic understanding of trauma and uses that to guide and reflect upon their religious practices and responses which is the basis of trauma-informed care in churches (Streets, 2015)

Elements of Effective Trauma Training

In order to see the implementation of trauma informed care in churches, the core components of trauma training need to be developed. First, church leaders need to understand trauma. This includes understanding the types of trauma, the holistic impact it has on the survivor, and the long-lasting effects that the survivor is living with. Second, trauma-informed practices need to be established within the church. This includes safe spaces where survivors can

talk about hard things (Rudolfsson & Tidafors, 2015). Survivors have reported that a safe place to express their spiritual doubts and emotions without being rushed toward forgiveness is key in their healing. Many survivors struggle with their spirituality after a traumatic experience, and therefore, church leaders need to accept that this is a concern and be ready to support the survivor through it (Rudolfsson & Tidefors, 2014). Additionally, teaching church leaders active listening skills and helping them avoid revictimization can increase trust between survivors and church leaders. Third, a set of initial guidelines within the church for handling disclosures and referring to outside help can relieve decision fatigue in church leaders. When approached by a survivor, many church leaders feel ill-equipped, therefore, a plan in place can increase confidence and ensure consistent care throughout the institution (Zust et al., 2017). Additionally, survivors said they want church leaders to acknowledge when they have reached their limits and refer them to an expert when necessary (Fortune, 2002; Rudolfsson & Tidefors, 2015). Fourth, when dealing with survivors of trauma, church leaders need to be aware of self-care practices. Church leaders take on many different roles in their institution and in the community. Therefore, without maintaining professional boundaries, the integrity of the church leader decreases, and they are no longer able to provide the best care for survivors (Hendron et al., 2012). Lastly, Partnerships with mental health professionals can help pastors understand the roles and limitations of survivors.

Integration into Training Programs

Once a trauma-informed training is developed that meets the unique needs of the church, these trainings need to be disseminated properly for church leaders to access. Previous research has shown that the best way to get backing within churches is building authentic relationships

with the lead pastor and providing flexible options (Coombs et al., 2022; Grudem, 2020; Hays, 2015; Williams et al., 2014). This will allow for increased usage across denominational and regional lines.

Additionally, this training should become standard in universities and training programs that are endorsing and equipping church leaders. At the time there is no ethical standard on trauma training and response for church leaders (Fleenor et al., 2022). This leaves church leaders in a predicament when they have expectations to help the hurting but no tangible resources to do so.

After initial training, ongoing evaluation and training is crucial. As evidenced by the significant finding of younger generations having higher confidence and competence in addressing trauma, the trauma-informed research is ever-growing and shifting. Unick et al. (2019) concluded that for an organization to be trauma-informed ongoing training is necessary and needs to include experiential aspects to help in the understanding and application of what they are learning.

Addressing Challenges and Opportunities

The implementation of trauma training in the church setting has many obstacles. First, churches have historically been unstandardized, each having the independence to do as they please in regards to services, training, hiring, and programing. Each denomination has their own belief system, practices, policies, and procedures making it difficult to implement a wide-reaching trauma-informed training that churches will adopt. Additionally, many church leaders have held their place of authority for many years, therefore, implementing training at the theological university level will take many years to reach saturation throughout American

churches. Lastly, equipping leaders who are qualified to teach trauma-informed response and culturally sensitive to the nuances of religious settings may be complex. Having enough of these trainers that are accessible, even to rural churches, would pose financial challenges and logistical challenges. Nonetheless, solutions such as seeking grants, developing online modules for training that can be flexible to the needs of each denomination, and partnering with local mental health professionals can help alleviate the burden of trauma-training implementation.

The Call To Action

Overall, this current research is calling for action as church leaders are addressing survivors of trauma regularly while remaining unequipped and unsure about how to best support this population. While the implementation of trauma-informed trainings within church settings is a large undertaking that will have many unforeseen challenges, survivors deserve support that allows them to have validation, control, and confidentiality within a trauma-informed space (Munro-Kramer et al., 2017; Ranjbar & Speer, 2013). This effort will take time, effort, and resources; however, it is clear that trauma-informed organizational environments significantly improve self-awareness, outlook, coping ability, self-worth, and self-determination (Shier & Turpin, 2022; Sweaney et al., 2018; Unick et al., 2019). Implementation of trauma-informed training benefits not only the survivor but the church and the community as a whole.

This research calls attention to the critical role that churches play in the broader field of community care and counseling, especially for underserved populations. While many communities lack resources for survivors, churches are abundant, even in rural areas. Many churches have large buildings that can be used, providing flexibility in services and churches are open hours and days that traditional mental health services are unavailable. Furthermore, the

church already has the trust of many minority populations which positions the church as a place of influence in expanding needed services to these populations. Churches have a unique vantage point of being able to address clients from a holistic point of view providing mental, physical, and spiritual care to survivors. They often build trusting relationships through church-related activities that can provide valuable, lasting support to survivors.

Henceforth, community care should consider religious institutions as a vital resource and be making efforts to connect, equip, and support churches in helping survivors. Lastly, the study emphasizes the Christian responsibility to care for those in need. By integrating trauma-informed practices and fostering collaboration with mental health professionals within the community, churches can become a holistic support for survivors and fulfill their mission of caring for the hurting and sharing the love of Christ within their communities.

Limitations

Research, by its very nature, has flaws and room for future evaluation. Therefore, this current study is subject to further evaluation regarding the limitations that are present. This study focused on the competence and confidence of church leaders in the Midwest when addressing survivors of sexual trauma. The research aims to address the limitations while highlighting the meaningful insights that are present in the findings. Understanding the limitations of the study is crucial for the integrity of the study. Additionally, the limitations set the stage for future research that can mitigate the limitations that emerged in this research. This section aims to dissect the limitations that were encountered, particularly those affecting the internal and external validity. These limitations are central to understanding the scope of the research conclusions and the extent to which these findings can inform practice and future studies.

Internal validity is concerned with the rigor of the study's design and the extent to which the research methodology allows for accurate findings. In this study, internal validity was primarily safeguarded through the systematic application of statistical controls, including the management of Type 1 and Type 2 errors via a predetermined significance level ($\alpha = 0.05$). This significance level was outlined in the methodology of Chapter 3 and is designed to minimize the probability of incorrectly accepting or rejecting the null hypotheses, thereby enhancing the reliability of the findings (Faul et al., 2007).

External validity, on the other hand, addresses the generalizability beyond the immediate context of the research study. This study focused on the population of Midwest church leaders and therefore, there are inherent limits to expanding the findings to other regions or institutions without caution. While the methodology of the study increases the internal validity of the given study, the demographic and geographical focus restricts the universality of its application. Consequently, while the findings have valuable insights, the relevance may be constrained to the given boundaries.

Specific Limitations Affecting Internal Validity

Maintaining internal validity within this study is directly impacted by the control of Type 1 and Type 2 errors. By setting the significance level at $\alpha = 0.05$, the study aimed to balance the risk of both Type 1 and Type 2 errors. Additionally, this study utilizes statistical power to calculate the necessary sample size. G*Power software facilitated this process and found a sample size of 213 participants necessary to achieve a power level of 80% (Faul et al., 2007). This study achieved 213 participants which enabled a robust statistical foundation that mitigated any errors.

Inversely, the reliance on self-report measures introduces the possibility of response bias despite the statistical measures employed (Warner, 2021). The use of the Readiness to Work with Trauma-Exposed Patients (RTEPS) as a primary measure assumes that the responses given by participants accurately reflect their confidence level when they are met with addressing a survivor of sexual trauma. Overall, the subjective nature of this measurement may impact the internal validity of the findings.

The study employed the Trauma-Informed Care Questionnaire (TICQ) and the Readiness to Work with Trauma-Exposed Patients (RTEPS) survey to assess competence and confidence, respectively. While these instruments are widely used and reliable in research, they may not fully capture the complex nuances of these constructs within the context of religious institutions. The TICQ, for example, focuses on broader aspects of trauma, originally designed for case workers, potentially overlooking the specific knowledge and skills necessary for addressing sexual trauma in a faith-based setting. Likewise, the RTEPS might not adequately capture the unique confidence factors when navigating the intersection of religious beliefs, pastoral care, and legal/ethical considerations surrounding sexual trauma. Therefore, future research could benefit from the development of competency and confidence measures tailored to the specific needs and context of church leaders in addressing sexual trauma.

Specific Limitations Affecting External Validity

The demographically and regionally defined group of Midwest church leaders allows for an in-depth exploration within the given population. However, it simultaneously restricts the ability to generalize the results to broader populations which poses a threat to the external validity of the given study. Firstly, the study's context of the Midwest is a unique region that

possesses its own cultural and organizational norms that differ from other areas across the United States. The unique aspects of this demographic may be apparent in the nuanced challenges that faith-based communities face in approaching trauma-informed care. The denominational beliefs and administrative structures apparent in this demographic may vary across regional and organizational lines, limiting the generalizability of the study.

Furthermore, the recruitment strategy for participants may have influenced the representativeness of the sample population. Although the research aimed to reach a diverse spectrum of church leaders that crossed gender, racial, denominational, state, and age lines, the possibility of selection bias remains (Warner, 2021). This bias may potentially skew the sample towards individuals with a particular interest in or prior awareness of trauma-informed care. Consequently, the findings might not accurately reflect the perspectives and experiences of church leaders in the Midwest as a whole, especially those who may not have the same level of knowledge or engagement with trauma-informed approaches.

Additionally, it is important to acknowledge that the sample size of 213 participants, while sufficient for conducting the required statistical analysis and obtaining statistical power, may not be entirely comprehensive in capturing the vast amount of viewpoints and experiences within the population of Midwest church leaders. A sample that is larger or more geographically diverse could potentially enhance the generalizability of the study's conclusions. This is particularly important because the current sample leans heavily towards a specific demographic. It comprised 127 males (59.60%) and 86 females (40.40%), with 84.50% identifying as White, followed by 14.10% Black and 1.40% Asian. This skewed demographic composition, particularly the overrepresentation of White males, raises concerns about the generalizability of the findings to the entire population of Midwest church leaders. The demographic skew in this

study may be attributed to the existing belief systems within many church communities regarding gender and leadership roles. Nevertheless, a more diverse sample encompassing individuals from various racial and ethnic backgrounds, as well as a more balanced representation of genders, would allow for deeper insights into the given research. Additionally, this may reveal complex relationships at play regarding gender dynamics and racial perspectives within the context of church leadership. This improved representativeness would strengthen the external validity of the current research study and give a more comprehensive understanding of the phenomenon.

Finally, it is important to note that the study focused solely on Midwest church leaders. This population has unique characteristics and contexts that may not be applicable to other religious sects, cultural background, or geographical regions. Therefore, attempting to directly translate the study's findings to different contexts would be inappropriate without further research and considerations of the complexities of those populations.

Mitigation Steps Taken

Several mitigation steps were taken to ensure that the limitations of this study were addressed. First, a detailed data screening process was conducted. Additionally, compliance with statistical analysis assumptions and procedures was prioritized to increase the internal validity of the current findings. The utilization of the Statistical Package for Social Sciences (SPSS) for data analysis ensured best practices. Furthermore, the Kolmogorov-Smirnov test of normality ensured the reliability of the statistical procedures employed (Faul et al., 2007). Additionally, careful consideration regarding the score of the study and the transparency of the methodology were developed with the intention of enhancing clarity and credibility in the research.

Despite these efforts, the potential for response bias, the lack of a representative sample, and other limitations could not be completely eliminated from the given study. These inherent limitations within the study highlight the importance of transparency in research to ensure the application of the study's findings are understood in light of the limitations.

Impact of Limitations on Study Findings

The identified limitations that are present in this study directly impact the interpretation and application of the findings. The results of the given study have valuable insight regarding the confidence and competence of church leaders addressing sexual trauma and the demographic factors at play. However, the limitations require a cautious approach to the generalizability of the findings. Reflecting on the study's results in the context of its limitations offers a thorough view of the complexity of this study. The non-significant relationship between the confidence and competence of church leaders in addressing sexual trauma within the given demographics examined builds a framework for understanding the trauma-informed church response to sexual trauma. The limitations related to sample representativeness and the specificity of the measures utilized suggest that additional factors, potentially beyond the scope of this study, may influence these outcomes.

The investigation into the demographic influence on confidence and competence contributes to the emerging body of literature on trauma-informed care within religious settings despite the limitations discussed. This body of research is enhanced by the study's findings and underscores the integral nature of competence and confidence among church leaders. Therefore, these results point towards the intersection of personal, professional, and contextual factors shaping the readiness of church leaders to address sexual trauma within their congregations.

Recommendations For Future Research

In evaluation of the results, implication, and limitations of this study, many possibilities arise for future research. Further work in this field should consider additional demographic considerations, qualitative approaches to research, the development of confidence and competence scales, and the consideration of technology's role in trauma-informed care.

The first recommendation for future research lies in the desire to see the exploration of the impact of additional demographic, regional, and denominational variables on the confidence and competence of church leaders in responding to survivors of sexual trauma. The current study lacked diversity in participants; therefore, subsequent studies can focus on the recruitment of a more diverse sample to gain a broader picture of the given phenomenon. Ultimately, this research would enhance the generalizability of the research.

Another area of limitations for this study included the lack of nuanced measures for trauma-informed confidence and competence in religious settings. Therefore, this limitation opens the opportunity for future development and validation of assessment instruments specifically designed for this complex intersection. The development of these tools should include elements indicative of a clear understanding of theological concepts, legal and ethical considerations, and the ability to navigate complex spiritual and psychological concerns inherent in addressing sexual trauma. Specialized measures that are tailored to this population will allow researchers to gain a more accurate and comprehensive understanding of the relationship between confidence and competence among church leaders. This granularity will make way for the development of more targeted and effective training and support interventions.

Additionally, findings surrounding denominational differences beg the question of whether being a part of that denomination leads to higher confidence or competence or if higher

confidence and competence leads people to choose that denomination. Research on this dynamic would give greater insight into the findings that were laid out in the current study. Another area of opportunity lies in the need for trauma training tailored specifically for church contexts. As discussed earlier, these trainings would empower church leaders to effectively support survivors and prevent revictimization. Due to the great impact that these trainings could have in equipping the church to be a vital source of support within the community, further research into effective training strategies for churches and the development of robust training programs have the potential to yield high results in the efforts of supporting survivors of sexual trauma. These efforts would not only provide tangible resources for churches but also increase the confidence of church leaders in their capacity to care for survivors of sexual trauma.

Deeper Analysis

The current research employed a quantitative design; nevertheless, future research would benefit from incorporating qualitative methodologies such as in-depth interviews and focus groups. This would allow the research to hear the lived experiences, personal narrative, and perspectives of church leaders making way for a deeper understanding of the phenomenon. Open-ended conversations with leaders allow one to delve into the motivations, challenges, and strengths that church leaders identify when supporting survivors of sexual trauma within their churches and communities. Understanding the subjective experiences of these leaders can pair well with the objective results of the given study to provide a deeper context and inform the development of more targeted support and training initiatives.

This study provides a snapshot of the current state of competence and confidence of church leaders. However, this is a phenomenon that is constantly shifting. Therefore, future

research could employ a longitudinal design to track changes that occur in these factors over time. By following a group of church leaders over an extended period, researchers can investigate how their competence and confidence evolve through various experiences, including the participation in training initiatives, encountering challenges in their ministry roles, and engaging with support networks and resources. This longitudinal approach can offer insight into the factors that contribute to the development and growth of confidence and competence in addressing sexual trauma. This insight can directly impact the development of effective interventions and support for church leaders.

Trauma-Informed Church Development

While this study shed light on the current state of church leaders' competence and confidence in addressing sexual trauma, a critical next step involves establishing a gold standard for trauma-informed policies and practices within religious communities. This gold standard would encompass comprehensive guidelines, protocols, and resources specifically tailored to the unique needs and contexts of faith-based environments.

Developing a standard for religious settings requires extensive research in order to identify and evaluate the best practices and ensure alignment with established trauma-informed care principles. This research should include collaboration with various stakeholders, including survivors, church leaders, mental health professionals, and researchers. In addition to the development of a gold standard, there is a critical need for the creation and implementation of standardized training programs and assessments specifically designed for church leaders. These training programs should be designed in such a way that church leaders are equipped with the knowledge, skills, and resources to confidently implement and uphold the established gold

standard within their congregations. Furthermore, the development and validation of reliable measurement tools would allow for ongoing monitoring and evaluation of the effectiveness of this gold standard to ensure that the policies and procedures are proving to be valuable to churches and survivors alike.

The prioritization of research in these crucial areas will assure the movement from understanding the current state to developing a comprehensive and evidence-based framework for supporting survivors within religious settings. This framework, grounded in a gold standard for trauma-informed care, paired with useful training and assessments, has the potential to significantly enhance the confidence and competence of church leaders responding to survivors of sexual trauma. This in turn, will provide a safer and more supportive environment for all who look to the church or support.

Trauma-Informed Institutions

Given the vitally important need to have trauma-informed support across various institutions, it is imperative that future research endeavors expand beyond the church context to include leaders from a wide spectrum of institutions, such as educational settings (grade schools and universities), healthcare facilities, law enforcement agencies, and support services (shelters, housing services, and domestic violence shelters). This expanded focus would provide comprehensive insights into the current state of institutional response to survivors of sexual trauma. Additionally, this research would give a deeper understanding of the diverse settings and the readiness of those settings to implement trauma-informed care which can inform the development of training, policies, and procedures. Survivors of sexual trauma deserve the best care available no matter the first contact. This comprehensive approach would significantly

improve the body of literature surrounding trauma-informed institutions, paving the way for a more cohesive and effective response to survivors of sexual trauma.

Summary

Chapter five has explored the findings that emerged from the research on the confidence and competence of Midwest church leaders when addressing survivors of sexual trauma. The findings reveal that leaders generally possess a basic understanding of sexual trauma and have a willingness to help, however, their confidence and competence levels are not up to par. This variation highlights the need for further exploration and support within this population.

However, this study is not without limitations. The demographic focus narrowed in on Midwest church leaders which limits the generalizability of the findings to the regionally defined group. Additionally, the recruitment strategy allows for the introduction of response bias, potentially influencing the representativeness of the sample. Future inquiry could address these limitations by expanding to diverse denominations, geographic locations, and demographics within church leadership. The use of qualitative methodologies alongside quantitative measures may offer deeper insights into the lived experiences and perspectives of church leaders.

Regardless of the limitations outlined in this chapter, the study provides valuable insights with significant implications. Firstly, the findings emphasize the need for comprehensive and readily available training programs specifically designed to equip church leaders with the knowledge, skills, and resources necessary to respond to sexual trauma in a way that is benevolent and nonmaleficence. Secondly, the study underscores the importance of fostering open dialogue and collaboration within faith communities to create safe and supportive environments for survivors and build a culture of prevention.

Furthermore, this research paves the way for future exploration in several foundational areas. Expanding the study to include a diverse representation of races, genders, denominations, regions, and leadership roles can provide a comprehensive understanding of how various faith traditions address sexual trauma. The utilization of qualitative methods empowers the researcher to evaluate the unique experiences and perspectives of church leaders that is missed in quantitative research. The evaluation of online resources and training modules, alongside the analysis of ethical considerations of using technology in this context, can inform the development of innovative and accessible support for church leaders. Finally, the establishment of a gold standard for trauma-informed policies and procedures within religious communities is a cornerstone of building a comprehensive and evidence-based framework for supporting survivors of sexual trauma. This gold standard will include policies, procedures, training mechanisms, and assessment measures, ensuring a well-rounded approach to implementation.

The evaluation of limitations, exploration of implications, and active pursuit of further research avenues ensures the establishment of a more informed and empowered faith community that is equipped to address the complex challenges of sexual trauma with confidence and competence. This is an ongoing conversation that is paramount to the safety and well-being of all individuals within religious communities.

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Appendix A

Demographic Survey

Please provide the following information. Your responses are anonymous and will be used for research purposes only.

1. Personal Information:
   - Age: [Open-ended]
   - Gender: [Male, Female, Other, Prefer not to say]
2. Racial/Ethnic Background:
   - Please select your racial/ethnic background (check all that apply):
     - [ ] White
     - [ ] Black or African American
     - [ ] Hispanic or Latino
     - [ ] Asian
     - [ ] Native American or Alaska Native
     - [ ] Native Hawaiian or Pacific Islander
     - [ ] Other (please specify): _____
3. Denomination/Affiliation
   - What is your church denomination or affiliation? [Open-ended]
4. Ministry Experience:
   - Are you actively serving in a church at this time?
     -[ ] Yes
     -[ ] No
   - How many total years have you been engaged in ministry roles? [Open-ended]
   -Are you compensated for the role you have in the church?
     -[ ] Yes
     -[ ] No
5. Educational Background:
   - Please select your highest level of education:
     - [ ] No Formal Degree Earned
     - [ ] High School Diploma/GED
     - [ ] Associate's Degree
     - [ ] Bachelor's Degree
     - [ ] Master's Degree
     - [ ] Doctoral Degree
     - [ ] Other (please specify): _____
   - Please list the various trauma trainings you have had and the number of hours that training consisted of. [Open-ended]
   - Did any of your courses in your degree(s) contain information about trauma-informed care? If so, how many hours would you estimate was focused on that? [Open Ended]
7. Current Role:
   - What is your current role in the church or ministry? [Open-ended]
   - Does your role hold responsibility for the spiritual guidance of others?
     -[ ] Yes
     -[ ] No

9. Location
   -What State is your Church located in?
   - [ ] Illinois
   - [ ] Indiana
   - [ ] Michigan
   - [ ] Ohio
   - [ ] Wisconsin
   - [ ] Iowa
   - [ ] Kansas
   - [ ] Minnesota
   - [ ] Missouri
   - [ ] Nebraska
   - [ ] North Dakota
   - [ ] South Dakota
   - [ ] Other
10. Working with Survivors of Sexual Trauma
   -Have you ever provided support to or been approached for help by a survivor of sexual trauma?
   - [ ] Yes
   - [ ] No

Readiness to Work with Trauma-Exposed Patients (RTEPS)
Please rate each item on a 5-point scale (0 = completely disagree;1= disagree,2= neither agree, nor disagree, 3 = agree,4= completely agree).
Assessment
1. I can easily identify whether my client's experience can be described as traumatic.
2. I find it quite easy to identify if my client has posttraumatic stress disorder.
3. I know a sufficient number of tools (tests, scales, etc.) that I can use in order to assess the posttraumatic stress of my client.

Treatment
1. It is likely for me to be aware of how to help clients after identifying their posttraumatic stress symptoms.
2. I am quite confident that I have enough knowledge and skills to apply therapeutic methods for traumatized clients with posttraumatic stress disorder.
3. I am quite confident that I have enough knowledge and skills to help my clients with complex posttraumatic stress that is associated with severe or prolonged traumatization.

Affect tolerance
1. Talking with my clients about their traumatic experiences is very difficult for me.
2. Talking with my clients about their traumatic experiences is upsetting and troubling.
3. Talking with my clients about their traumatic experiences is eliciting hopelessness and helplessness in me.
4. I find it hard to cope with my clients' strong emotions, triggered by talking about their traumatic experiences.

Trauma-Informed Care Questionnaire (TICQ)
Please pick one response for the following questions:

1. What is traumatic stress?
    a. Physical and emotional responses of an individual to events that threaten the life or physical integrity of the child or someone critically important to the individual
    b. Post Traumatic Stress Disorder (PTSD)
    c. Acute stress in the individual
    d. Anxiety related to significant negative events that feel traumatizing
3. Which of the following statements are true?
    a. Nonfamily members are the mostly likely to abuse children
    b. Most perpetrators are unknown to their victims
    c. Children who are from lower income communities are significantly more likely to experience abuse
    d. Over half of child maltreatment cases occur with children who are under the age of five
4. Which statements are accurate about polyvictimization?
    a. Children are more likely to report it due to the severity
    b. More suffering is experienced than chronic single type victimization
    c. The signs of abuse are more obvious, and easy to investigate
    d. 85% of victims report an injury within the last year
5. What are the different types of traumatic stress?
    a. Chronic trauma
    b. Acute trauma
    c. Complex trauma
    d. All the above
6. What are some essential elements of trauma informed care?
    a. Increase sense of safety, help individual find meaning, coordinate services
    b. Case management, professionalism, stress management
    c. Building trust, social skills, healthy relationships
    d. Family interventions, healthy relationships, and positive change
7. Which of the following is not a way to maximize the individual's sense of safety?
    a. Assess one's perception of safety
    b. Establish protection orders
    c. Provide support and comfort
    d. Do not give the individual realistic information
8. What is a trauma reminder?
    a. The day the individual had the trauma
    b. When a victim is faced with people or situations that remind him of traumatic events
    c. When a counselor reminds the individual of the trauma
    d. When the victim is made to talk about the trauma
9. What can helping professionals do about cultural factors related to child abuse?
    a. Interpret results of assessments that consider cultural membership
    b. Adjust family interventions due to family identity
    c. Find caregivers who embrace the child's cultural identity

d. Learn appropriate trauma informed care techniques for specific cultures

10. Which of the following is true developmentally about young children who experience mistreatment?
    a. Uncertain about appropriate behavior
    b. Become passive, quiet and easily alarmed
    c. Children may isolate themselves
    d. Aggressive behavior may result as a defense mechanism
11. What are some ways helping professionals can address the impact of trauma?
    a. Discuss behavioral problems, offer coping strategies, team collaboration on secondary trauma
    b. Provide psychoeducation about trauma, discuss family interventions, build self esteem
    c. Adjust negative thought patterns, fears and strengthen social support system
    d. Identify strengths, decrease stress, impulse control
12. What are questions to ask mental health providers when making a referral?
    a. How are cultural competency addressed?
    b. Is there clinical supervision and on-going training?
    c. Is the agency familiar with evidence-based treatment?
    d. All the above
13. What are some important elements of comprehensive assessments of child trauma?
    a. Be aware of only essential key traumatic events
    b. Share details with caregivers
    c. Learn about protective factors
    d. Assess for high levels of anxiety
14. Support and guidance to the child's family and caregivers should include which of the following?
    a. Help them find mutual support
    b. Assist caregivers get support for their trauma experiences
    c. Empower families to set goals for themselves
    d. All the above
15. What are common sources of secondary trauma?
    a. Lack of self care
    b. Investigating vicious abuse or neglect
    c. Years of experience with mistreatment cases
    d. Witnessing exasperated trauma
16. Teenagers who run away from home:
    a. Are often drug abusers looking for more drugs
    b. May be fleeing an incredibly abusive situation
    c. Do not want help at all
    d. Do not qualify for services from a child advocacy center
17. Which of the following is true about children who experience trauma.
    a. Child traumatic stress reactions are the same regardless of developmental stage.
    b. Children expend a great deal of energy responding to, coping with, and coming to terms with the event.
    c. There are generally no disruptions to mastering developmental tasks.
    d. The longer traumatic stress goes untreated, the better the development of the child

Appendix B

FIU IRB Approval# 13—0207 5/30/13

Date:

Trauma Informed Care Questionnaire

Developed by: Maureen C. Kenny, Ph.D.

All questions contained in this questionnaire are strictly confidential and will be used for research purposes only.

Code: Since we may ask you to complete this questionnaire again in the future, it will be necessary to create a code that you can use so that your first survey responses can be connected to your second survey responses. Please create a personal code with the following information. Your name will not be connected with this code or any of your responses on this survey.

Example: You are 25 years old, born in November and your phone number ends in 7777. Your Code would be:

2	5	1	1	7	7	7	7
Age		Numbers of birth month (use 01, 02, etc.)		Last 4 digits of phone #			

Please create your Code:

Age		Numbers of birth month (use 01, 02, etc.)		Last 4 digits of phone #			

I. Personal Information **Age:**

Gender: ☐ M ☐ F

Race/Ethnicity:

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American (not of Hispanic origin)
- ☐ Hispanic or Latino
- ☐ White or Caucasian (not of Hispanic origin)
- ☐ Other _____

Highest Degree Attained:

- ☐ High School Diploma/Equivalent
- ☐ Associate of Arts (AA)/ Associate of Science (AS)
- ☐ Bachelors (BA/BS)
- ☐ Graduate Degree (MA/MS/EdD/PhD)

What is your primary language?

☐ English ☐ Spanish ☐ Creole ☐ Other _____

How often does your agency provide professional development training? (e.g. in-service training).

☐ Never/Rarely ☐ Once a year ☐ Twice a year ☐ More than twice a year

Have you had any prior Trauma Informed Care training?

☐ Yes ☐ No

How many years have you worked for the Child Advocacy Center?

☐ Less than 1 year ☐ 1-5 years ☐ 5-10 years ☐ 10-20 years ☐ More than 20 years

What is your current position at your site?

- ☐ Case manager
- ☐ Receptionist/Secretarial
- ☐ Support Staff
- ☐ Security Officer
- ☐ Transportation/Driver
- ☐ Other_____

- ☐ Multidisciplinary partner (circle one)
  - *CPC
  - *Law enforcement
  - *Guardian Ad item
  - *State Attorney's office

Part II. Please pick one response for the following questions:

1. What is child traumatic stress?
   a. Physical and emotional responses of a child to events that threaten the life or physical integrity of the child or someone critically important to the child
   b. Post Traumatic Stress Disorder (PTSD) in children
   c. Acute stress in children
   d. Anxiety related to significant negative events that feel traumatizing

2. Approximately how many victims of child maltreatment were there in 2011?
   a. 1,000,000
   b. 206,000
   c. 681,000
   d. 530,000

3. Which of the following statements are true?
   a. Nonfamily members are the mostly likely to abuse children
   b. Most perpetrators are unknown to their victims
   c. Children who are from lower income communities are significantly more likely to experience abuse
   d. Over half of child maltreatment cases occur with children who are under the age of five

4. Which statements are accurate about polyvictimization?
   a. Children are more likely to report it due to the severity
   b. More suffering is experienced than chronic single type victimization
   c. The signs of abuse are more obvious, and easy to investigate
   d. 85% of victims report an injury within the last year

5. What are the different types of traumatic stress?
   a. Chronic trauma
   b. Acute trauma
   c. Complex trauma
   d. All the above

6. What are some *essential* elements of trauma informed care?
   a. Increase sense of safety, help child find meaning, coordinate services
   b. Case management, professionalism, stress management
   c. Building trust, social skills, healthy relationships
   d. Family interventions, healthy relationships, and positive change

7. Which of the following is not a way to maximize the child's sense of safety?
   e. Assess child's perception of safety
   f. Establish protection orders
   g. Provide support and comfort

h. Do not give the child realistic information

8. What is a trauma reminder?

a. The day the child had the trauma
b. When a child victim is faced with people or situations that remind him of traumatic events
c. When a counselor reminds the child of the trauma
d. When the child victim is made to talk about the trauma

9. What can helping professionals do about cultural factors related to child abuse?

a. Interpret results of assessments that consider cultural membership
b. Adjust family interventions due to family identity
c. Find care givers who embrace the child's cultural identity
d. Learn appropriate TIC techniques for specific cultures

10. Which of the following is true developmentally about young children who experience mistreatment?

a. Uncertain about appropriate behavior
b. Become passive, quiet and easily alarmed
c. Children may isolate themselves
d. Aggressive behavior may result as a defense mechanism

11. What are some ways helping professionals can address the impact of trauma?

a. Discuss behavioral problems, offer coping strategies, team collaboration on secondary trauma
b. Provide psychoeducation about trauma, discuss family interventions, build self esteem
c. Adjust negative thought patterns, fears and strengthen social support system
d. Identify strengths, decrease stress, impulse control

12. What are questions to ask mental health providers when a making a referral?

a. How are cultural competency addressed?
b. Is there clinical supervision and on-going training?
c. Is the agency familiar with evidence-based treatment?
d. All the above

13. What are some important elements of comprehensive assessments of a child's trauma?

a. Be aware of only essential key traumatic events
b. Share details with caregivers
c. Learn about protective factors
d. Assess for high levels of anxiety

14. Support and guidance to the child's family and caregivers should include which of the following?

a. Help them find mutual support
b. Assist caregivers get support for their trauma experiences

c. Empower families to set goals for themselves
d. All the above

15. What are common sources of secondary trauma?

a. Lack of self-care
b. Investigating vicious abuse or neglect
c. Years of experience with mistreatment of children
d. Witnessing exasperated trauma

16. Teenagers who run away from home:

a. Are often drug abusers looking for more drugs
b. May be fleeing an incredibly abusive situation
c. Do not want help at all
d. Do not qualify for services from a child advocacy center

17. Which of the following is true about children who experience trauma.

a. Child traumatic stress reactions are the same regardless of developmental stage.
b. Children expend a great deal of energy responding to, coping with, and coming to terms with the event.
c. There are generally no disruptions to mastering developmental tasks.
e. The longer traumatic stress goes untreated, the better the development of the child

Part III.

18. Case Example: A 9-year-old child arrives for his appointment at the CAC. He is running around the waiting room and pulling things off the shelf and making a lot of noise. He is also making bullying comments to other children who are waiting for their appointments. What would be the best course of action?

a. Have the guard intervene
b. Physically restrain the child
c. Ask the child to join you for art work
d. Call the child's parent out of their appointment

Appendix C

Author Permission To Use TICQ

request for TIC measure

MK Maureen Kenny [redacted]
To Eryka McMillan

Reply | Reply All | Forward

Wed 8/30/2023 5:59 AM

2016 Implementation and program evaluation of trauma-informed care training.pdf
274 KB

TIC Measure (4).docx
29 KB

External Email

Your request was forwarded to me. I have attached the paper and the measure we used with scoring. Good luck with your research.

Maureen C. Kenny, Ph.D.
Professor, Associate Chair Academic Personnel and Diversity
Dept of Psychology
Florida International University
Miami, Florida 33199

Permission To Alter TICQ

RE: Request for Modification to TICQ Questionnaire for Research Study

MK Maureen Kenny [redacted]
To Eryka McMillan

Reply | Reply All | Forward

Wed 10/4/2023 12:14 PM

External Email

Your edits look fine. You have my permission to adapt the measure to fit your needs. Good luck.

Maureen C. Kenny, Ph.D.
Professor, Associate Chair Academic Personnel and Diversity
Dept of Psychology
Florida International University
Miami, Florida 33199

Appendix D

Consent

Title of the Project: The Confidence and Competence of Church Leaders in Addressing Sexual Trauma: A Quantitative Study of Midwest Church Leaders
Principal Investigator: Eryka McMillan, Doctoral Candidate, Department of Community Care and Counseling, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must meet specific criteria: You should hold leadership roles within a church, be located in the U.S. Midwest region, actively serve in your role, and have experience working with at least one congregant who has encountered trauma. Non-leadership roles within the church are excluded from participation. Your participation in this study is voluntary.

Please read this form and feel free to ask questions before deciding to participate.

What is the study about and why is it being done?

The purpose of this study is to investigate the confidence and competence of church leaders in addressing sexual trauma within their congregations. The study aims to understand how different demographic factors may influence church leaders' responses to survivors of sexual trauma. Your participation will contribute to the advancement of knowledge in this important field.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to complete a survey that includes questions about your demographic information, experiences working with survivors of sexual trauma, and your perceptions of confidence and competence in addressing sexual trauma. This survey will take approximately 30-45 minutes to complete.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study. Your participation will help advance our understanding of trauma responsiveness among church leaders, potentially leading to improved support for survivors of sexual trauma in faith-based communities.

What risks might you experience from being in this study?

The expected risks from participating in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

How will personal information be protected?

The records of this study will be kept private. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be anonymous.
- Data will be stored on a password-locked computer. After seven years, [all electronic records will be deleted.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time prior to submitting the survey.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please exit the survey and close your internet browser. Your responses will not be recorded or included in the study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Eryka McMillan. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at [redacted].

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the IRB. Our physical address is Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA, 24515; our phone number is 434-592-5530, and our email address is irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

Before agreeing to be part of the research, please be sure that you understand what the study is about. You can print a copy of the document for your records. If you have any questions about the study later, you can contact the researcher using the information provided above.

Appendix E

Recruitment Email

Dear Potential Participant,

As a doctoral candidate in the Department of Community Care and Counseling at Liberty University, I am conducting research as part of the requirements for a doctoral degree. The purpose of this study is to investigate the confidence and competence of church leaders in addressing sexual trauma within their congregations. The study aims to understand how different demographic factors may influence church leaders' responses to survivors of sexual trauma. I am writing to invite you to join my study.

Participants must meet specific criteria: you should hold leadership roles within a church, be located in the U.S. Midwest region, actively serve in your role, and have experience working with at least one congregant who has encountered trauma. Non-leadership roles within the church are excluded from participation. Participants will be asked to complete a survey that includes questions about your demographic information, experiences working with survivors of sexual trauma, and your perceptions of confidence and competence in addressing sexual trauma. This survey will take approximately 30-45 minutes to complete the procedure listed. Participation will be completely anonymous, and no personal, identifying information will be collected.

To participate, please click here (insert hyperlink to online survey) to complete the online survey.

A consent document is provided as the first page of the survey. The consent document contains additional information about my research.

Because participation is anonymous, you do not need to sign and return the consent document unless you would prefer to do so. After you have read the consent form, please click the button to proceed to the survey. Doing so will indicate that you have read the consent information and would like to take part in the study.

Sincerely,
Eryka McMillan
[redacted]

Social Media Recruitment

ATTENTION CHURCH LEADERS: I am conducting research as part of the requirements for a Community Care And Counseling Doctoral Degree at Liberty University. The purpose of my research is to investigate the confidence and competence of church leaders in addressing sexual trauma within their congregations. The study aims to understand how different demographic factors may influence church leaders' responses to survivors of sexual trauma. To participate you should hold leadership roles within a church, be located in the U.S. Midwest region, actively serve in your role, and have experience working with at least one congregant who has encountered trauma. Non-leadership roles within the church are excluded from participation. Participants will be asked to complete a survey that includes questions about your demographic

information, experiences working with survivors of sexual trauma, and your perceptions of confidence and competence in addressing sexual trauma. This survey will take approximately 30-45 minutes to complete. If you would like to participate and meet the study criteria, please click here (include hyperlink to online survey). A consent document is provided as the first page of the survey. Please review this page, and if you agree to participate, click the "proceed to survey" button at the end.

Appendix F

Letter From IRB

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

December 4, 2023

Eryka McMillan

Debra Perez

Re: IRB Exemption - IRB-FY23-24-682 The Confidence and Competence of Evangelical Church Leaders in Addressing Sexual Trauma: A Quantitative Study of Midwest Church Leaders

Dear Eryka McMillan, Debra Perez,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under the following exemption category, which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:104(d):

Category 2.(i). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:

The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects;

Please note that this exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us at irb@liberty.edu.

Sincerely,

G. Michele Baker, PhD, CIP

Administrative Chair

Research Ethics Office

Appendix G

Table 1
Sociodemographic Characteristics of Participants

Characteristic	*n*	%
Gender		
Male	127	59.60
Female	86	40.40
Race		
White	180	84.50
Black	30	14.10
Asian	3	1.40
Denomination		
Assembly of God	3	1.40
Baptist	100	47.40
Catholic	2	.90
Christian Church	13	6.20
Episcopal	5	2.40
Evangelical Free Church	4	1.90
Methodist	18	8.50
Non-Denominational	36	17.10
Pentecostal	4	1.90
Presbyterian	26	12.30

Note. $N = 213$ (for denomination $N = 211$).

Table 2
Means and Standard Deviations for Study Variables

Characteristic	*n*	*M*	*SD*
Age	212	45.52	14.26
Years of Ministry experience	211	18.57	12.62
Hours of training	213	22.98	47.83

Table 3

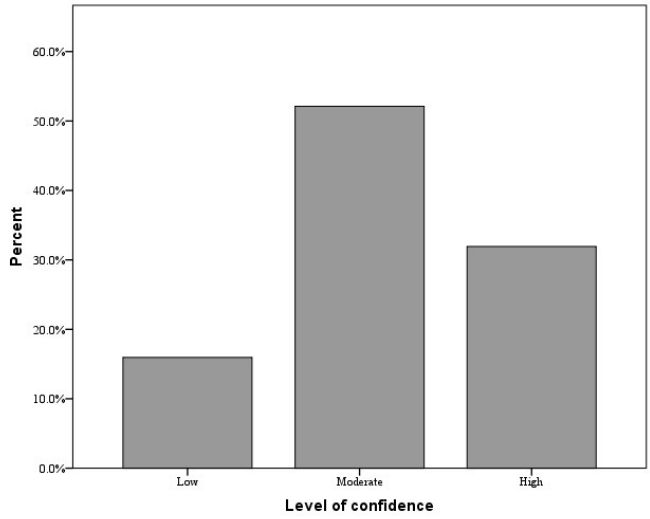
Means and Standard Deviations for Church Leader's Competence and Confidence in Addressing Sexual Trauma

Characteristic	*M*	*SD*
Church leader's competence in addressing sexual trauma	9.63	1.49
Church leader's confidence in addressing sexual trauma	22.52	5.94

Note. $N = 213$

Figure 1

Bar chart for Church Leader's Level of Confidence in Addressing Sexual Trauma



Note. The graph shows the church leader's level of confidence in addressing sexual trauma. The x-axis shows level of confidence (low, moderate, high), while the y-axis shows percent of participants.

Table 4
Relationship between Competency Level and Confidence

	1	2
3. Church Leader's Competence in Addressing Sexual Trauma	1	
4. Church Leader's Confidence in Addressing Sexual Trauma	.004	1

Note. $N = 213$.

Figure 2
Scatterplot for the Relationship between Competency Level and Confidence

Note. The graph shows the relationship between competency level and confidence. The x-axis shows church leaders' confidence in addressing sexual trauma, while the y-axis shows church leader's competence in addressing sexual trauma.

Table 5

Regression Analysis: Confidence Levels and Demographic Factors

Effect	Estimate	*SE*	95% CI		*p*
			LL	*UL*	
Constant	27.38	1.98	23.47	31.29	< .001
Race					
White	.65	1.25	-1.82	3.11	.606
Asian	-1.49	3.60	-8.59	5.61	.679
Gender					
Female	-1.09	.87	-2.81	.64	.215
Age	-.09	.03	-.14	-.03	.004
Years of Ministry Experience	-.03	.04	-.10	.04	.348
Hours of Training	.03	.01	.01	.04	.002
Denomination					
Assembly of God	8.13	3.47	1.28	14.98	.020
Baptist	-1.05	1.22	-3.45	1.35	.390
Catholic	-3.61	4.25	-11.99	4.76	.396
Christian Church	.43	1.97	-3.46	4.32	.828
Episcopal	-3.80	2.82	-9.37	1.76	.180
Evangelical Free Church	-2.29	3.10	-8.41	3.83	.461
Methodist	-.74	1.70	-4.09	2.61	.663
Pentecostal	.19	3.11	-5.94	6.32	.950
Presbyterian	-3.60	1.55	-6.65	-.55	.021

Note. N = 213. CI = confidence interval; *LL* = lower limit; *UL* = upper limit. Dependent variable: Church Leader's Confidence in Addressing Sexual Trauma

Table 6

Regression Analysis: Competence Levels and Demographic Factors

Effect	Estimate	*SE*	95% CI		*p*
			LL	*UL*	
Constant	10.54	.47	9.61	11.47	< .001
Race					
White	.31	.29	-.28	.90	.294
Asian	.54	.86	-1.15	2.24	.530
Gender					
Female	.62	.21	.21	1.03	.004
Age	-.02	.01	-.04	-.01	.003
Years of Ministry Experience	-.02	.01	-.03	.001	.065
Hours of Training	-.001	.002	-.01	.003	.759
Denomination					
Assembly of God	1.41	.83	-.22	3.05	.090
Baptist	-.35	.29	-.93	.22	.226
Catholic	.94	1.01	-1.06	2.93	.358
Christian Church	.35	.47	-.58	1.27	.464
Episcopal	.67	.67	-.66	1.99	.324
Evangelical Free Church	1.51	.74	.04	2.96	.044
Methodist	-.63	.41	-1.43	.17	.124
Pentecostal	-1.53	.74	-2.99	-.07	.040
Presbyterian	-.12	.37	-.85	.61	.749

Note. $N = 213$. CI = confidence interval; *LL* = lower limit; *UL* = upper limit. Dependent variable: Church Leader's Competence in Addressing Sexual Trauma

Table 7
Summary Results and Hypotheses

	DV: Confidence level		DV: Competence level	
Independent variable	**Hypothesis**	**Impact**	**Hypothesis**	**Impact**
Race	Null hypothesis 1a: not rejected	0	Null hypothesis 1a: not rejected	0
Age	**Null hypothesis 2a: rejected**	-	**Null hypothesis 2a: rejected**	-
Gender	Null hypothesis 3a: not rejected	0	**Null hypothesis 3a: rejected**	+
Denomination	**Null hypothesis 4a: rejected**	±	**Null hypothesis 4a: rejected**	±
Hours of training	**Null hypothesis 5a: rejected**	+	Null hypothesis 5a: not rejected	0
Years of ministry experience	Null hypothesis 6a: not rejected	0	Null hypothesis 6a: not rejected	0

Note. 0: non-significant; -: statistically significant negative; +: statistically significant positive. ±: mixed results (both positive and negative impacts reported)

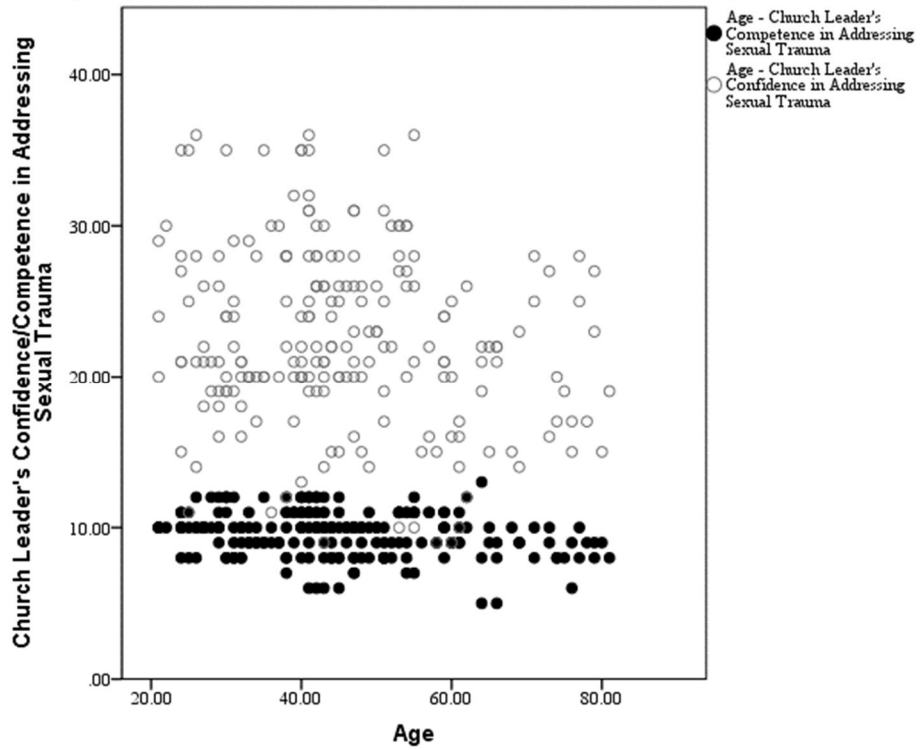
Table 8
Multivariate Analysis of Covariance (MANCOVA)

Effect	Wilks' Lambda	*F*	Hypothesis df	Error df	*p*	Partial η^2
Intercept	.14	514.57	2.00	180.00	< .001	.85
Age	.93	6.28	2.00	180.00	.002	.06
Years of ministry experience	.97	1.93	2.00	180.00	.147	.02
Hours of training	.94	5.27	2.00	180.00	.006	.05
Race	.99	.17	4.00	360.00	.951	.00
Gender	.96	3.45	2.00	180.00	.034	.03
Denomination	.77	2.78	18.00	36000	< .001	.12
Race * Gender	.98	1.40	2.00	180.00	.248	.01
Race * Denomination	.92	2.51	6.00	360.00	.022	.04
Gender * Denomination	.88	2.30	10.00	360.00	.012	.05
Race * Gender * Denomination	.93	2.10	6.00	360.00	.052	.03

Note. Dependent variables: Church leader's competence in addressing sexual trauma and church leader's confidence in addressing sexual trauma

Figure 3

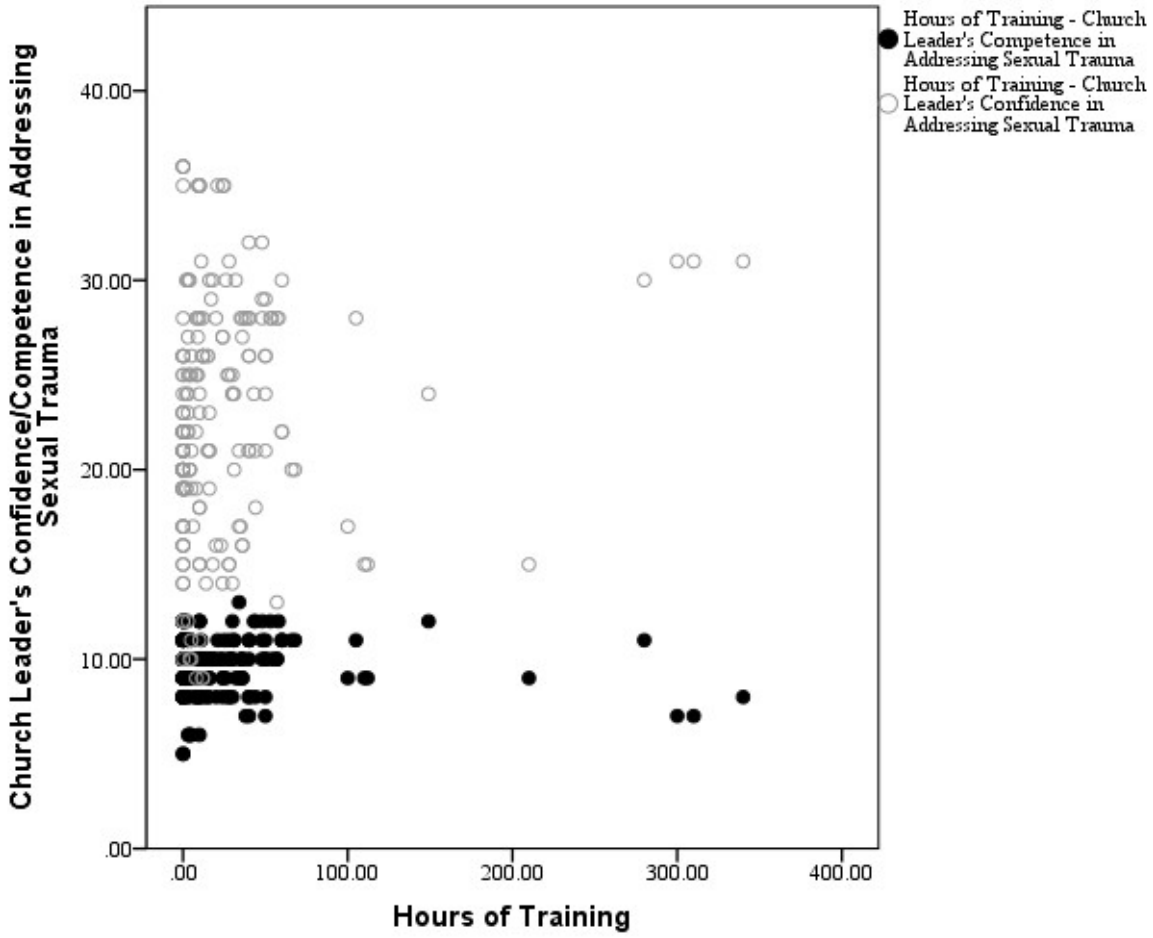
Scatterplot for the Relationship between Competency, Confidence, and Age



Note. The graph shows the relationship between competency, confidence, and age. The x-axis shows age, while the y-axis shows church leader's confidence and competence in addressing sexual trauma.

Figure 4

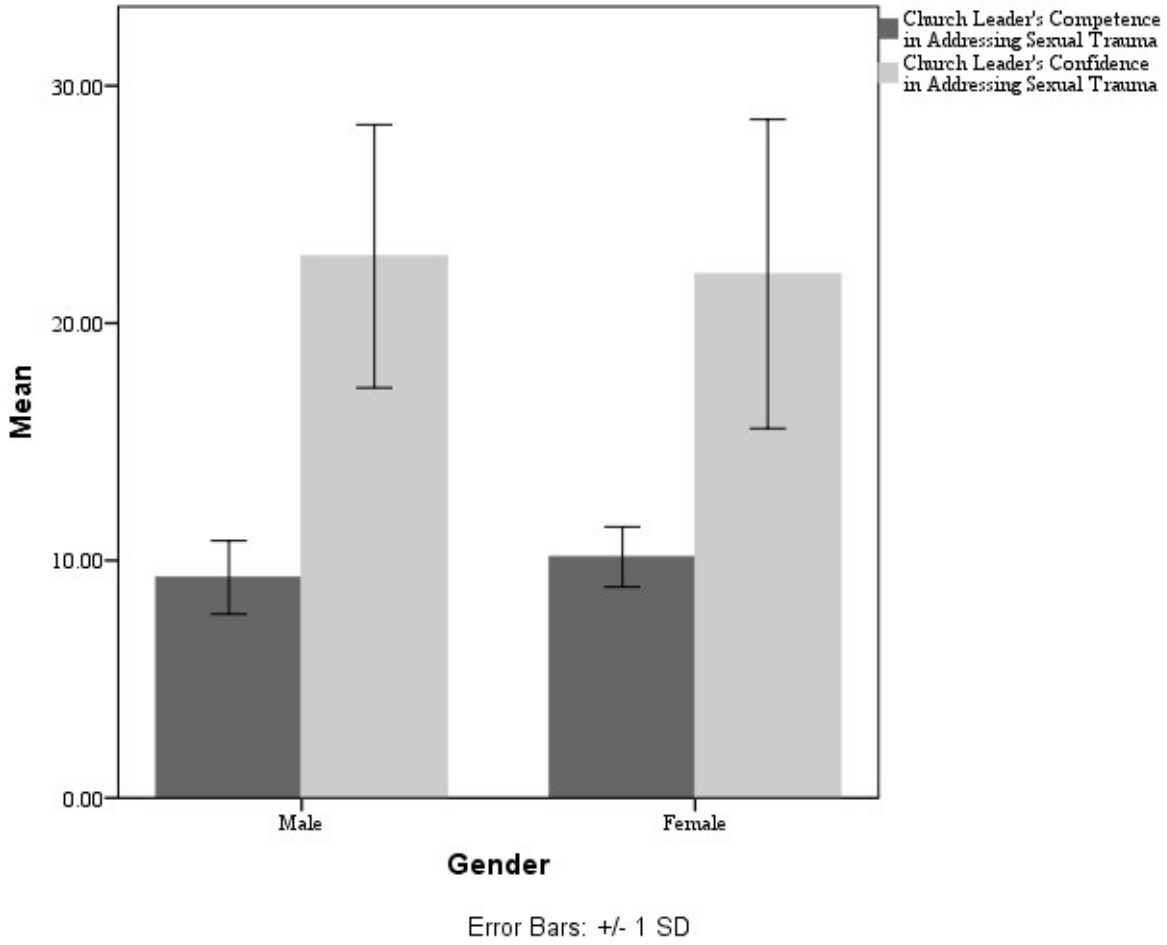
Scatterplot for the Relationship between Competency, Confidence, and Hours of Training



Note. The graph shows the relationship between competency, confidence, and hours of training. The x-axis shows hours of training, while the y-axis shows church leader's confidence and competence in addressing sexual trauma.

Figure 5

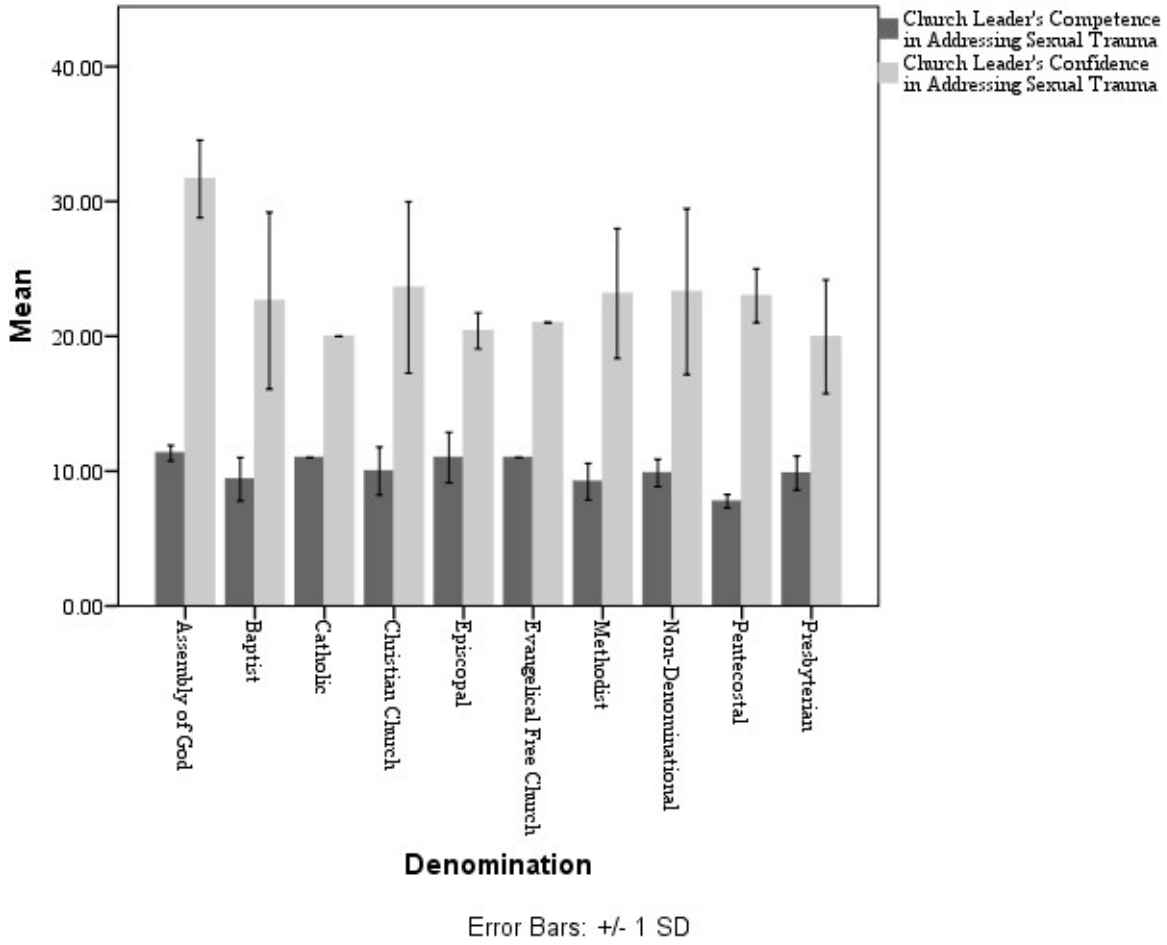
Bar chart for Competency and Confidence by Gender



Note. The graph shows church leader's confidence and competence in addressing sexual trauma by gender. The x-axis shows gender (male or female). The y-axis shows mean church leader's confidence and competence in addressing sexual trauma. Error bars show +/- 1 standard deviation.

Figure 6

Bar chart for Competency and Confidence by Denomination



Note. The graph shows church leader's confidence and competence in addressing sexual trauma by gender. The x-axis shows denomination. The y-axis shows mean church leader's confidence and competence in addressing sexual trauma. Error bars show +/- 1 standard deviation.

Table 9

Multivariate Analysis of Covariance (MANCOVA) – Tests of between Subjects Effects

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	*F*	*p*	Partial η^2
Corrected Model	Church Leader's Confidence in Addressing Sexual Trauma	2083.94	27	77.18	2.61	< .001	.28
	Church Leader's Competence in Addressing Sexual Trauma	137.40	27	5.08	2.75	< .001	.29
Intercept	Church Leader's Confidence in Addressing Sexual Trauma	7611.83	1	7611.83	257.68	< .001	.58
	Church Leader's Competence in Addressing Sexual Trauma	1353.04	1	1353.04	731.13	< .001	.80
Age	Church Leader's Confidence in Addressing Sexual Trauma	146.75	1	146.75	4.96	.027	.02
	Church Leader's Competence in Addressing Sexual Trauma	13.05	1	13.05	7.05	.009	.03
Hours of training	Church Leader's Confidence in Addressing Sexual Trauma	312.86	1	312.86	10.59	.001	.05
	Church Leader's Competence in Addressing Sexual Trauma	.13	1	.13	.07	.786	.002
Gender	Church Leader's Confidence in Addressing Sexual Trauma	11.02	1	11.01	.37	.542	.002
	Church Leader's Competence in Addressing Sexual Trauma	11.83	1	11.83	6.39	.012	.03
Denomination	Church Leader's Confidence in Addressing Sexual Trauma	872.35	9	96.92	3.28	.001	.14
	Church Leader's Competence in Addressing Sexual Trauma	37.76	9	4.19	2.27	.020	.10
Error	Church Leader's Confidence in Addressing Sexual Trauma	5346.67	181	29.54			
	Church Leader's Competence in Addressing Sexual Trauma	334.96	181	1.85			

Table 10

Kolmogorov-Smirnov Test of Normality Results

	Kolmogorov-Smirnov		
	Statistic	**df**	**p**
Church Leader's Competence in Addressing Sexual Trauma	.165	213	< .001
Church Leader's Confidence in Addressing Sexual Trauma	.089	213	< .001

Figure 7

Normal P-P Plot of Regression Standardized Residuals

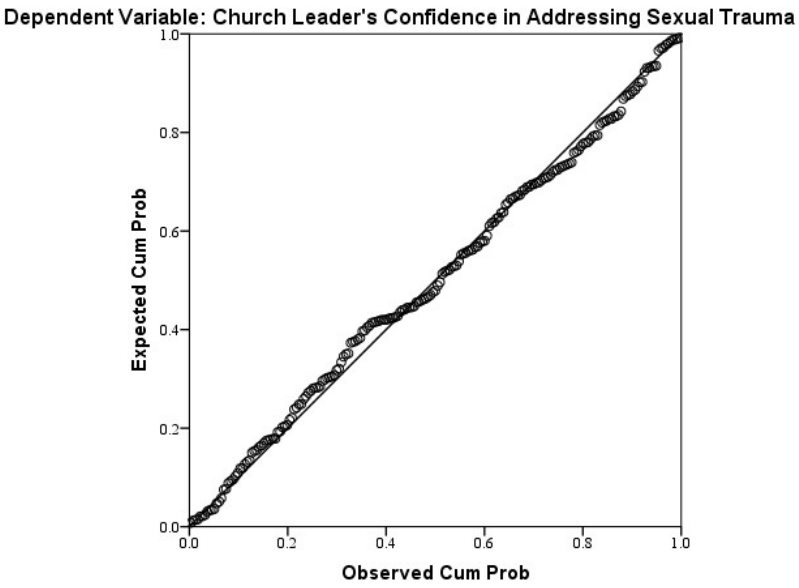


Figure 8

Normal P-P Plot of Regression Standardized Residuals