Bridging Faith and Restoration: A Phenomenological Study Exploring Evangelical Pastors' Experiences Ministering to Congregants with Trauma in the Greater Toronto Area

Lindsay Knox McVety

Department of Community Care and Counseling, Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

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Abstract

The purpose of this transcendental phenomenological study was to understand how evangelical pastors in the Greater Toronto Area describe their experiences with discussing trauma with congregants and their experiences with trauma-informed care in the church. The theory guiding this research is Transformative Learning Theory (TLT). As discussed by Mezirow (1991), TLT explains transformation occurs by increasing knowledge by learning about topics where outdated or misinformed concepts previously existed. The main research question is, how do evangelical pastors in the Greater Toronto Area describe their experiences ministering to congregants who have experienced trauma? Further sub-questions ask, how do evangelical pastors in the Greater Toronto Area describe the challenges faced when ministering to congregants who have experienced trauma? How do evangelical pastors in the Greater Toronto Area describe the strategies implemented when ministering to congregants who have experienced trauma? How do evangelical pastors in the Greater Toronto Area describe their experiences with trauma-informed care? The study's qualitative research design was transcendental phenomenology by Clark Moustakas (1994). Data was collected by in-depth, semi-structure interviews with 9 participants selected by a purposive, criterion sampling method. Data analysis was managed through bracketing, phenomenological reduction, imagination variation, horizontalization, coding, and the synthesis of meaning and essence of the data. Four themes emerged: "Theme 1: Experiences with Trauma", "Theme 2: "Understanding Trauma", "Theme 3: Challenges", and "Theme 4: Strategies." The implications of the study apply to evangelical pastors, the church, researchers on trauma-informed care, Mezirow's (1991) TLT, and mental health professionals.

Keywords: Trauma-informed care, evangelical pastors, transformative learning theory, trauma, the church

Dedication

First and foremost, I dedicate this work to God for guidance throughout my education journey. Your influence has infused every aspect of this work, from the genesis of its topic to the depths of my pursuit for knowledge in systems close to my heart.

To my cherished son, Maverick, you were considered at every stage of this research, and most thoughtfully when considering how to possibly improve future systems which may impact your development and experience. It is my heartfelt wish that the findings of this study may contribute positively to your life's path.

My heartfelt appreciation extends to my beloved family and friends, whose boundless support has made this academic odyssey possible. Special recognition is reserved for my husband, whose unwavering encouragement and adaptability have been instrumental in navigating the twists and turns of this pursuit. I am deeply appreciative of my collogues for the constant support throughout this process.

I extend profound thanks to my esteemed mentors and dissertation committee at Liberty University for their invaluable guidance and expertise, which have shaped this work into its current form.

Acknowledgments

I wish to extend a heartfelt acknowledgment to the participants of this study. Your willingness to share your experiences has been instrumental in enriching the counseling field, exemplifying the essence of collaboration and progress. I deeply honor your dedication to serving others and providing spiritual leadership within your communities. It is my sincere prayer that this study will aptly reflect your steadfast commitment to embodying the teachings of Christ in your ministries.

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List of Abbreviations

CRPO – The College of Registered Psychotherapists of Ontario

GTA – Greater Toronto Area

HPA – Hypothalamic-Pituitary-Adrenal

IRB – Institutional Review Board

PTSD – Post-Traumatic Stress Disorder

QDAS – Qualitative Data Analysis Software

RSA – Respiratory Sinus Arrhythmia

SES – Social Engagement System

TIC – Trauma-Informed Care

TLT – Transformative Learning Theory

Chapter 1: Introduction

Humanity has been riddled with issues related to mental health and spiritual health since the beginning of man's time on earth, first dealing with issues of loneliness followed by issues related to power and control. However, the field of psychology developed much later than the beginning of humanity, dating to the late 1800s, beginning with research such as the controversial psychological experiments by Wilhelm Wundt, known as one of the fathers of modern psychology (Danziger, 1994; Rieber & Robinson, 2012). As those in mental health circles began to take part in the conversation about healing and trauma, practices were developed for professionals outside of the psychology field who work directly with individuals impacted by trauma. Workers without specific training in mental healthcare who aid in trauma care are called paraprofessionals (Kanel, 2018). These paraprofessionals who work with trauma include those working within the church in leadership roles such as pastors and care providers, including but not limited to childcare providers and youth or young adults' leaders. There remains a continued need for community-based approaches focused on care for trauma survivors. These trauma needs are addressed by implementing educational programs designed to help non-counseling professionals who seek to offer support. A greater understanding of the current level of care in churches has developed by looking into the lived experiences of evangelical pastors in the Greater Toronto Area (GTA) when discussing trauma with their congregants and the trauma care offered by their churches.

This chapter discusses trauma, trauma-informed care (TIC), and the church's historical, social, and theoretical backgrounds. First, I considered the historical background of trauma and mental healthcare within the church and identified the roles of evangelical pastors with their congregants. Then, I investigated the social context, highlighting the need and impact of social

support in the GTA for individuals who have experienced trauma. Lastly, the theoretical context was explored by discovering essential variables related to trauma survivors and the theoretical concepts of trauma. I outlined my motivation for conducting this study and my current philosophical assumptions. The research problem was stated, along with the purpose of this study and its significance. The two research questions and two sub-questions are explained, followed by definitions for the major topics addressed throughout this study. This chapter ends with a summary that transitions the focus from the foundation of the research into the literature review and theoretical framework of the study.

Background

First, trauma must be defined, along with the types of traumas, statistics and prevalence rates, and the multidimensional impact of trauma on both the survivor and those impacted by the survivor's experience. The literature on trauma is extensive, as a tremendous number of studies seek to understand the implications of trauma on society. The early attempts to define trauma led to many medical and legal controversies (Micale & Lerner, 2001). However, the recognition of post-traumatic stress disorder (PTSD) in 1980 laid the foundation for the concept and verbiage of trauma to exist (Micale & Lerner, 2001). Since this time, trauma rates have been further explored through studies on the various roles of trauma, crises, and stress. Data related to trauma rates and rates of revictimization guide trauma care practices and methods toward preventing further trauma by working through initial traumas (Duckworth & Follette, 2012).

Historical Overview

The concept of trauma has been evolving, yet it remains that there is no single definition for trauma that is agreed upon by all professionals in the field. Historically, trauma was deemed a rare occurrence. However, more recent research indicates that trauma is a ubiquitous experience

(Benjet et al., 2016; Christian-Brandt et al., 2019; Crosby et al., 2021; Dorflinger & Masheb, 2018; Friedman, 2015; Karstoft & Armour, 2022; Van Ameringen et al., 2008). With a fundamental goal to understand trauma, researchers in the field of psychology have investigated the impact, the various causes of trauma, and methods to process and recover from the symptoms of trauma (Bouchard et al., 2020; Covey, 2005; Karstoft & Armour, 2022). As mental health issues become mainstream and more visibly prevalent in society, a shift has occurred towards more accessible mental health care, an expansion of paraprofessional training, and a de-stigmatization of mental health needs (Bouchard et al., 2020; Covey, 2005; Weaver et al., 2019; Wesselmann & Graziano, 2010).).

Until recently, mental health remained a taboo topic in church settings. Historically, the church was a source of support for people in times of need, even though talks about psychology were not always welcome (Heward-Mills et al., 2018; Hill & Yancey, 2022; Nche & Agbo, 2022; World Vision International, 2021). Individuals dealing with mental health-related struggles often reach out to the church for support rather than seeking professional mental health counseling (Costello et al., 2021; Hardy, 2014; Hill & Yancey, 2022; Kane & Green, 2009; Weaver et al., 2019).

Research revealed a connection between mind, body, and spirit (Helmke et al., 2017; Hill & Yancy, 2022; Pargament et al., 2000; Vazquez et al., 2023). Care specializing in mental, spiritual, or physical health overlaps with each other, as this connection amongst the three areas is considerably strong (Helmke et al., 2017; Hill & Yancy, 2022; Pargament et al., 2000; Vazquez et al., 2023). The biopsychosocial spiritual model began opening the eyes of those involved in spiritual care, as it highlighted the need for more research on the role of spirituality (Anim et al., 2022; Engel, 1997; Saad et al., 2017; Sulmsay, 2002; Van Dened et al., 2022). TIC

is a methodological approach to offering care for trauma survivors in settings outside of the mental health field, such as in hospital settings or with childcare provider roles (Beck et al., 2022; Dennis et al., 2022; Gutowski et al., 2022). This type of care is integrated within these settings to simultaneously meet an individual's trauma needs while maintaining the organization's intended work (Beck et al., 2022; Dennis et al., 2022; Gutowski et al., 2022). Essentially, TIC methods offer an extra layer of support by organizations to intentionally help trauma survivors.

Social Overview

When individuals outside of the mental health care field, such as medical doctors and nurses, are equipped with TIC practices, those who have experienced trauma are better served (“What is Trauma-Informed Care?”, 2021). With this goal of better serving individuals with trauma exposure, church leaders and ministers can become better educated on TIC and equip themselves to work directly with the individuals in their congregations and communities. Practices that belong in the church include those that simply acknowledge trauma, see survivors’ needs, and implement practices that promote growth and healing.

The GTA is home to a diverse, multicultural population represented by people from all over the world, many being first- and second-generation Canadians. While many religious backgrounds are represented across the GTA, the 2021 census revealed that Christianity makes up 46.2% of the GTA population, a drop from 54.1% according to the 2011 census (Statistics Canada, 2013; 2023). The Christian churches in the GTA can serve the community well by helping improve the spiritual health and mental wellness of those living in the city and surrounding suburbs. Some churches staff social workers and counselors to work with their congregation. However, counselors credentialed by the College of Registered Psychotherapists of Ontario (CRPO) are limited when integrating the Christian faith into psychotherapy practice

due to the Regulated Health Professions Act (RHPA), which prohibits practitioners from using prayer or spiritual means in treatment (Registered Psychotherapists, Information, 2018). It is relevant that churches become equipped to serve not only the spiritual health but also the mental wellness of congregants at some level.

Theoretical Overview

One of the problems found when addressing mental health in the church was how the care being provided sometimes causes more setbacks than progress in healing (Streets, 2015). The issue is not the effort of those providing care. Often, the problem is the information and education they have received when it comes to providing specific care for individuals who have experienced trauma. Those providing care are limited without proper training in mental health practices (Guiking & Jacobs, 2022). There is a need for more mental health education for pastors and church leaders (Costello et al., 2021; Williams et al., 2014). This lack of training impacts the whole church, including those seeking care, those interacting with people in need, and those in leadership roles offering care (Guiking & Jacobs, 2022).

Transformative learning theory (TLT) suggests that education is critical for progressing a system into better, more up-to-date practices (Mezirow, 1991). Little research has been done on integrating TIC in church settings (Crosby et al., 2021). However, tremendous research exists on the impact of TIC in other settings such as schools, hospitals, residential facilities (Brown et al., 2013; Cafaro et al., 2023; Forkey et al., 2021; Forrest et al., 2018; Galvin et al., 2022; Harlow et al., 2023; Lamminen et al., 2020; Morton & Berardi, 2018; Parry et al., 2021; Schulman & Menschner, 2018). Additionally, research supports the positive impact of church attendance on individuals with trauma exposure (Costello et al., 2021; Hill & Yancy, 2022; Mathew et al., 2020; Williams et al., 2014).

This research focused on the current level of care for trauma survivors being offered in the church, the experiences of evangelical pastors towards this type of care, and the openness of evangelical pastors to integrate TIC practices in their churches. Specifically, evangelical pastors and church leaders benefit from this research as they learn more about TIC and discuss integrating these practices through educational methods. Secondly, those seeking care in the church benefit from this research, as it helps to further the conversation about TIC and offer better management of mental health in church settings. There was very little research on this topic, and this study aimed to fill the gap by directly communicating with local evangelical pastors in an interview process to learn from their first-hand experience.

Situation to Self

As a researcher, I have been positioned with one foot in the counseling field and the other foot in the church, as my professional work as a licensed professional Christian counselor parallels my work as an ordained evangelical pastor. My motivation for conducting this study was rooted in a deep concern for how the church can better meet the needs of its congregants, specifically where the mental health field falls short. Through my educational experience in the mental health field, my exposure to extensive trauma as a child, and my work within the church, I have a multidimensional motivation. I was motivated to further trauma care practices and interventions in professional counseling and lay settings, such as pastoral care and church ministry programs. My assumptions stemmed from over 14 years of studying human development, crisis intervention, and traumatology. In hopes of bridging the gap between the local church and the mental health care practice, I have highlighted the importance of care, which focuses on both psychological and spiritual healing for trauma survivors.

Motivation for Conducting Study

My goal for this study was to better understand the gap between mental health care and the church which was intrinsically tied to my motivation for improving this relationship. My motivation stemmed from several personal experiences related to the research, both positive and negative, and the current professional positioning of being involved in counseling and pastoral work. I have personal experiences as a congregant with trauma exposure seeking care from the church, secular counseling settings, and Christian counseling settings. When seeking care from the church, I felt that my needs were unmet and that a deeper level of care could have been offered. This experience shaped my perspective on the care offered by the church. Later, after experiencing Christian counseling, which addressed both mental health and spiritual needs, I felt the impact of care that was both psychological and spiritual, and I began to consider a further connection between trauma and the care offered by churches. After a very positive experience with a trauma-informed medical team while giving birth, I became motivated towards this idea of integrating TIC within church settings where caring for others is a priority of the leaders.

Philosophical Assumptions

The ontological, epistemological, rhetorical, and axiological beliefs culminate the philosophical assumptions (Creswell & Poth, 2018). Ontological beliefs describe an individual's stance regarding reality, specifically their beliefs about the nature of reality (Creswell & Poth, 2018). Epistemological ideas speak to how people know what they know and exist as the rationale for many beliefs and assumptions (Creswell & Poth, 2018). Rhetorical constructions come from the use of language and the perspective on how language and the interpretation of language factor into research (Creswell & Poth, 2018). Axiological beliefs make up the views towards values and the role of values within the research (Creswell & Poth, 2018). Each

assumption category is paired with a question. Ontological assumptions ask, "What is the nature of reality?" (Creswell & Poth, 2018, p. 17). Epistemological assumptions ask, "What is the relationship between the researcher and that being researched?" (Creswell & Poth, 2018, p. 17). Axiological assumptions ask, “What is the role of values?” (Creswell & Poth, 2018, p. 17). Lastly, Rhetorical assumptions ask, “What is the language of the research?” (Creswell & Poth, 2018, p. 17).

My ontological assumptions were rooted in my belief that multiple realities exist within the same dimension. For example, two individuals experiencing the same phenomena can experience different realities of their experience, which may lead to different outcomes. My epistemological assumptions stemmed from the knowledge of trauma, trauma treatment, TIC, and the church. By further researching how the church provided care for congregants who have experienced trauma, I have increased my knowledge and added to the existing research on trauma care. My rhetorical assumptions involved a belief that open-ended questions, in-depth discussions, and answers from participants lead to a deeper understanding of the participant's experiences. My axiological assumptions were rooted in values focused on providing care for others, meeting the needs of others, and promoting healing and growth in others. My social constructivism interpretive paradigm highlighted my interest in TIC, as a method that improves organizations that were not designed for trauma care to become educated, aware, and equipped to better care for their community when trauma conversations arise.

Problem Statement

The problem identified was a gap between the mental health field and the church, specifically for those who have experienced trauma and sought help from the local church in the

GTA. While both the mental health field and the church aimed to care for the community and meet their needs, often, the need for care in the lives of individuals overlaps these two fields. Due to the nature of trauma, the needs extended to multiple facets of human life, including their psychological and spiritual facets (Saad et al., 2017; Sulmsay, 2002; Van Dened et al., 2022). When the church and mental health field cannot work together to meet the extent of trauma needs, these two fields tend to collide rather than collaborate. Trauma is prevalent, and the impact of trauma demanded to be acknowledged, addressed, and treated appropriately. Statistics reflected that an estimated 70% of the global population is directly impacted by trauma (Benjet et al., 2016). All humans were subject to exposure to trauma regardless of their demographic, culture, socioeconomic background, family history, or religious affiliations (Karstoft & Armour, 2022). The prevalence of trauma exists in every society, on every continent, and within every community (Kilpatrick et al., 2013). In Canada, exposure to trauma reportedly was experienced by 75% of the population (Dennis et al., 2022). Healing from the impact of trauma cannot be the sole responsibility of the one who has experienced trauma, as the burden carried by survivors was often far too heavy for one person. In these cases, people benefited from a community approach to addressing their trauma (Everett et al., 2020). Using TIC was one way that communities could better serve the sensitive needs of those impacted by trauma (Arthur et al., 2013). While these practices were well-utilized in medical and hospital settings, there were still other avenues for integrating TIC, such as in church and religious settings, specifically in programs with a Christian framework (Crosby et al., 2020). Christian leaders often accepted the responsibility of caring for the needs of others, and TIC practices and frameworks can increase one's ability to better care for the individuals in their community who were faced with trauma (Crosby et al., 2020).

The current knowledge base was insufficient because there was not enough research on the integration of mental health-related practices, such as TIC, in religious settings. Tremendous research existed on the impact of TIC in hospitals, schools, residential facilities, and crisis-related industries (Brown et al., 2013; Cafaro et al., 2023; Forkey et al., 2021; Forrest et al., 2018; Galvin et al., 2022; Harlow et al., 2023; Lamminen et al., 2020; Morton & Berardi, 2018; Parry et al., 2021; Schulman & Menschner, 2018). However, there was a glaring gap in the literature on using TIC in local churches and religious centers. Other reports reflected the impact of trauma on the church and in church communities and the need for more assistance from church leadership regarding the mental health needs of congregants (Costello et al., 2021; Williams et al., 2014). However, little has been done to incorporate practices outside of integrating counseling programs within churches that equip pastors and leaders to better serve with TIC practices. This was also true for many non-religious settings (Dennis et al., 2022). While this type of care was seen throughout the community in schools, hospital settings, residential programs, and others, it was not seen in church settings where hurting people are coming for answers. This research focused on pastors' experiences when talking with congregants about trauma, the care provided by the church and their openness toward integrating methods of TIC in their practice.

Purpose Statement

The purpose of this transcendental phenomenological study was to describe evangelical pastors' experiences ministering to congregants who have experienced trauma in the GTA. This study sought to understand the challenges faced by evangelical pastors during these experiences and the strategies implemented. The theory guiding this study was transformative learning theory (Mezirow, 1991), as it supported education as a progressive method of moving an individual

from one perspective to another without the risk of regression to an outdated or earlier perspective. Since change is difficult, this theory helps spur changed perspectives through educational methods. The connection between education, mental health, and the church was rooted in practices of TIC and how the fundamental teachings of trauma-informed practices shift the perspective of a community-based approach towards care.

Significance of the Study

Research existed on the impact of trauma (APA, 2022; Kartstoft & Armour, 2022; Kumari & Mukhopadhyay, 2016; Pugach et al., 2023). Researchers have discovered a unique connection between trauma and spirituality (Choruby-Whiteley & Morrow, 2021; Hipolito et al., 2014; Moran et al., 2020; Van Denend et al., 2022). Additionally, studies reflected the need for TIC in settings unrelated to the mental healthcare field (Bargeman, 2022; Gross et al., 2020; Kramer et al., 2015; Sperlich et al., 2017). A study on a single church found that 90% of its church staff reported engaging with congregants who had trauma exposure (Guiking & Jacobs, 2022). The literature reflects how churches were a beacon of hope for people facing tragedies and trauma (Hill & Yancey, 2022). Studies also reflected where the church has fallen short in caring for these needs (Alviar & Del Prado, 2022; Bouchard et al., 2020; Covey, 2005; Wesselmann & Graziano, 2010). In-depth studies have investigated the procedures for becoming a pastor and the training for obtaining positions within churches (Cadge et al., 2020). The current literature reflected a need for specific training for pastors to provide more specialized care to their congregants (Carey & Rumbold, 2014; Costello et al., 2021; Muravchik, 2011).

This research sought to contribute to the current literature by identifying where other research stopped by carrying the investigation further. Unlike previous research, this study aimed to fill a gap within the literature through directly engaging with evangelical pastors in

discussions about TIC within church settings. By extending the investigation of trauma care in the church through direct engagement with evangelical pastors, this study sought to investigate the church directly as a place for fieldwork with TIC practices.

This research discovered what pastors in the GTA churches are currently doing to meet the needs of individuals faced with trauma and filled the gaps in the literature where researchers have yet to uncover where improvements can be made in better equipping church leaders and ministers in TIC. By surveying a subset of local churches across the GTA, this research looked at the gap of TIC within church settings across different denominations. Many individuals outside the healthcare industry were unaware of TIC practices or were ill-equipped to work with individuals faced with trauma and healing.

Statistics Canada (2023) stated that the GTA is home to over 6 million people. The city of Toronto developed a public health plan for creating a "Trauma-Informed City" by integrating TIC practices in schools, police programs, hospitals, community services, and universities (Thrive Toronto and the Wellesley Institute, 2021). This initiative identified the underserved population of the GTA and addressed the need for more care for individuals who have experienced trauma. The population did not have to be underserved, and a combined effort between the mental health field and the church can help to increase the quality of life for individuals in the GTA who have experienced trauma, especially those who are more comfortable seeking help from their local church than in a hospital or clinical setting. Pastors' mandatory training did not require formal training on mental health practices (Cadge et al., 2020). With many pastors offering care already, their limited understanding of trauma support prevented the complete integration of best practices due to a lack of knowledge. Research existed on the need for better support and the problems that arise from limited resources, care, and

education (Carey & Rumbold, 2014; Cadge et al., 2020). However, little research has been done on integrating TIC teaching in church settings.

The practical significance of this study was clear, as it created a path for TIC integration to exist in churches across the GTA. This path was developed by first investigating the current level of understanding and openness towards such integration, then understanding the current position of the local church on TIC integration, and then developing programs for disseminating better educational practices and integrating TIC in church settings. This research focused on the GTA. However, its reach goes far beyond the local church in this community, as the methodology can be replicated in other locations worldwide where trauma exposure and church settings exist.

Research Questions

The phenomenological research methodology involved four stages: preparation, data collection, organization, and analysis. Preparation began by formulating a research question (Moustakas, 1994). Research questions were characterized by investigating the essence of human experience and by using meticulous descriptions of the experience (Moustakas, 1994). The two research questions and two sub-questions for this study related to understanding pastors' experiences when discussing trauma with congregants and their current understanding of TIC methods.

The human experience being investigated was the encounters of evangelical pastors interacting with congregants who have faced trauma. I sought to understand the level of care available in the church, the level of training received by those offering care, and the openness toward additional training to become better equipped for future experiences with this population.

From this study, implications were made for future researchers and evangelical pastors on further developing and implementing TIC in the church.

Research Question 1: How do evangelical pastors in the Greater Toronto Area describe their experiences ministering to congregants who have experienced trauma?

The first research question of this study sought to understand the lived experiences of evangelical pastors who have walked through the phenomena of trying to care for an individual within their church who has been exposed to trauma. In their experience, they have acquired perspectives of the events that took place and assigned meaning to those perspectives. I wanted to know about those perspectives and the meanings attached to their experiences. With this knowledge, I was able to further investigate the implications of pastoral experiences discussing trauma, providing trauma care and pastoral care, and the possibility of integrating TIC into their church practices.

Research Sub-Question 1: How do evangelical pastors in the Greater Toronto Area describe the challenges faced when ministering to congregants who have experienced trauma?

This first sub-question acknowledged that challenges may arise for evangelical pastors as they work with congregants' trauma needs. Understanding their experienced challenges can guide future research on overcoming these challenges.

Research Sub-Question 2: How do evangelical pastors in the Greater Toronto Area describe the strategies implemented when ministering to congregants who have experienced trauma?

This second sub-question went deeper into the experiences of evangelical pastors, aiming to understand the strategies evangelical pastors use while speaking to congregants about

their trauma. This information helped to understand the extent of their knowledge on trauma topics and how they were caring for their community's trauma needs.

Research Question 2: How do evangelical pastors in the Greater Toronto Area describe their experiences with trauma-informed care?

By first understanding the experiences of evangelical pastors in the GTA, I better understood how their perspective on trauma and trauma care impacted their experience with TIC in the church. This second question spoke to the impact of those experiences. Their experiences shaped their perspective on the value of trauma care in a church setting and determined the openness toward organizational training on trauma-informed methods. This question was answered by digging deeper and exploring the current care offered in the church, drawing a correlation to the pastor's experiences in that church. I understood the current climate of church practices related to mental health care and trauma. This information explored pastoral perspectives' potential implications and pitfalls toward integrating TIC practices within church programs. My interviews with evangelical pastors in the GTA opened the conversation for this integration in church settings, and the future of church ministry with trauma-informed workers were discussed.

Definitions

The section includes a list of terms used throughout this study. Each term was defined to help bring a deeper understanding of the topics being researched and discussed in the study. These key terms made up the focus of what is being researched in this study and were critical to me and the reader. A full understanding of each term was necessary for conducting the study.

1. *Biopsychosocial spiritual model* – The Biopsychosocial spiritual model is a holistic approach to mental health with humanistic principles focusing on a multidimensional

treatment that acknowledges four interconnected dimensions of a human by design (Anim et al., 2022; Engel, 1997; Saad et al., 2017; Sulmasy, 2002; Van Dened et al., 2022).

2. *Church* – The church is a place known best for social and religious gatherings, and it is often a place where people go to seek help in times of need (Bouchard et al., 2020; Scheffler & Genig, 2021; Trueman & Gould, 2017; Walker et al., 1985).
3. *Community-based care* – Community-based care is available in communities where professionals in various vocations work together to provide a more complete and holistic healing process (Costello et al., 2021).
4. *Master of Divinity* – A Master of Divinity is a specialized graduate-level degree offered by colleges and universities as the standard degree program for those interested in a career in ministry as a pastor (Cadge et al., 2020).
5. *Pastors* – Pastors are the leaders of a church and the congregation, or group of people, who make up the church's community. These leaders work in various ways to fulfill their dynamic role in a church, often including care for the mental and spiritual health of the church's community (Weaver et al., 2019).
6. *Pastoral care* – Pastoral care, different from pastoral counseling, is the basic level of counsel provided by pastors to others, which involves a non-judgmental approach, good listening skills, and possibly working with other professionals to help those in the church and community seeking care within the church setting (Carey & Rumbold, 2014).
7. *Pastoral counseling.* - Unlike pastoral care, pastoral counseling is a deeper level of counsel and care offered by pastors who have received academic training and are equipped to diagnose, draw inferences, and provide treatment (Bernau, 2021).

8. *Pastoral training* – Pastoral training refers to the education gained by pastors, which is used in their active role in ministry; this training is not limited to theological topics and often includes the option for elective courses in areas of pastoral care, pastoral counseling, and skills related to chaplaincy and clergy work (Cadge et al., 2020; Carey & Rumbold, 2014; Muravchik, 2011).
9. *Psycho-religious synthesis* – Psycho-religious synthesis refers to the combination of theological, psychological, and social work-related training for those in a ministry position as a pastor or chaplain (Carey & Rumbold, 2014; Muravchik, 2011).
10. *Trauma* – Trauma involves exposure to serious injury, sexual violence, death, or the threat of death and a natural response of helplessness, horror, or intense fear (APA, 2022; Karstoft & Armour, 2022; SAMHSA, 2022).
11. *Trauma-informed care* – Trauma-informed care is used by professionals outside of the mental health field to help mitigate the impact of trauma, prevent retraumatization, and provide a level of educated care within modified practices at an organization (Gutowski et al., 2022; Stavropoulos, 2019; Zettler, 2021).
12. *Transformative learning theory* – Transformative learning theory is a theoretical framework developed by Jack Mezirow that focuses on adult learning, developing a progressive paradigm, and underlying beliefs and assumptions (Mezirow, 1991; Mezirow, 1995).

Summary

This chapter has introduced the study, including the key components and strategies guiding the research. A closer look at the study's historical background, social context, and theoretical overview was discussed. My motivation for conducting the study and their

philosophical assumptions and paradigms were addressed. The problem, purpose, research questions, and significance of this study were outlined, explaining in detail the contributions and the practical significance of this study. Lastly, the key topics were defined to guide the reader through the research with a more informed understanding of key terminology used throughout the study. The information from this introduction presented the framework of the study and described the key elements guiding this research.

Chapter 2: Literature Review

The focus of this research was trauma, the church, and the care offered by pastors to congregants who have experienced trauma. I sought to understand the impact of pastors' experiences ministering to congregants who have experienced trauma and their perspective on integrating Trauma-Informed Care (TIC) in local churches in the Greater Toronto Area (GTA). Further, I was interested in how these experiences impacted the care offered in church settings. This chapter discussed the theoretical framework for this research study. It revealed the existing literature on trauma, the church, trauma care in the church, and potential integrations of better methods for better care within the church. This research was based on an educational theoretical framework and investigated how further education on trauma could benefit pastors and their roles in the church as they seek to help their congregants. I aimed to understand if increased education could lead to better care for congregants who have been through trauma.

The main topics discussed in this study included trauma and the church, and within trauma descriptions, I discussed different types of traumas, the impact of trauma, and statistics related to trauma exposure. I adhered to the belief that humans are made up of four separate parts, intrinsically connected, including one's biological, psychological, sociological, and spiritual parts. The literature review discussed the impact of trauma on each of these four parts and how attention to each part is necessary for complete healing to occur in those who have experienced negative symptoms because of their trauma experience. When addressing the church, the subtopics covered included historical positions of the church, the roles and leadership, and how pastors are helping their congregants currently. Additionally, this study covered the training involved in preparation for pastoral work, the counseling-related conversations and topics discussed between congregants and their pastors, and a potential gap

where more education can exist for further implementation of better care provided by pastors to their congregants. Further, TIC was discussed as a pathway to healing for congregants who have experienced trauma, and an integrated approach for the church was described.

Theoretical Framework

The theoretical foundation of this study was based on the transformative learning theory (TLT) (Mezirow, 1991). The research problem centered on the essential shift in the church's perspective on trauma care. This transformation was aimed at being realized through adult education in TIC. TLT insisted that a change in perspective is possible through intentional methods. TLT, developed by Jack Mezirow (1991), involved a "movement toward more developmentally progressive meaning perspectives" (p. 192). This theory acknowledged that adult learning differs from teachings for children and adolescents, as cognitive development is completed in early adulthood. When perspectives were changed through intentional methods derived by TLT, old perspectives faded as new perspectives shaped the individual. Mezirow (1991) taught that "the transformative learning process is irreversible," insisting that "We do not regress to levels of less understanding" (p. 152). This idea of learning addressed lower level thought and higher-level learning, where progressive ideas and more forward-thinking replaced old beliefs, assumptions, and ideas with newly formed perspectives that shape one's worldview due to education on topics where information was previously lacking.

The key to TLT was examining the underlying assumptions of individuals as we aimed. for openness and objectivity when presenting data and assessing rationales while reviewing the evidence and arguments surrounding ideologies (Mezirow, 1991). Mezirow taught that there are ten steps or phases of achieving transformative learning. These included the following: a

disorienting dilemma, self-examination of assumptions, critical reflection on assumptions, recognition of dissatisfaction, exploration of alternatives, plan for action, acquisition of new knowledge, experimentation with roles, competence building, and reintegration of new perspectives into one's life (Mezirow, 1991).

A disorienting dilemma was the disconnect between the intended goal of helping others and the limited resources care providers offer. This disorienting dilemma highlighted a need within the infrastructure of a system or organization (Mezirow, 1991). Examining assumptions involved looking into new methods or patterns different from the current infrastructure of thoughts or behavior to promote better outcomes. A critical reflection on assumptions involved an inward investigation of problematic beliefs or thoughts preventing progress toward one's goals. Recognizing dissatisfaction was a critical step towards that pivotal moment where change began to take shape as one acknowledged the need for updated methods and the validity of a different approach or action plan.

After acknowledging change, an exploration of alternatives fell into place, and individuals became open to new thoughts, beliefs, ideas, and methods (Mezirow, 1991). A plan for action set the stage for progress and change. Acquisition of new knowledge allowed the action plan to play out effectively in real scenarios, such as obtaining training with new methods than previously used to meet goals. Experimentation with roles opened the door to further understanding an infrastructure's different variables. Competence building led to confidence in new roles through practice with new skills, which increased thinking to a higher level than previous levels filled with unexplored assumptions. A reintegration of new perspectives into one's life happened when one is willing to walk through these steps and open one's mind to new perspectives, roles, and skills.

A core understanding of TLT was that change is necessary for progress in a system with room for improvement (Mezirow, 1991). Utilizing education methods, as outlined in this theoretical framework, educators and pastors can work to shift perspectives, reduce assumptions, and create space for enlightenment and more up-to-date and informed decision-making regarding caring for congregants and their mental health. This is possible by following the 10-step outline above and working alongside others in the community who share a desire to care for people in times of need and crisis. Integrating the ten steps in this study begins by sourcing the disorienting dilemma, which can be stated as the recognition of congregants' need for mental and spiritual support within church settings. The goal of this research was to understand pastors' experiences ministering to congregants exposed to trauma and the existing infrastructure of care offered by the church. This theoretical framework guided the research by identifying disorienting dilemmas and offering new skills and perspectives on trauma that pastors could decide to explore further.

Through the interview outlined in Chapter 3, the questions addressed steps 2-5. I asked questions that aided in self-examining assumptions, critically reflecting on assumptions, recognizing dissatisfaction, and exploring alternatives (Mezirow, 1991). From the information gathered in the interview, steps 6-10 took shape at the willingness and discretion of the pastor. These steps involved developing an action plan, acquiring new knowledge, experimenting with roles, building competence, and reintegrating new perspectives into one's life (Mezirow, 1991). These last five steps could be further discussed in a secondary study for future research where pastors work with a researcher to experiment with roles and examine the contrasting differences of care before acquiring new knowledge compared to care after transformative learning has taken shape. Results

could further support a deeper reintegration of these new perspectives into all aspects of the pastors' lives and ministry.

This theory drove the entire study. Education was a critical component of change, as it alters one's perspective through enlightenment and a deeper understanding of topics. This theory related to the specific problem of this study, as I sought to understand the pastoral experiences with their congregants who present symptoms of trauma and the methods used to care for these congregants. Where educational systems for pastors lacked teaching in how to care for the mental health needs of congregants, supplementary training in TIC may help to meet the needs of both the pastors seeking to help and the congregants seeking help from their pastors.

Trauma

Trauma had many defining qualities and lacked a universally agreed-upon definition. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2012) described trauma as "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being" (p. 2). The American Psychiatric Association (APA, 2022) defined trauma as an exposure “to actual or threatened death, serious injury, or sexual violence" (p. 271). Karstoft and Armour (2022) defined trauma as a person experiencing, witnessing, or being confronted with an event with "actual or threatened death or serious injury or a threat to the physical integrity of oneself or others" and their response to the event involved "intense fear, helplessness, or horror" (p. 2).

A defining quality of trauma was the threat to the physical or physiological integrity of the individual (Brewin et al., 2000). Trauma exists when there is an overwhelming stress response to the experience (McEwen, 1998). A disruption of normal coping mechanisms was

experienced during and often after trauma exposure (Lazarus & Folkman, 1984). Experiencing trauma led to an impact on cognitive processing (Ehlers & Clark, 2000). Different from retraumatization due to outside triggers, another defining quality of trauma exposure was intrusive re-experiencing of the trauma event, which can occur through flashbacks, nightmares, and night terrors (Foa et al., 1989). Avoidance and numbing responses were typical coping methods seen in individuals impacted by trauma (Litz et al., 2000). There was often a long-term impact on functioning when dealing with trauma (Herman, 2015).

Experience with trauma was unique, and one's response to trauma was affected by many factors, including resiliency and support system (Sanderson, 2012). The intensity and nature of trauma were often threatening (Brewin et al., 2000), violating, and overwhelmingly intrusive (Foa et al., 1989) for those who experience life-altering events (McEwen, 1998). Initially, trauma was an unexpected experience, especially in the event of a car accident, when the event was unexpected. However, when trauma became persistent, one may be able to predict their next traumatic experience, especially in instances of repeated sexual abuse (Sanderson, 2012). Trauma was not limited to one's personal experience of a traumatic event, as trauma exposure may be indirectly experienced by a loved one or a friend (Friedman, 2015).

Karstoft and Armour (2022) noted that "the assessment of trauma exposure across studies might not be limited to diagnosis-qualifying events, and some studies include events that might not be considered traumatic but instead are described as *stressful life events*" (p. 2). Trauma did not always lead to lasting and significant psychological distress or meet diagnostic criteria. Therefore, a post-traumatic stress disorder (PTSD) diagnosis cannot always be made (APA, 2022). Trauma can exist without a disorder, as

levels of inherited resiliency from previous exposures and built-in coping strategies from treatment or personal growth and development can reduce its impact (Dodd et al., 2022).

Types of Trauma

The causes of trauma included years of abuse or a single car accident, and symptoms stemming from the traumatic events can vary from person to person depending on a variety of factors, including resiliency and support. Trauma was not simply labeled as a stressful life event, as this might reduce the understanding of the impact of the experience to something that is not clinically defined as traumatic. The qualities consistently recognized when defining trauma included experiencing an event, often unexpected, that causes extreme fear due to threat or actual injury and leads to lasting, sometimes debilitating, negative impacts (APA, 2022; Karstoft & Armour, 2022; SAMHSA, 2022).

Verbal, physical, sexual, and psychological forms of abuse were all named as causes of trauma, in addition to witnessing any of these types of abuse happening to others (Chu, 2011). Events such as house fires, car accidents, combat, terrorism, and disasters could also cause trauma (Bloom, 2013). Any threat to one's life or any perceived threat in which a person fears for their life was a cause of trauma (Sanderson, 2015). This concept of trauma being a perceived threat was critical to highlight because it is the perception of the experience that requires healing. Traumatic experiences were perceived differently from person to person, and something that caused a perceived threat to life to one person might not cause the same perception in another. Likewise, these varied perceptions led to different responses to trauma exposure. By acknowledging an event as being traumatic, clinicians create a space for clients who have experienced trauma better to understand both the nature and cause of trauma and their responses to it (Friedman, 2015).

Impact

Trauma can be dramatic and create symptoms that impact daily life (Pugach et al., 2023). Avoidance (Litz et al., 2000), negative emotions, and PTSD symptoms were common ways that unresolved trauma affects daily life (Pugach et al., 2023). Trauma can alter one's worldview and can lead to significant psychological disorders, such as PTSD involving intrusive symptoms (Foa et al., 1987), persistent avoidance of stimuli (Litz et al., 2000), adverse changes in cognition and mood, and alterations in arousal (APA, 2022; Kartstoft & Armour, 2022; Kumari & Mukhopadhyay, 2016). The consequences of trauma exposure included but are not limited to anxiety, depression, anger, hostility, interpersonal difficulties, substance abuse issues, physical health problems, self-harm, suicidal tendencies, risky behaviors, retraumatization, relationship struggles, isolation (Burlaa et al., 2020; Fallot & Blanch, 2013; Fross et al., 2020; Kane & Green, 2009; Koenig et al., 1992; Lee, 2019; Mathew et al., 2020; Murray et al., 2022; Resick et al., 2017; Upenieks, 2023; Weaver et al., 2019). An individual's resilience was crucial to preventing a traumatic event from negatively impacting their psyche. However, in all instances where trauma was present, there was a need for psychological evaluation, even if only in the form of debriefing (Fekadu et al., 2019). By looking into each dimension of the human experience, one would see how the impact of trauma. The adverse effects of trauma transcend beyond the psychological experience and go deeper into one's makeup, causing changes or symptoms to arise biologically, psychologically, socially, and spiritually. Specific examples of how trauma impacts each dimension were outlined in the next section.

Biopsychosocial spiritual Model

The biopsychosocial spiritual model is a holistic approach to client conceptualization with a humanistic view and a multidimensional treatment (Anim et al., 2022; Saad et al., 2017).

The development of this model was an extension of the original biomedical model, which focused only on the biological components and is a less comprehensive healing method. The biomedical model was first modified to the biopsychosocial model, which built on this model and addresses the social and psychological dimensions (Anim et al., 2022; Engel, 1997; Sulmasy, 2002). Further modifications to these approaches led to the biopsychosocial spiritual model which included the spiritual component of the human experience (Saad et al., 2017).

Sulmsay (2002) modified Engel's (1997) widely accepted biopsychosocial approach by including one's spiritual component (Saad et al., 2017; Van Dened et al., 2022). The biopsychosocial spiritual framework looks at four parts of each person: biological, psychological, social, and spiritual (Saad et al., 2017; Van Dened et al., 2022). Sulmsay (2002) argued that we cannot understand the whole of a person without considering their spiritual domain. A holistic approach toward wellness and health included all aspects of the human, which is accomplished using the biopsychosocial spiritual model (Saad et al., 2017; Sulmsay, 2002; Van Dened et al., 2022). Van der Kolk (2014) advocated for a holistic approach to trauma treatment and highlights the importance of a mind, body, and spirit connection.

Biological Impact of Trauma. Trauma can impact an individual's neurobiological functioning, and stress can leave a lasting impact on an individual's brain development when it is heightened in childhood (Stebnicki, 2016). Biological changes during trauma exposure include changes in cortisol levels and the hypothalamic-pituitary-adrenal (HPA) axis function (Motsan et al., 2022). Salivary cortisol levels are a biomarker for stress response, and trauma exposure led to an increase in salivary cortisol levels (Hellhammer et al., 2009; Motsan et al., 2022). The physiological symptoms of changes in cortisol levels and HPA axis functioning due to trauma involved increased heart rate, blood pressure changes, glucose metabolism changes, muscle

tension, digestive issues, alterations in inflammatory responses, immune system suppression, sleep disturbances, weight fluctuations, and impaired cognitive functions (Elenkov & Chrousos, 2002; Ehlers & Clark, 1984; Fries & Dettenborn, 2009; McEwen, 2007; Sapolsky et al., 2000; Chrousos, 2009; Heim & Nemeroff, 2001); Lupien et al., 2009).

Biological changes after trauma exposure include higher respiratory sinus arrhythmia (RSA), higher Bala levels shown by CT scans, and higher stress response (Motsan et al., 2022). RSA is the standard alteration in cardiac rhythm generated by vagus nerve stimulation and changes in cardiac filling pressures during respiration; while Bala levels were a concept from Ayurvedic medicine referring to the strength and ability of the body or part of the body to cope with various physical stressors (Motsan et al., 2022). The human body reacts as trauma occurs, and the impact was measured through RSA and Bala levels. As biological beings, humans are genetically shaped by the health of their neurological structures, and since individual biology is complex, when faced with trauma, it can break down (Motsan et al., 2022). This disrupts the entire framework of a person the biopsychosocial perspective was considered (Motsan et al., 2022). Motsan et al. explained:

> The parasympathetic nervous system, a branch of the autonomic nervous system (ANS), plays an essential role in regulatory functions, supporting sustained attention and social engagement. RSA is a reliable marker of parasympathetic activity—high resting RSA indexes flexible adaptation to changing environmental conditions, a key feature of resilience. In contrast, low resting RSA is associated with high-risk rearing, troubled mother-child relationships, and functional impairments. (p. 1341)

Van der Kolk (2014) highlighted the physiological impact of trauma, and he insists that trauma is not solely a psychological experience. In fact, van der Kolk extensively explored the impact of trauma on the body and brain, highlighting the role of the body during traumatic experiences. Pat Ogden (Ogden et al., 2006), the founder of Sensorimotor Psychotherapy, advocated for attention on the mind and body connection to trauma, teaching that the self can disconnect from the body during trauma exposure. The body essentially stores traumatic memories as a natural method of coping and survival instinct during traumatic events (van der Kolk, 2014). Due to the traumatic memory storage of the body, there was a need for body-oriented approaches in trauma therapy (van der Kolk, 2014). Traumatic experiences not only impacted the body but van der Kolk's (2014) research revealed how trauma can alter brain structure and functioning. Specifically, emotional regulation (Levine, 1997), memory, and self-awareness was impacted by brain alterations from trauma (van der Kolk, 2014).

Any physical injury related to a trauma event can be a lasting reminder of the trauma experienced during that event (Carstensen et al., 2008). For example, a broken arm, whiplash, or a more extreme injury such as the loss of a limb or a significant scar – these are all physical consequences of trauma that may have a psychological impact. In cases where extreme physical injuries resulted from the trauma, it is possible that the trauma experienced could become more complex if repeated traumatic experiences follow the accident. Herman (1997) introduced this concept of complex trauma and the lasting impact of repeated trauma. Additionally, an individual whose trauma led to more trauma, such as a car accident with significant physical injuries, increases the risk of psychological distress (Carstensen et al., 2008). When dealing with complex trauma, van der Kolk (2014) suggested that repeated exposure to trauma during early

developmental experiences can impact attachment patterns, trauma responses, and long-term mental health outcomes.

Psychological Impact of Trauma. The psychological impact of trauma encompasses mental health needs and symptoms associated with the mind of an individual. Judith Herman (1997), a trauma expert, taught the importance of addressing the psychological needs of individuals faced with trauma and advocates for a survivor-centric approach to trauma. By focusing on the strengths and resilience of individuals, mental health workers aim to avoid pathologizing trauma responses by validating the experiences of the survivor (Herman, 1997).

Anxiety. Psychological experiences during trauma exposure include anxiety and experiencing the fight/flight/freeze impulse (Entwistle, 2021). Levine (1997) expressed that the freeze response was a common reaction to trauma, and his concept of thawing the frozen state of a person after trauma spoke to the mind and body connection. Internal experiences and capacities can lead to incredible abilities, such as higher resiliency and healing from tremendous traumas. However, built-in limitations can lead to personal distress and brokenness (Entwistle, 2021). Psychological changes after trauma exposure include poor self-esteem, avoidant behavior, dissociation, negative or blunted emotions, and cognitive impairment (Ehlers & Clark, 1984; Silberman, 2019). Trauma also produces symptoms focused on anxiety (Silberman, 2019).

Sleep. Nightmares, intrusive dreams, and flashbacks are all-natural psychological responses to trauma (Foa et al., 1987; Luik et al., 2019). However, these trauma symptoms can also impact a person's physical state, as sleep deprivation causes many physical and psychological challenges (Luik et al., 2019). Sleep disturbances are a

common symptom noticed in the short-term experience after a traumatic accident. When treated with proper care, an individual can develop coping strategies and healing that prevent this symptom from becoming long-term (Luik et al., 2019). Research indicated that sleep disturbances should take an early priority in treatment for trauma, especially when dealing with intrusive memories from the traumatic event (Foa et al., 1987; Luik et al., 2019).

Avoidance. Avoidance issues are common after trauma exposure (Litz et al., 2000). Avoidance may begin as a coping strategy that a person developed to help curb the occurrence of intrusive memories or re-experiencing (Foa et al., 1987; Litz et al., 2000). Additionally, avoidance as a coping strategy (Litz et al., 2000) may be a result of extreme levels of fear stemming from one's experience of a car accident (Berna et al., 2012). In these cases, implementing better healthy coping strategies may be necessary to replace avoidance with a better way of preventing symptoms. Avoidance, commonly a psychological factor for trauma survivors, can also impact a person's sociological experiences, as an inability, or avoidance, towards specific experiences, may limit one's ability to maintain a social life, including spending time with friends and family (Litz et al., 2000).

Social Impact of Trauma. Humans are social creatures affected by social and cultural environments and relational beings with social needs and capacities (Entwistle, 2021). Some of the key social impacts of trauma on an individual include a disruption of social bonds (van der Kolk, 2014), isolation and alienation (Herman, 1997), interpersonal difficulties (Ogden et al., 2006), community disruption (Lifton, 1993), stigmatization and marginalization (Herman, 1997; van der Kolk, 2014), cultural and societal effects (Fisher, 2017), secondary traumatization (Figley, 1995), and an impact on social institutions (Herman, 1997; van der Kolk, 2014).

When social bonds are disrupted due to trauma, individuals struggle to form new relationships or maintain current relationships (van der Kolk, 2014). Trauma can negatively impact the ability to form healthy attachments, inhibiting social functioning (Maercker et al., 2021). Porges (2011) introduced the concept of the Social Engagement System (SES) which is impacted by trauma. The SES was a system promoting communication, social connection, and feelings about safety (Porges, 2011). When an individual experiences trauma that impacts the ventral vagus nerve, a disruption in SES functioning can occur, ultimately leading to difficulty in managing social bonds (Porges, 2011).

Isolation and alienation are often a trauma response when, after experiencing a trauma, someone feels they cannot trust people or struggle to relate to people (Herman, 1997). Stigmatization and marginalization can impact the social standing of individuals and the risk of isolation (Herman, 1997; van der Kolk, 2014). Interpersonal difficulties emerge when individuals struggled to connect or communicate with others due to trauma exposure, and this can further risk isolation (Ogden et al., 2006).

Trauma impacts the entire family, and Charles Figley (1995) introduced the concept of secondary trauma. When one person experiences trauma, the entire family felt the impact. Family systems theory includes perspectives that highlight the impact of trauma on both the survivor and their families (Silvestre & Tarquinio, 2022). Fitzgerald et al. (2020) noted that "intergenerational transmission of trauma often leads to behavioral and emotional problems in children of parents with a history of trauma" (p. 406). Issues faced by families dealing with trauma include relational distress, changes in family dynamics, non-pathological individual distress, and confusion about interacting with one another (Coulter & Mooney, 2018).

Whole communities are disrupted when collective traumatic experiences occur, and a sense of social cohesion is lost, causing fragmentation (Lifton, 1993). Cultural and societal implications of trauma reveale that communities are impacted by systemic factors related to mental health and trauma (Fisher, 2017). The overall social fabric of a community is influenced when traumatic experiences impact social institutions like schools, religious centers, and workplaces (Herman, 1997; van der Kolk, 2014).

Ogden et al. (2006) drew attention to the relational aspects of trauma and highlights the importance of a therapeutic healing relationship. Support systems can be broken because of trauma. Nonetheless, it was essential to discuss how they can be a source of healing after trauma (Maercker et al., 2021).

Spiritual Impact of Trauma. The connection between trauma and spirituality is discussed in detail in the next main section. However, this section focuses on the impact of trauma on one's spirituality. The aftermath of trauma leaves individuals struggling in many areas, including their spirituality. Some of the spiritual issues that surface in the aftermath of trauma involved a loss of faith, a sense of hopelessness, and an alteration in systems of meaning (Fallot & Blanch, 2013; van der Kolk, 2014). A profound loss of meaning and purpose is a significant spiritual impact of trauma (van der Kolk, 2014).

When Herman (1997) discussed the spiritual dimension of trauma, she highlighted feelings of being spiritually disconnected from one’s faith or beliefs. Another significant spiritual impact of trauma is the potential for an existential or spiritual crisis to develop where individuals may question their existence (Lifton, 1993). Spirituality can be impacted when one’s trauma exposure interferes with their ability to participate or engage in spiritual practices or rituals (Levine, 1997; Ogden et al., 2006).

Fisher (2017) spoke to the impact of trauma on belief systems and explains how trauma can either strengthen or challenge a person's spiritual beliefs. Leaning into faith-based coping strategies is a recognized impact of trauma as individuals may draw on their beliefs and faith community after trauma exposure (Ogden et al., 2006). Individuals seek out spiritual guidance and lean into their faith more after experiencing trauma than before their experience (Fallot & Blanch, 2013). In these cases, the impact of trauma on spirituality can be positive, as individuals strengthen their religious beliefs and increase their faith in God (Fallot & Blanch, 2013).

Rates of Trauma

Until more recently, trauma was considered a rare, uncommonly experienced event. A shocking statistic in a global study revealed that 70% of the world's population has already experienced a traumatic life event (Benjet et al., 2016; Kessler et al., 2017). However, research indicates that trauma is prevalent in society as the causes of trauma become more known (Breslau et al., 1998; Felitti et al., 1998; Finkelhor et al., 2007; Friedman, 2015; Herman, 1997; Kessler et al., 1995; van der Kolk, 2014). Trauma is more common than many realize and can begin early in life. It was reported that two-thirds of children will experience trauma before entering adulthood, which can lead to both short- and long-term problems, including chronic issues related to physical and mental health (Christian-Brandt et al., 2019). One in six children will experience four or more traumatic events during childhood (Crosby et al., 2021). Karstoft and Armour (2022) stated that trauma exposure frequently occurrs across the lifespan, as most people experienced at least one traumatic event during their lifetime.

Violence is considered a worldwide public health problem and is to blame for more than 1.6 million deaths annually (Centers for Disease Control and Prevention (CDC), 2024). Gun

violence is a significant category of violence and is responsible for one-fifth of the deaths mentioned in the previous statement (CDC, 2024). The most recent rates on intimate partner violence reflects that 1 in 3 women and 1 in 4 men will experience a form of physical violence with a partner (Smith et al., 2015). Yearly rates of sexual assault indicate nearly 433,648 people above the age of 11 experience rape or sexual assault in the United States (Rape, Abuse & Incest National Network (RAINN), 2021).

Other traumas to consider include water injuries and motor vehicle accidents, as they are both leading causes of death in the US. Trauma due to water injuries could include drowning, boating, and diving accidents, injuries due to nature and wildlife, and accidents resulting from water sports and recreational activities. Drowning was considered a leading cause of death for US citizens traveling abroad to countries where water recreation is a major activity (CDC, 2024). According to the Centers for Disease Control and Prevention (2024), 3,700 people around the world are killed daily in motor vehicle crashes; this includes bicycles, cars, motorcycles, trucks, buses, and pedestrians.

At-Risk Populations

Trauma can happen at any time, and everyone is at risk, though risky lifestyles involving excessive drinking or drug use can carry a greater risk of exposure (Karstoft & Armour, 2022). Understanding a person's trauma history reveals the psychological implications of previous traumas that may influence their response to recent or current trauma exposure (Bosch et al., 2020). PTSD symptoms are widespread among veterans due to their greatly heightened exposure to trauma (Dorflinger & Masheb, 2018).

Demographics and cultural issues lead to a higher risk of exposure. Migrant populations often comprise the most vulnerable groups in our communities and need integrated care from

their support systems (Harlow et al., 2023). Aboriginal groups often face intergenerational trauma, leading to complex symptoms (Marsh et al., 2015). Further, the growing population of refugees finding asylum in Canada also deals with the impact of trauma, which can be exacerbated due to the stress related to resettlement (Frounfelker et al., 2022). The impact of trauma on refugee children enters the school system when their trauma was disclosed, and teachers discuss issues related to unexpected disclosures from these students and the risk of burnout from their emotional consequences (Mayor, 2021).

Children in welfare programs have a high risk of experiencing multiple traumas unless access to proper mental health care was available and may take extreme actions such as attempting suicide or having PTSD-related symptoms (Murray et al., 2022). Childhood trauma is associated with more significant persistent psychological problems and a poorer quality of life (Bosch et al., 2020). Children and youth dealing with maltreatment in Ontario face a variety of traumas, with child sexual abuse having the highest prevalence (Stewart et al., 2023). Symptoms facing children and youth in Ontario who are dealing with trauma included depressive symptoms, suicidal thoughts and ideation, self-harm, anxiety, risk to self and others, and externalizing behaviors (Stewart et al., 2023).

Trauma and Spirituality

Trauma impacts spirituality. Likewise, spirituality impacts and could improve an individual who has experienced trauma (Hill & Yancy, 2022). Acknowledging the connection between spirituality and mental health paves the way for understanding the impact of trauma on spirituality and vice versa. Both empowerment (Levine, 1997) and spirituality reportedly supports individuals who require healing from trauma (Hipolito et al., 2014).

In some religious settings, women attribute their worth to their virginity, and when sexual abuse occurrs, especially in childhood, this impacts their religious views and perspectives on self-worth (Choruby-Whiteley & Morrow, 2021). Research indicated the experience of trauma from rape can have a tremendously negative impact on one's religiosity and spirituality (Piggot & Anderson, 2023). Piggot and Anderson (2023) found that the impact of rape on spirituality involves women who experience rape reporting religion to be a substantially less critical factor in their lives compared to the women who had not been raped. Additionally, in instances of sexual assault, individuals feel shame, guilt, and a distorted sense of self-worth, which can negatively impact their spirituality (Bass & Davis, 2008).

Other types of traumas that can negatively impact spirituality include interpersonal violence and abuse (Herman, 1997), combat trauma (Litz et al., 2009), natural disasters (Pargament, 2007), health trauma (Park, 2013), loss and grief (Kübler-Ross & Kessler, 2014), cultural or religious persecution (Abu-Raiya et al., 2026). A disruption in one's sense of safety occurs after abuse or domestic violence, and this might interfere with one's perspective of a higher power (Herman, 1997). Combat-related trauma leads to questions about beliefs and values, which can challenge one's spirituality (Litz et al., 2009). Natural disasters lead to a struggle with the concept of a higher power and feelings of safety (Pargament, 2007). Changes in spiritual beliefs can come from health-related trauma (Park, 2013) and experiences of loss and grief (Kübler-Ross & Kessler, 2014). Cultural persecution leda one to struggle with one's religious identity, complicating one's spiritual connection and positivity toward spirituality (Abu-Raiya et al., 2016).

As spirituality is often impacted by trauma, it simultaneously exists as a source of healing through trauma (Moran et al., 2020). For example, increased awareness of spirituality may result

in positive coping associated with a more outstanding quality of life and correlated with several well-being-integrations (Moran et al., 2020). Spiritual well-being is also significantly correlated to overall well-being and life satisfaction in physical, mental, and social health, mobility, and social integration (Moran et al., 2020). Spirituality is impacted by religion, and this can have negative and positive outcomes when faced with trauma and processing traumatic events (Van Denend et al., 2022).

Trauma-Informed Care

The use of TIC in a church setting or any organization begins with understanding the fundamentals of TIC and the role it has within an organization. Trauma-informed means being relationally oriented, gender-sensitive, and racially and culturally responsive (Gutowski et al., 2022). TIC has five core attributes: safety, trust, empowerment, choices, and collaboration (Knight, 2019; Stavropoulos, 2019). Trauma-informed programs aim to mitigate the effects of trauma (Zettler, 2021).

TIC skills are used to meet the unique needs of patients and clients who have been exposed to trauma and are dealing with the negative consequences of trauma (Dennis et al., 2022; Gutowski et al., 2022). A knowledge of trauma terminology and TIC skills must be in place to use its techniques successfully (Bargeman, 2022).

When organizations aim to become trauma-informed, leaders agree to changes in existing models and practices (Douglas et al., 2021; Gutowski et al., 2022). These changes are not limited to clinical interviews and may need to be implemented at all levels of the organization (Croghan & Brown, 2010; Douglass et al., 2021; Evans et al., 2013; Stanley, 2023). When implementing TIC, organizations created a space where

trauma needs are identified at individual and systemic levels (Parry et al., 2021). TIC requires a clear set of policies and procedures.

The Role and Components of Trauma-Informed Care

The role of TIC maintains many similarities amongst organizations and can be slightly modified to meet the specific needs of each community, including a church setting. Instead of dealing with trauma-related symptoms directly through treatment methods, TIC exists to create a safe space for individuals who have experienced trauma (Arthur et al., 2013). The TIC approach acknowledges the impact of trauma, recognizes the signs of trauma exposure, and respondsd by integrating trauma-related policies that help prevent retraumatization (SAMHSA, 2014).

The five core principles of TIC are safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice, and choice (Bowen et al., 2016; SAMHSA, 2014). Being trauma-informed ensures the physical and emotional safety of an individual, and this is a foundational principle of TIC (Bowen et al., 2016; SAMHSA, 2014)). Like in counseling, building rapport and establishing trust and an open space for transparency are crucial principles of TIC (Bowen et al., 2016; SAMHSA, 2014). A trauma-informed person recognizes the value and importance of peer support (Bowen et al., 2016; SAMHSA, 2014). A willingness toward collaboration and respectful relationships among service providers is necessary when implementing TIC (Bowen et al., 2016; SAMHSA, 2014). Lastly, promoting empowerment by giving survivors a voice and offering choices when necessary are crucial for TIC (Bowen et al., 2016; SAMHSA, 2014).

TIC is effective in settings not considered 'trauma specific' when practices are used that support the core principles of TIC. This can be done while maintaining the roles required of those working in that setting (Knight, 2019). For example, when individuals can fulfill their

expected responsibilities while adhering to the five core principles of TIC practices, they operate with trauma-informed methods.

TIC is needed in communities that serve the needs of individuals who have been exposed to trauma. Trauma is a common aspect of the human experience, affecting an estimated 70% of the global population (Benjet et al., 2016). According to Statistics Canada (2022), 64% of Canadians reported having experienced trauma exposure during their lifetime. TIC is relevant to all who seek to help others, including those in a church or faith community (Guiking & Jacobs, 2022). Due to the extended impact of some disasters and trauma exposures, TIC should be part of multiple programs within the community to best meet the needs of those impacted by trauma (Everett et al., 2020). As the length of one's journey within the church can vary, the impact of TIC can be lasting regardless of the length of time one receives help.

Trauma-Informed Care Integration

TIC integration occurs through a variety of methods, one being through assessment and training (Harris & Fallot, 2001). Following TLT (Moustakas, 1994), adult education can be offered through training across organizational levels, and training is one of the ways that TIC can be implemented into an organization (Harris & Fallot, 2001). Leadership commitment to change is a crucial step toward integrating TIC within an organization, and this commitment at a high level can guide the interest of others in the organization (SAMHSA, 2014). Along with leadership commitment exists policy and procedure review, which opened the door to effective change (Ford & Russo, 2006). A key element of integrating TIC includes creating a safe environment, and this is done by understanding trauma and the needs of trauma survivors through education and commitment to change (Bloom, 2000). Creating a safe space involves a welcoming space that ensured confidentiality and security and efforts to minimize potential

triggers (Bloom, 2000). Some other critical integration tools include trauma screening, which can lead to personalized care and support (Ford & Bloom, 2013), focusing on client-centered practices that empower individuals in decisions about their care (Najavits, 2002), and staff self-care and support, which can be done by offering resources to staff (Jennings, 2015).

An integrated approach to TIC involves several tenets that assist in successfully implementing trauma-informed practices into an organization (Gutowski et al., 2022). These principles were listed in the previous section and are discussed again briefly towards the end of this section. Trauma integration begins with understanding trauma and its impact on the community, learning about at-risk populations within one's community, and becoming aware of how the community has been underserved historically (Brown, 2017; Chavez-Dueñas et al., 2019; Gutowski et al., 2022). Necessary components of trauma include an understanding of the survivor mentality, available trauma services and resources, and the service relationship (Harris & Fallot, 2001). This understanding goes beyond learning a few current statistics on trauma rates and takes the knowledge base deeper, increasing trauma awareness.

Another tenet of TIC is developing healthy connections with their congregation and becoming better informed on how to care for their community (Bloom, 2013; Chioneo et al., 2020; Gutowski et al., 2022; Jordan, 2017). By adhering to this principle, organizations using TIC respect how they can benefit from the recommendations of mental health practitioners and those who have already integrated TIC into their practice (Gutowski et al., 2022). Staff avoid repeating the cycle of trauma and retraumatization by using their new understanding of trauma and its patterns and impact on the community through TIC (Comas-Díaz, 2016; Gutowski et al., 2022). The final tenet is advocating for the community through TIC practices and implementing

change within the organization that will improve current processes for seeing the community's trauma-related needs (Gutowski et al., 2022).

Gutowski et al. (2022) offered recommendations for integration that include fostering safety, embracing cultural and racial sensitivity, prioritizing connection, valuing collaboration, inquiring about trauma, responding with compassion, promoting healing and recovery, fostering networks, striving to eliminate coercion, promoting staff well-being, and changing policy. Herman (1997) also stressed the importance of establishing safety, encouraging remembrance and mourning, and experiencing reconnection when working through trauma. Safety is the most critical component of integrating change within an organization, and while it can be challenging to maintain, it is mandatory for all involved (Bloom, 2013; Brown, 2009; Herman, 2015). Embracing cultural and racial sensitivity requires a humble nature, a willingness to learn, and respect for the culture of others (Mosher et al., 2017).

Effective integration is only possible when the connection is prioritized and collaboration is valued over an approach that relies solely on personal knowledge and power (Flückiger et al., 2018; Gutowski et al., 2022; Jordan, 2017). TIC builds a foundation for healing and recovery by inquiring about trauma with compassion. Some essential elements of trauma healing and recovery include empathy and active listening, trauma-informed approaches, cultivating trust, respecting autonomy, understanding triggers, encouraging self-expression, connection to resources, promoting self-care, and offering ongoing support (Courtois & Ford, 2009; Harris et al., 2001; Herman, 1997; Njavits & Walsh, 2012; Roth et al., 1997). This is the goal of TIC practice, far above simply understanding trauma and knowing the signs and symptoms (Gutowski et al., 2022; O'Dwyer et al., 2019; Wilson et al., 2015). Fostering connections with individuals dealing with trauma promote healing by helping the individual find the proper

channel for treatment. However, one should never be coerced into specific treatment (Bloom, 2013; Goodman & Smyth, 2011). Prioritizing safety and staff well-being is critical in preventing burnout, promoting mental stability, and maintaining a consistently effective system (Gutowski et al., 2022; Johnson et al., 2018). Lastly, TIC is integrated only when change occurs, which may involve changes in policies, practices, and personnel, which is often challenging (Bloom & Farragher, 2011; Isobel & Edwards, 2017).

Facilitating Resilience and Preventing Retraumatization

Trauma impacts resilience, which can affect social functioning. Levels of resilience may be altered in a way that one struggles to carry out everyday conversations (Maercker et al., 2021). A deficit in resilience significantly impacts relationships. Isolation is a common symptom occurring after trauma and is an indicator related to PTSD (Maercker et al., 2021). Resilience and perceived social support are needed to overcome the impact of trauma because they diminish intrusive rumination and perceptions of entrapment, thereby reducing the symptoms of PTSD (Foa et al., 1987; Lee, 2019).

When spirituality is ignored, and trauma is buried rather than discussed in a therapeutic framework, significant discomfort developed and led to deeper issues such as suicidality or substance use (Van Denend et al., 2022). A multifaceted research study investigated the link between congregational/church support and mental wellness (Vazquez et al., 2023). Results from the survey used indicated a direct connection between perceived social support and spiritual coping (Vazquez et al., 2023). Research indicated that the impact of this form of coping on an individual involved adjustments such as stress-related growth and improvement related to physical, mental, and emotional distress (Pargament et al., 2000).

Dealing with trauma either directly or secondarily posed a risk for retraumatization, and parameters must exist to prevent more trauma from occurring (Herman, 1997; Levine, 1997). Porges (2011) advised against interventions that risk retraumatization. One goal of TIC is to prevent retraumatization of survivors by creating a space where others can understand their unique needs (Arthur et al., 2013). Retraumatization happened when clients who have experienced trauma are unable to be present for therapy or other treatment due to fear, causing their mental health needs to be unmet by clinicians due to a lack of information (Granner & Seng, 2021). The methods practitioners used to implement TIC are essential to successfully engaging with trauma survivors without re-traumatizing them (White et al., 2016). Providers should make efforts not to absorb trauma during treatment.

An example of TIC integration focuses on preventing retraumitization is seen when trauma-informed workers address the needs of childhood trauma survivors. An example is creating a safe space for the individual to disclose information where they feel secure and protected with the freedom to disclose private information (Herman, 1997). Additionally, TIC methods recognize triggers that might impact a childhood trauma survivor, such as being touched, loud noises, and feelings of manipulation (Herman, 1997; Levine, 1997). Trauma-sensitive language looks like saying, "You are in control here" or "It's okay if you don't want to talk about it, but if you do, we have space for you to do that too." These examples allow the individual to feel safe by placing the power and control back in their hands, and this helps to prevent retraumatization (Herman, 1997).

Trauma-informed approaches also extend to veterans dealing with combat trauma, and a consideration for this community is providing a calm environment focused on

minimizing stimuli to avoid triggering trauma responses (Herman, 1997). Specifically, this means avoiding loud, unexpected noises or unexpected flashes of light that could trigger a flashback to a combat-related traumatic experience. There are other trauma-informed methods that support veterans with combat trauma in their healing, such as positioning in rooms where exits are visible, approaching slowly, and avoiding swift or unexpected physical engagements such as a pat on the back or approaching quickly from behind. These techniques specifically aim to prevent retraumitization by avoiding physical touch that could be triggering (van der Kolk, 2014).

Attending to the specific trauma needs of survivors is another way to integrate TIC. For example, when working with individuals who have been displaced from their homes due to trauma, it is critical to provide them with available resources to support them (Wright et al., 2022). Young people facing homelessness are at a high risk of retraumitization (Wright et al., 2022). Some of these resources include shelters, food, rides to appointments, childcare options, and anything that will help with the immediate physical needs of the survivor (SAMHSA, 2012; Wright et al., 2022). Consider a family whose home has burned and left them without food, shelter, medicine, care kits for personal hygiene needs, and any tangible items that they require (SAMHSA, 2012; Wright et al., 2022). By offering any of the resources listed above, they might feel supported, but support can go beyond immediate basic human needs and extend to items that make the individual more comfortable, such as a comforting book, a soft blanket, or toys for children. These examples offer support that helps build resilience by actively helping the individual take necessary steps forward from their traumatic experience (SAMHSA, 2012). Offering hope is an excellent way to build resilience, and that is done when support meets critical needs like housing and food security (Wright et al., 2022).

Treatment Using Trauma-Informed Care

Empirically supported treatments for trauma often focuses on the outcomes of anxiety, depression, and symptoms of PTSD (Resick et al., 2017). Trauma-informed treatments aim "to ensure basic knowledge, support psychological safety, build resilience, and eliminate retraumatization" (Beck et al., 2022, p. 477). When multiple clinicians are involved, they all operat with a trauma-informed level of care to prevent undoing each other's progress (Beck et al., 2022). TIC requires a clear set of policies and procedures to be used by clinicians in any organization seeking to use TIC methods (Bargeman, 2022). Specific examples of integrating TIC in settings like hospitals, schools, and welfare programs are discussed in the next section.

The long-term impact of trauma throughout the lifespan requires better care from those committed to helping, including improving mental wellness (Crawley et al., 2021). Groups that serve children should be equipped with TIC practices and training, including religious organizations and churches (Crosby et al., 2021). As churches often concentrate on families and work with children in focused ministries, there is a prominent place for TIC integration within this community. Knowing where TIC can be applied is vital. For church leaders, a concern is whether TIC can be integrated into a church setting. Any organization or person working with children should utilize TIC practices (SAMHSA, 2014). Researchers consider that everyone is exposed to trauma at some point in their lives (Friedman, 2015; López-Zerón & Blow, 2017; Karstoft & Armour, 2022). TIC training increases one’s knowledge and self-efficacy, which is relevant when mentoring (Hays et al., 2023). The church can look to the integration of TIC in pediatric settings for evidence of appropriate strategies when working with children.

Christian-Brandt et al. (2019) examined the numerous approaches used for TIC among pediatric patients with medical traumatic stress and found that it is helpful in all systems of care.

There are aspects of pediatric care that can be traumatic, such as being diagnosed with a health problem, undergoing medical procedures, learning about poor outcomes in others, and interacting with many different providers (Stenman et al., 2019). A specific example of integrating TIC with pediatric patients is how a doctor might incorporate play-based activities during appointments, such as simple games or playful language when asking questions (Stenman et al., 2019). Play in pediatric settings helps to foster positive interactions between providers and patients, reducing anxiety, restoring a sense of normalcy, relieving boredom, providing distraction, and processing emotions (Stenman et al., 2019).

Trauma-Informed Care Models

The literature on TIC shows a growing number of treatment programs that already exist successfully, including hospital settings, child welfare workers, juvenile justice staff, and resource/foster families (Kramer et al., 2015). Studies on TIC models are extensive and can be used to provide a solid basis for adding them to an organization's practices. Trauma-informed design is a concept used to highlight and address psychological needs, including perceived safety and security, and is a form of TIC (Ajeen et al., 2022). Trauma-informed examinations exist in many healthcare environments. This model involves a basic understanding of trauma, the general needs of an individual exposed to trauma, and specialized care that is aware of the impact of trauma, such as creating a safe space, using trauma-specific language, and offering resources (Ely et al., 2017).

Trauma-informed integration involves using trauma-informed practices within an existing model. Several factors are considered when developing an appropriate trauma-informed integration (Kalokhe et al., 2022). A TIC model highlights the understanding of trauma and its

impact, recognizes paths to recovery, and responds with knowledge and understanding of trauma and how to merge TIC into all related practices (SAMHSA, 2014).

TIC in Schools

Trauma-informed schools have become a topic of conversation in Ontario. However, teachers remain concerned and underserved by the lack of proper training in TIC, which put them and their students at a disadvantage when trauma is unexpectedly disclosed (Mayor, 2021). Areas addressed by TIC with children and teens include understanding the impact of trauma, recognizing the signs of trauma, integrating trauma education into practices and policies, and preventing retraumatization of patients (Harlow et al., 2023; Menschner & Maul, 2016; Schulman & Menschner, 2018).

Due to trauma rates and their impact on children, schools have become a place where TIC is used as an effective approach for traumatized children (Cafaro et al., 2023; Morton & Berardi, 2018). Schools that blend TIC into their staff training support a systemic strategy towards better supporting students exposed to trauma (McIntyre et al., 2019). Proper training and assessment are mandatory for teachers who intend to use TIC (McIntyre et al., 2019). Educators receive TIC training through professional workshops, in-service training by district school boards, online courses and webinars focused on TIC, collaborating with mental health professionals, and attending conferences and seminars focused on TIC. Some resources available to teachers seeking to become trauma-informed include the SAMHSA's trauma-informed approach guide (SAMHSA, 2014), the trauma-informed educational practices initiative (Carello & Butler, 2015), and *The Trauma-Sensitive Schools: Learning Communities Transforming Children's Lives, K-5* book (Craig, 2016).

Trauma-informed approaches benefit both students and teachers as they encounter the effects of trauma in the classroom (Morton & Berardi, 2018). Trauma-informed teachers are better equipped to manage difficulties of behavioral and emotional self-regulation often seen in children who have experienced trauma (Morton & Berardi, 2018). Trauma symptoms are reduced in students when evidence-based trauma interventions and TIC are carried out by teachers and school staff (Cafaro et al., 2023). Teachers report feeling more equipped to manage and teach students experiencing trauma after receiving TIC instruction (Cafaro et al., 2023; Morton & Berardi, 2018).

Offering TIC in school settings means developing a safe environment where students know what to expect, where positive behavior is reinforced, and where support systems are visible to the students (Martin et al., 2017; Nicholson et al., 2019). An example of integrating TIC into a school system involves training the staff on how to use trauma-informed language and taking a strengths-based approach when working with students (Martin et al., 2017; Nicholson et al., 2019). Student support teams are excellent resources for students with trauma as they can include counselors, mental health professionals, and social workers who work alongside teaching staff to minimize trauma symptoms while at school (Martin et al., 2017; Nicholson et al., 2019). Teachers who use trauma-informed classroom management offer choices to their students, set clear expectations, and provide a routine with structure (Martin et al., 2017; Nicholson et al., 2019). These methods aim to support students who have experienced trauma but make school a safe environment where the minimization of triggers is a priority (Martin et al., 2017; Nicholson et al., 2019).

TIC in Healthcare

Nurses in healthcare systems work in a problem-focused and task-oriented environment. However, Isobel and Edwards (2017) found benefits to incorporating TIC in medical settings. When healthcare is provided with a trauma-informed approach, crisis prevention, and physical and mental recovery can occur (Stanley, 2023). Medical, mental health and social needs are met for the most vulnerable of patients through staff collaboration, including administrators, nurses, doctors, and others engaging with patients (Forkey et al., 2021; Harlow et al., 2023; Schulman & Menschner, 2018).

Organizations attending to individuals' wellness provide immediate relief through TIC strategies (Stanley, 2023). In addition to helping patients, TIC practices benefit nursing staff as they experienced distress involved in care and workforce stress (Isobel & Edwards, 2017). The benefits of TIC go beyond benefits to patients and impact the organization (Croghan & Brown, 2010; Evans et al., 2013; Stanley, 2023). TIC wellness skills "strengthen the system's quality of care, client well-being, and workforce cohesion" (Stanley, 2023, p. 14).

Families of homicide victims often interact with healthcare staff in the aftermath of their family member's death, and their secondary trauma is a valid cause for trauma-informed practices (Mastrocinque et al., 2023). When aiming to prevent exacerbating their traumatic event further, hospital staff take steps to better support families of homicide victims, such as understanding the fears they may be experiencing. An example of a threat to safety experienced by the families of homicide victims is the fear of perpetrators who were not convicted and the vulnerability of not knowing what to disclose (Mastrocinque et al., 2023). When providers create a safe space, it might look like a persistent demonstration of concern from the healthcare provider (Herman, 1997; Mastrocinque et al., 2023). However, providers are cautious of being

perceived as having ulterior motives, as this is critical when developing trustworthiness (Mastrocinque et al., 2023). Offering a consistent, careful tone and sensitivity to the needs of families is critical in maintaining this trust and preventing retraumitization (Herman, 1997; Mastrocinque et al., 2023).

Empirical research findings indicate a need for TIC in hospital obstetrics units when expectant mothers have sustained trauma in the past (Gross et al., 2020). By incorporating TIC into obstetric practices, practitioners help meet the needs of such patients and work to prevent retraumatization (Sperlich et al., 2017). Trauma inquiry in TIC in this setting involves explaining to patients the rationale for such questions to best engage them on a potentially sensitive topic (White et al., 2016). For example, when a nurse is making a trauma inquiry with a patient in the emergency room who is showing signs of domestic abuse, the nurse began by building rapport, using trauma-sensitive language, clarifying the purpose of the inquiry, explaining confidentiality, offering empathy, validating the client, and being specific about the nature of the inquiry while assuring safety (Herman, 1997; SAMHSA, 2014; van der Kolk, 2014). Trauma sensitive language includes statements such as, “Hi, I am a nurse, and I am here to help you. I am going to ask you some questions that might be difficult to answer. The purpose of these questions is to ensure that our staff provides care that makes you feel supported during this process.”

Interviews from nursing staff reflecte a willingness, associated with reasonable concerns, to learn TIC and incorporate necessary changes to better support patients with experienced trauma. Additionally, nursing staff report a perceived value of TIC in medical settings (Isobel & Edwards, 2017). A concern from nursing staff is the expectations associated with TIC, such as the timing that occurrdwith the added training to become trauma-informed and the time

constraints when working with a full caseload of patients while trying to offer individualized care.

TIC is a beneficial approach as it can seamlessly integrate with pre-existing staff responsibilities. The role of a trauma-informed nurse is not to treat mental health-related disorders (Isobel & Edwards, 2017). Instead, the purpose of TIC is to have an awareness of the potential needs of patients with trauma exposure and to provide specialized care in instances where trauma exists (Harlow et al., 2023; Isobel & Edwards, 2017). An example of carrying out TIC with a patient includes a discussion about the use of restraints for patients with past trauma (Barton et al., 2009; Isobel & Edwards, 2017). While safety is a necessary concern, retraumatization is also a concern (Herman, 1997; Levine, 1997); both are addressed through a trauma-informed lens (Barton et al., 2009; Isobel & Edwards, 2017).

TIC in Residential Care and Welfare Settings

Studies on child welfare systems and residential programs for youth identify a need for additional social work-related training that includes trauma-informed practices (Brown et al., 2013; Forrest et al., 2018; Galvin et al., 2022; Lamminen et al., 2020; Parry et al., 2021). When positive outcomes for youth are prioritized over the costs of residential youth programs, efficacy within trauma-informed programs is seen (Forrest et al., 2018). For example, Building Communities of Care is a successful trauma-informed model with age-appropriate behavioral management strategies (Forrest et al., 2018). This model was specifically designed to meet the needs of youth in residential treatment programs (Forrest et al., 2018), and some of the practices can translate well into youth programs in churches. The core qualities of this model include being integrative, individualized, and proactive (Forrest et al., 2018). By integrating TIC into all areas

within an organization, this model ensures that all personnel are well-versed in trauma-sensitive language and able to offer trauma-informed observations and suggestions (Forrest et al., 2018). By adjusting standard care to a more individualized approach, this model looks at the specific needs of individuals and meets them accordingly (Forrest et al., 2018). Each of these qualities ensure that TIC is extended throughout the organization effectively.

The restorative parenting recovery program uses trauma-informed methods to essentially re-parent children and youth in residential programs to address and heal their past trauma (Parry et al., 2021). Child welfare systems see children facing complications in their relationships with family, child protective services, the court system, and caregivers. However, trauma-informed models help workers in child welfare programs mitigate the impact of trauma on youth in their programs by offering resources, using trauma-sensitive language, and taking steps to reduce trauma triggers and retraumatization (Lamminen et al., 2020). These are all methods that can easily guide a church as it seeks to integrate TIC practices.

The Church

The church has long been a source of hope and healing for individuals, especially in times of trouble (Schieffler & Genig, 2021; Trueman & Gould, 2017; Walker et al., 1985). The church is often a place for social and religious gatherings (Bouchard et al., 2020). The church also provides spiritual support with religious principles and strategies like positive religious coping (Krause, 2008, 2010; Upenieks, 2023). Further, the church is recognized as a place for education, social connection, and volunteering (Fields et al., 2016).

The role of the church in the face of trauma is that of a vital resource (Hill & Yancey, 2022). The Bible is replete with stories of traumatic events, including Abel's murder, Dinah's rape, Paul's stoning, Jesus' crucifixion, and the global flood, to name a few (*English Standard*

Version Bible, 2001). Symptoms associated with trauma can be met with healing from the church (Hill & Yancey, 2022; Hunsinger, 2011). For example, symptoms of isolation, loneliness, and hopelessness can be met with a faith community.

Historical Roles of the Church

Churches and ecclesiastical leaders were called on in times of need, and expectations for help continued due to the church's positive response throughout the centuries (Heward-Mills et al., 2018; Nche & Agbo, 2022; World Vision International, 2021). A historical view of the work of pastors and pastoral counselors added to working through everyday issues such as marital problems and depression (Abbott, 1988; Bernau, 2021). Four specific contrasting roles of the church included the church being used as a political tool, an instrument for stability and change, an oppressor and source of rejection, and a source of protection (Bouchard et al., 2020; Cnaan & Newman, 2010; Stroope, 2011; Wilcox, 2000).

Bolstering confidence and self-worth were two crucial roles carried out by this church historically, and these continue to play into the role of the contemporary church (Krause & Hayward, 2012). Building a community and creating a familial environment for congregants were important in the early church (Krause & Hayward, 2012). Creating a sense of togetherness and a place of belonging were also core roles of the church historically (Krause & Hayward, 2012). The church has long served as a place where congregants can find dignity, self-worth, and value (Krause & Hayward, 2012).

The roles of the early church included work with education and literacy, social welfare and charity, and missionary activities (Griffith, 2008; Walls, 1996; Wieruszowski, 1996). The church's role during medieval times involved education and literacy programs, and churches played a critical role in some of the earliest education institutions (Wieruszowski, 1996).

Churches have provided social welfare and charity in the community for decades, specifically reaching marginalized members of the community by aiding in the early development of orphanages, hospitals, and social service programs (Griffith, 2008). Missionary activities and extending the gospel across the globe have been crucial in the expansion of the Christian faith throughout history (Walls, 1996). Some of the specific contributions of the church during missionary work included the establishment of physical churches, building schools, and offering resources to the community (Walls, 1996).

Some of the cultural and social roles of this historical church included cultural and artistic patronage, community gathering and social cohesion, and cultural identity and heritage (Barron, 2014; Gillespie, 2006; Lev, 2018). Churches have long been a space for cultural expression where the arts are valued, and creativity is welcome (Lev, 2018). The church supported the community through gatherings and increasing social cohesion by offering its space as a center for gatherings, festivals, and community events, which fosters belonging and community (Gillespie, 2006). Churches have historically supported and contributed to preserving cultural heritage and identity by passing down traditions, rituals, and customs to maintain the integrity of culture (Barron, 2014).

Contemporary Roles of the Church

The current church continues to carry the responsibility of extending helping hands to the community, and many of the historical roles of the church are still intact. As the world has changed, new issues arose along with new approaches to serve. One example is the development of the internet and the many ways in which the church has leveraged the internet to extend the gospel and its services. As the world continues to be impacted by new stressors and the increasing demands of society, the church continues to be a beacon of hope and a space for

support. Shared below are some of the many ways in which the current church is serving the community and how the increased understanding of mental health has added to some of the new programs of church ministry.

Some of the roles carried out by the church in the community include health and security, and some can create further challenges within a community (Bouchard et al., 2020). The four core functions of a church include education, fostering community, service, and worship (Ammerman, 2009). An example of leaders helping the community was the COVID-19 pandemic, when health providers and governments expected church leaders to build social cohesion, help with anxiety, maintain trust, deliver practical information, and advocate for the most vulnerable (inte). The contemporary church stood as an instrument for community stability (Bouchard et al., 2020). The global church is also known for fulfilling its role as a source of protection (Bouchard et al., 2020). Some congregants offered support to others through empathy, love, care, assistance with chores, or transportation (Upenieks, 2023).

The church continues to be a place for spiritual formation, where worship can happen in many different forms, such as through prayer, meditation, music, and teaching (Warren, 1995). Community engagement and social justice continue to be critical roles for the church (Keller, 2012). Digital ministry and online outreach are new ways that the church is serving the community both locally and abroad (Wise, 2014). As technology adds new challenges to the lives of congregants, the church makes efforts to reduce the impact of stress and pressures on the online community with teachings about the safe use of technology (Crouch, 2017). The church continues to be a place that celebrates and preserves culture while remaining diverse and inclusive (Opstal, 2022).

The church continues to reach others through service projects in mission work, and this work increased tremendously over the years with the use of technology aiding the increased awareness of global issues related to poverty and injustice (Piper, 2020). As the awareness and understanding of mental health increases, the church becomes a place where individuals can go for individual support and care within family systems (Keller, 2013; Simpson, 2013). By offering support for mental health issues, the church help to break the stigma both in the community and in the church (Simpson, 2013). Churches continue to support families, as they have done across the ages, but the inclusion of marriage and family ministry is a newer way in which the church offers support for married couples and families (Keller, 2013).

Pastors and Church Leadership

Pastors and church leadership are critical for a sustainable organization of church facilities and are met with tremendous expectations. The value of a pastor's role in society is high, though challenging to maintain due to the many dual relationships within the community (Pooler, 2011). Qualities expected and often held by pastors include competence, moral rectitude, self-control, intelligence, and skills in helping others (Pooler, 2011). The role of a pastor is multifaceted and encompasses areas of leadership, care, teaching, and engagement (Keller & Keller, 2013; Keller, 2015; Loritts, 2009; Peterson, 2011; Sanders, 2017). The leadership roles of a pastor extended to administration and organizational oversight (Loritts, 2009), guiding those within the congregation and throughout the community (Sanders, 2017). A key role of the pastor is to preach the gospel and provide teachings that explain the various Biblical topics as they relate to everyday life (Keller, 2015). Pastoral care and counseling marriage (Peterson, 2011) and family ministry (Keller & Keller, 2013) are two of the areas where the role of a pastor directly intersects with mental health care.

The role of pastors from a community outreach perspective is to support those in the community through a variety of challenging issues while promoting healthy lifestyles (Allen et al., 2014; Anshel & Smith, 2014; Barnes & Curtis, 2009; de Oliveira Maraldi, 2020; Sklar & Goldman, 2023). The credibility of pastors within communities allows their role to help promote health (Anshel & Smith, 2014). Pastors are expected to maintain inclusion and promote diversity within communities (Newbell, 2014). Modeling the Christian lifestyle is another key role of the pastor (Eswine, 2015). Crisis and conflict resolution are critical roles of the pastor, and these extended to the community within and outside of the church (Sande & Johnson, 2015). As the role of pastors continues to grow and expand, it is critical that they remain dedicated to continued learning and professional development (Merida, 2009).

Pastoral Support for Mental Health

Pastors are responsible for leading their churches and setting the tone for a congregation's global mental health and counseling perspective. Pastors help congregants and those in the community through various methods involving one-on-one engagement and group activities. Faith-based behaviors that promote positive psychological or social-psychosocial functions for mental health include prayer, devotional activities, and small group engagement. These activities promote hope for change, healing, and enhanced self-worth (Ellison, 1995; Koenig et al., 1992; Nooney & Woodrum, 2002). Pastors who foster a community of care through their leadership help congregants carry out behaviors that promote mental health. Church-based groups led by pastors and other clergy members exist to offer interventions for issues related to mental health (Weaver et al., 2019).

Pastoral Training

A Master of Divinity is a standard degree for one seeking to serve in a pastoral role, according to the Association of Theological Schools (Cadge et al., 2020). While this specialized degree program is designed to equip future pastors fully, it often failed to include all necessary training for ministry (Cadge et al., 2020). Some institutions provide specialized courses and programs to further train those interested specifically in spiritual care (Cadge et al., 2020).

A combination of theological training, psychological education, and social work-related skills is recommended for those seeking to serve as clergy or chaplain (Carey & Rumbold, 2014; Muravchik, 2011). This combination is referred to as a 'psycho-religious synthesis' (Carey & Rumbold, 2014; Muravchik, 2011). These specialized courses were added within the past 20 years and are an indicator of the trends in church counseling and the lack of mental health training and TIC within ministry settings (Cadge et al., 2020).

Appropriate chaplaincy and pastoral care skills include being a good listener, working as a team with other professionals, and being non-judgmental (Carey & Rumbold, 2014). Understanding the differences between professional and pastoral counseling is critical, and not appreciating them causes frustration and role confusion (Carey & Rumbold, 2014). Chaplains and clergy report a need for further education in pastoral counseling (Carey & Rumbold, 2014). Legitimate pastoral counseling includes the ability to assess, infer, and treat because of academic training (Bernau, 2021). Pastoral counseling requires that one's methods are exclusive, measurable, effective, and client specific (Bernau, 2021).

Degree programs focused on training pastoral counselors includes formal theological education with a specialized course of study specific to the counseling practice (Graham & Whitehead, 2006). Religious knowledge and practices are taught using personal beliefs,

vocational direction, and professional skills and identity as the foundation (Graham & Whitehead, 2006). To become a pastoral counselor, one obtains formal training in theological education, which paired with formal training in professional counseling (Bernau, 2021; Graham & Whitehead, 2006). This type of study typically exists within schools of theology, as a subcategory or specialized degree program (Bernau, 2021; Graham & Whitehead, 2006). This differed from the standard Master of Divinity program, as the focus is solely directed to the role of a pastoral counselor with the specific purpose of offering counseling.

In addition to training on how to serve their church, community, and staff, pastors and church leaders required training to maintain their mental health, as this can impact their ability to serve others (Terry & Cunningham, 2020). Being intentional to maintain a healthy mental state helped pastors to efficiently help others. Physical and spiritual self-care, social support outside of work, work-related support, and holistic health care are all ways in which clergy promoted positive mental health in their lives and better meet the demands of their work and ministry (Bickerton et al., 2015; Galek et al., 2011; Proeschold-Bell et al., 2011; Terry & Cunningham, 2020).

Spirituality and Healing

Not only does trauma impact one's spirituality, but one's spirituality can improve the response to trauma. The biopsychosocial spiritual model, presented earlier in this chapter, speaks to the connection between mind, body, and spirit. The original biopsychosocial model was modified to include the spiritual aspects of a person's life as it relates to healing (Van Denend et al., 2022). As examined previously, trauma impacts each facet of a person: biological, psychological, social, and spiritual.

When attending to the post-trauma needs of an individual, each aspect is considered in the healing process. Spiritual well-being is a notable protective factor against adverse emotional reactions (Bufford et al., 2022). Secular counseling settings need to consider the impact of trauma on spirituality, especially in instances where trauma came from religious abuse (Cashwell & Swindle, 2018).

Due to some of the unique messaging surrounding women and their bodies in some religious settings, the spiritual needs of women who have experienced childhood sexual abuse differ from those of other women who do not have a religious background (Choruby-Whiteley & Morrow, 2021). Survivors of trauma related to child abuse report an improvement in emotional health, a renewed sense of meaning, and a purpose to live as a direct result of their spirituality and faith (Burlaka et al., 2020). Each of these improvements due to spiritual support and faith are increased with the methods listed below. Social support is a huge component offered by the church. Herman (1994) highlighted the importance of social support in trauma recovery and healing. The structure and meaning offered by rituals and healing practices within churches, such as times of prayer and meditation, help trauma survivors find solace and comfort. Van der Kolk (2014) described rituals and healing practices as a helpful part of recovery for trauma survivors. Churches often offer community resources such as counseling, support groups, and outreach programs. Offering community resources is a critical component for some trauma survivors, especially when their needs demanded immediate care (Levine, 1997).

Multiple case studies find five critical components to help people use spiritual tools and practices in stressful times. These tools include attention to the sacredness, acceptance of all, spirituality modeling, encouraging value, and involving ethics (Plante, 2022). Explaining these elements helps church leaders grasp the connection between trauma and spirituality and the value

of using these tools with congregants who are dealing with trauma. Underscoring the sacredness of all means acknowledging spirituality in all humans and respecting the sacred part of individuals (Plante, 2022). This involves working with individuals of a different religion and being able to facilitate healthy conversation without disrespecting their spirituality. Acknowledging the sacred aspect of others helps to prevent judgment and demonizing someone for their differences (Plante, 2022). Learning to accept others, even with faults, is an extension of the first element, and this is done by choosing not to judge others when they are different or even wrong (Plante, 2022). The benefit of this element is that it increases relationships, builds rapport and trust, and strengthens community bonds.

Focusing on spiritual modeling came from the idea of observational learning and modeling, which is highlighted by psychological research (Bandura et al., 1966; Plante, 2022). This is like the notion of practicing what you preach. By modeling spiritual practices and actions that are consistent with spiritual teachings, others recognized the behavior and model it in their own lives (Plante, 2022). Encouraging virtues of forgiveness, kindness, gratitude, and compassion are some of the ways Biblical practices can be modeled. This element strengthened the bond of the community and created a safe environment for others (Plante, 2022). Incorporating ethics into daily decision-making meant acting in an ethical manner and according to a moral code both at church and away from the church (Plante, 2022). This type of element transcends beyond the church community and takes spirituality into account in all aspects of life. The combined effort of incorporating all five elements into a church setting helps to promote the core elements of a trauma-informed church, such as by creating a safe space, considering others, building rapport and trustworthiness, seeing the needs, and accepting the differences of others.

Research on natural disasters and the trauma involved with these crises indicates a connectedness to existential constructs, as well-being is challenged during such events (Ai et al., 2023). A holistic approach to treatment involves healing one's spiritual self (Helmke et al., 2017). Psalm 90 represents a reflection and lament and is often used in distress (Brown & Collicutt, 2022). In this psalm, Moses acknowledged his crisis, considered the catastrophic implications, and asked God for help (*English Standard Version Bible*, 2001). These steps can be applied to traumatic exposure in those who are open to the reality of and direction from God (Brown & Collicutt, 2022).

Numerous researchers identify a connection between religious affiliation and positive mental health compared to no religious affiliation and a lower mental health status (Koenig et al.,1988; Levin & Chatters, 1998; Nooney & Woodrum, 2002). Despite the negative impact of trauma on spirituality, it also leads to growth in individuals who seek out counsel for their trauma-induced wounds (Hill & Yancey, 2022; Smith, 2004). The connection between trauma and spirituality is relevant, as are healing approaches that consider a spiritual focus on growth, new meaning, and purpose (Hilly & Yancey, 2022; Smith, 2004).

Trauma-Based Needs of Congregants

With the prevalence of trauma, it is expected that Christians carried the weight of trauma exposure with them into their church settings. Of the 10 million people dealing with mental health problems in the United States each year, at least 35% did not seek professional help from a care provider (SAMHSA, 2017). Those dealing with mental health issues often reach out to their faith community for counsel instead of connecting with mental health professionals (Costello et al., 2021; Hardy, 2014; Hill & Yancey, 2022; Kane & Green, 2009; Weaver et al., 2019). Community outreach is an integral part of ministry in many churches. Through these

programs, the church consistently sees the reality of mental health needs (Triplett et al., 2013). Exposure to mental health-related issues is a factor in opening the eyes of church and religious leaders who may have previously shied away from this need (Hilly & Yancey, 2022). The church helps neighborhood organizations confront domestic violence and crime, often addressing mental health needs (Cnaan, 2002; Kinney & Winter, 2006; Triplett et al., 2013).

Some of the personal and relational issues related to trauma that people bring to the clergy when seeking counsel include LGBTQ+-related struggles, spouse or partner abuse, job loss, and relationship problems (Kane & Green, 2009). Psychological issues presented to clergy involve trauma-related symptoms such as anxiety, coping, bereavement, drug use, depression, and suicidality (Kane & Green, 2009; Upenieks, 2023; Weaver et al., 2019).

Improving Care for Congregants

The care provided by pastors for individuals seeking mental health care had positive or negative outcomes (Alviar & Del Prado, 2022). There will always be room for growth or improvement in any organization, including churches. While a preference for care administered by the church exists, a stigma surrounding mental health continues to exist within church communities (Weaver et al., 2019). The church's historical perspective on mental health concerns did not favor those seeking help (Bouchard et al., 2020; Covey, 2005; Wesselmann & Graziano, 2010).

Hurt and wounds from the church exist when people are underserved by it or when the church or its leaders act out of turn or with a lack of proper training or compassion in their service (Hipp et al., 2019; Zauzmer, 2017). Such wounds can be prevented by better education and training of church leaders and staff (Guiking & Jacob,

2020). Moreover, a trauma-informed church program has the potential to aid in positive coping and trauma healing (Crosby et al., 2020).

Mental health issues are recognized as prevalent among members of Protestant churches (Rogers et al., 2012). Studies report that some individuals who have experienced trauma did not feel supported by their church community when their trauma was disclosed (Guiking & Jacobs, 2022; Hipp et al., 2019; Streets, 2015; Zauzmer, 2017). Despite the challenges regarding contrasting church roles and stigmas faced by individuals seeking mental health assistance, the church continues to be a beacon of hope in the community (Hill & Yancey, 2022).

Clergy need mental health education and lay leaders to promote better community-based care to address issues faced by families having mental health needs (Costello et al., 2021). The church benefits when all involved have a basic understanding of trauma and how to address it as they work towards being trauma-informed in their practices (Guiking & Jacobs, 2022). Guiking and Jacobs (2022) revealed that some in church settings are more inclined to refer those who have trauma exposure to someone they feel is better equipped. Developing a culture that supports the safety of its community and its mental health and wellness involves leadership skills that include TIC, engagement, and individualized approaches (Dilks, 2020). As churches consider improving their methods for the mental wellness of their congregants, spiritual wellness will also be positively impacted.

Using Trauma-Informed Care in the Church

Tremendous research exists on the impact of TIC in hospitals and crisis-related industries (Forkey et al., 2021; Harlow et al., 2023; Schulman & Menschner, 2018). However, there as a gap in the literature on the role of TIC in local churches and religious centers. Reports reflect the impact of trauma on the church and in church communities. Researchers reveal the need for more

assistance from church leadership regarding the mental health needs of congregants (Costello et al., 2021; Williams et al., 2014).

Little has been done, though, to incorporate practices outside of integrating counseling programs within churches to equip pastors and leaders with TIC practices (Costello et al., 2021; Guiking & Jacob, 2022; Williams et al., 2014). This is also true for non-church settings (Dennis et al., 2022). Some churches and faith-based organizations recognize this lack and have developed programs for their staff. Churches partner with mental health professionals to meet this need in their organizations and communities (Costello et al., 2021; Williams et al., 2014).

I have heard pastors say that the church is to be a hospital for the broken; if this is the case, then the church can better help those in their community manage their trauma with methods from TIC. The local church can potentially be where TIC and its practices can promote healing for children and families (Crosby et al., 2021). Trauma-informed children's ministries highlight feelings of being safe physically and psychologically, regulated, connected, and valued (Crosby et al., 2021).

Mathew et al. (2020) studied the impact of church attendance on individuals with trauma exposure. They found that individuals who attended church weekly are 60% less likely to experience PTSD-related symptoms compared to those who did not do so. Churches that are trauma-sensitive can assist in the healing process of individuals within the congregation who have experienced trauma (Hill & Yancy, 2022).

The Gap

Research revealed that not all churches implement TIC, and some operate with less than supportive methods for helping their members who have been exposed to trauma (Crosby et al., 2021). Research on trauma competency in a single church revealed that 90% of their staff had

engaged with a congregant in their church who is impacted by trauma (Guiking & Jacobs, 2022). Lack of mental health resources in underserved communities lead individuals to churches for support of trauma-related symptoms (Bryant-Davis & Wong, 2013).

When religious abuse occurs, spiritual settings are a potential trigger, leading to a need for TIC (Cashwell & Swindle, 2018). A research study on the needs of children of incarcerated parents demonstrated the positive benefit of TIC in church environments (Hays et al., 2021). The impact of trauma leads to potentially disrupted social relationships, emotional distress, and behavioral changes (Crivatu et al., 2021). Church leaders address the issues of adolescent relationship abuse that are at the root of such symptoms due to the access to youth and the ability to communicate directly with them (Li et al., 2016).

The emotional pain inflicted by trauma is addressed by leaders offering relationships and support through healing in the church (Arjona, 2017; Hill & Yancey, 2022). Spiritual coping skills offered by those trained in the church can also help mitigate the impact of trauma on those in the congregation seeking help from the church (Blakey, 2016; Hill & Yancey, 2022; Klan, 2018). The role of the church in this regard is to offer hope, support, comfort, and meaning (Hill & Yancey, 2022; Van Hook, 2016).

Integrating TIC in Church Practices

The literature on TIC use in church settings is minimal. This research aimed to close the gap on this topic. Research on integrating TIC referenced ten recommendations for best practices listed above (Gutowski et al., 2022). A study on the implications of using TIC outside of mental health-related settings recommended a training session of at least a day with a series of teachings on trauma and its effects to begin the process of effectively integrating TIC into practice (Herman et al., 2020). Trauma-informed spirituality assessments can be used to provide care that

is both trauma-informed and sensitive to the spiritual needs of individuals who have experienced trauma (Hipolito et al., 2014). The church can be a place where TIC meets the needs of vulnerable populations, especially when the staff is adequately trained and has multicultural and multiracial orientations (Gutowski et al., 2022).

Developing a trauma-sensitive ministry covers multiple attributes, including an understanding of trauma and its impact on individuals, recognizing the implications of trauma for faith traditions, partnering with local mental health professionals, advocating for individuals faced with trauma, and a willingness to make necessary changes (Hill & Yancey, 2022; Streets, 2015). By providing TIC and developing a trauma-sensitive ministry, the church can be the hands and feet of Jesus by putting his teachings into practice with the care and compassion needed to encourage growth and healing following trauma (Garland & Yancey, 2014). Using TIC in children's ministry values "preparation, awareness, collaboration, and transparency" and aims to help children "feel safe, regulated, connected, and valued" (Crosby et al., 2021, p. 495). Continued research on spirituality indicates its protective role in trauma recovery. The church can apply this factor in developing a trauma-informed church-based model (Hipolito et al., 2014).

Summary

This literature review took a comprehensive look at the theoretical framework for this study, which is rooted in TLT as the driving force for this entire study. By considering how a change in perspectives can shift the entire infrastructure of the care offered in churches to those impacted by trauma, pastors can work to become better equipped to manage the needs of their congregants with methods of TIC. The literature explained the history of church perspectives and roles related to mental health work, and areas of improvement were addressed, including the

need for more training in pastoral care and counseling for leaders within the church, as this is not evident in the basic standards for ordaining bodies and degree programs directed in training pastors. Since the impact of trauma can leave wounds in both mental health and spiritual health, this research topic is valid, as it considers how the care that addresses both needs simultaneously in a safe, caring environment can exist within church environments.

Chapter 3: Methods

Although often not addressed or discussed, trauma exposure was prevalent in all communities, even impacting those who attend church regularly. When church congregants were impacted by trauma, the church could have played a critical role in addressing their trauma needs and symptoms without re-traumatizing the individual. This study assessed pastoral perspectives of trauma by exploring the experiences of evangelical pastors who have discussed mental health or trauma-related issues with their congregants. This study also considered the influence of trauma-informed care (TIC) in local churches in the Greater Toronto Area (GTA). I sought to understand the level of care being offered within churches for congregants who have trauma exposure. I looked at the gap of TIC within church settings across different denominations. Many individuals outside the healthcare industry were unaware of TIC practices or ill-equipped to deal with conversations regarding trauma and healing. This research discovered what the churches in the GTA were currently doing to meet the needs of individuals faced with trauma and learned about the openness towards better-equipping church leaders and ministers in TIC.

The purpose of this chapter was to introduce the research methodology, theoretical framework, and the researcher's role, and it described the data collection process and discussed data analysis. I used a qualitative methodology, specifically transcendental phenomenology. Interviews were conducted with a criterion sample of local evangelical pastors in the GTA to gain a deeper understanding of their experiences, training, and openness to new methods when working with congregants with trauma exposure. During the interviews, participants discussed the current level of mental and spiritual support offered by the church and the pastor's perspective on the church's role in the mental and spiritual health of the congregation and community.

Design

I used a phenomenological qualitative research design. Qualitative research included a natural setting, a researcher, access to multiple forms of data, inductive data analysis, discovering the meaning of participants' experiences, an emergent design, a theoretical lens, interpretive inquiry, and a holistic account (Creswell & Poth, 2018). Researchers used qualitative research to study problems, perspectives, and experiences that require a complex and detailed understanding (Creswell & Poth, 2018). The problems being explored in this study were the church's response to trauma and the relationship between evangelical pastors and congregants who had experienced trauma. Following the procedures outlined by Moustakas (1994), transcendental phenomenology shaped the methodology of this study.

Transcendental phenomenology was the method of choice due to its structured approach for researchers focusing on the experiences of multiple participants facing the same phenomena (Creswell & Poth, 2018). Since this study aimed to explore pastoral views towards integrating TIC in church programs, I believed a qualitative approach, using single-instrument interviews, best aligns with achieving the goal of better understanding the experiences of evangelical pastors and their perspectives on trauma and care for trauma. Each decision regarding methodology and research design was made with the purpose of this study at the forefront of the selection process. At every turn, transcendental phenomenology aligned most accurately with the goals and purpose of the research.

Qualitative Design

The following four critical facets framed qualitative research: assumptions, worldview, theoretical lens, and the research problem (Creswell & Poth, 2018). The assumptions explored in this study focused on trauma, the church, TIC, and pastoral roles. My worldview was rooted in

evangelical Christian beliefs, a Canadian/American culture, and lived experiences with trauma, seeking counseling from the local church, offering pastoral care to congregants, and a personal spiritual healing journey. It was my first assumption that the human experience does not exempt trauma from touching the lives of people in the church. I also believed evangelical pastors were being faced with issues related to trauma when ministering to their congregants, as trauma was a standard part of the human experience. The third assumption was, that while well-intended, evangelical pastors may require more training in TIC to better equip themselves on how to help their congregants when dealing with issues of trauma. The theoretical frameworks for the study included Mezirow's (1991) transformative learning theory (TLT) and Moustakas's (1994) transcendental phenomenology. I explored pastors' perspectives on TIC in the church to understand their experiences when engaging with people in the church who have experienced trauma. In interviews, I explored pastors' experiences and the existing support infrastructure within their church.

An interpretivist paradigm sought to explore the implications of pastoral views towards TIC and the integration of TIC in local churches in the GTA. Data was collected by interviewing local evangelical pastors about their experiences offering care to congregants who disclosed trauma and their perspectives towards TIC and openness to integrate change through TIC practices in their ministry. First, the interviewees disclosed pertinent, identifying information about their pseudonym name, title, role, and pseudonym church. Next, I asked each participant a series of closed-ended questions to establish basic knowledge of the church's existing programs related to mental health. Lastly, I asked open-ended questions in a single-session interview to better understand pastoral experiences with congregant discussions on trauma and their perspectives towards TIC and mental health-related discussions within the church.

I analyzed the interview data identifying themes regarding pastoral experiences with congregant trauma and perspectives on TIC and developed a better understanding of the openness towards future integration of TIC in the church. This data can be used in future research to develop best practices for TIC educators working with evangelical pastors. This cross-sectional study has implications for future research in spiritual health and mental wellness amongst congregants in local churches in the GTA.

Methodology and Theoretical Congruence

Data collection for this study came from personal interviews with each evangelical pastor. The use of interviews in qualitative study involved interpretation by the researcher (Levitt, 2020). The rationale for using interviews for data collection stemmed from a need for a deeper understanding of experience that cannot otherwise be explained through numerical data and testing. To fully understand the work and perspective of evangelical pastors, interviews were the best method for gaining insights into their work, as I gathered data that includes first-person accounts of personal experiences by evangelical pastors.

Using a qualitative approach, inductive research involved data collection through an interview completed one-on-one with each participant. The qualitative approach was selected due to the characteristics of qualitative research and how natural language and dialogue can be dissected to draw hypotheses (Levitt, 2020). A benefit of qualitative research included the ability to report participants' own words (Wendt & Gone, 2012). When using human subjects as participants, qualitative research dealt with challenges faced when working within a humanistic framework (Levitt, 2016).

Specifically, human subjects were multifaceted, and observations accounted for a variety of considerations (Levitt, 2016). This supported the fundamental principles of the

biopsychosocial spiritual model as it sought to consider all facets of the human experience in research and treatment (Saad et al., 2017; Van Dened et al., 2022). I asked open-ended interview questions to understand pastors' perspectives and experiences and drew conclusions about their views towards TIC. Qualitative research included analyzing natural language and non-numeric data, using an iterative process, emphasizing context and situation, and using a rhetorical style of reporting with the necessary limitations outlined (Levitt, 2020).

Clark Moustakas was an American psychologist who developed an approach for qualitative research using transcendental phenomenology with a set of research procedures (Blau, 2013). The core processes of Moustakas's (1994) approach included epoché, transcendental-phenomenological reduction, and imaginative variation. Epoché sought to explore the phenomena being studied with fresh eyes, a new vantage point, and a transcendental ego (Moustakas, 1994). Successfully finding a transcendental state of epoché involved minimizing the impact of preconceived notions, ideas, assumptions, and researcher perspectives on the studied phenomena (Creswell & Poth, 2018). This epoché process was achieved before the interview process of gathering data by bracketing out my experiences using a researcher’s journal which was then used throughout the interview process.

Transcendental-phenomenological reduction experiences were considered, and the phenomenon was described openly with complete descriptions of essential elements of consciousness, variations of thoughts and feelings, and textural descriptions of the phenomenon's essence (Moustakas, 1994). These descriptions provided details about the validity and significance of the experience with this phenomenon (Moustakas, 1994). Imaginative variation

sought to identify the structure differentiation between actual and possible cognitions and brought it to the point of synthesis (Moustakas, 1994).

The transcendental phenomenology methodology, specifically Moustakas' (1994) approach, considered the perspectives of participants expressed in interviews. Researchers used a phenomenological approach to understand human participants (Creswell & Poth, 2018). Transcendental phenomenology was best used for exploring the perspectives of a specific phenomenon in a human study with multiple participants (Moustakas, 1994). During data analysis, I categorized these perspectives in a thematic approach.

Iterative interpretation of the data sought to collect and interpret interview data to answer the research question and develop hypotheses for future research (Moustakas, 1994). This iterative process involved analyzing data in a circular manner where ideas and meanings were identified and re-identified as data interpretation unfolds (Levitt, 2020). Recurrent themes related to unifying concepts and the participants' perceptions were identified to inform predictions of future relationships between evangelical pastors and congregants in the church.

Research Questions

Research Question 1: How do evangelical pastors in the Greater Toronto Area describe their experiences ministering to congregants who have experienced trauma?

Research Sub-Question 1: How do evangelical pastors in the Greater Toronto Area describe the challenges faced when ministering to congregants who have experienced trauma?

Research Sub-Question 2: How do evangelical pastors in the Greater Toronto Area describe the strategies implemented when ministering to congregants who have experienced trauma?

Research Question 2: How do evangelical pastors in the Greater Toronto Area describe their experiences with trauma-informed care?

Setting

The setting for this study was on Zoom, the online meeting platform. I used this virtual space for all interviews with participants to reduce scheduling conflicts, increase availability of the participants and researcher, allow for confidential recording, and promote a feasible means to transcribe the interviews. In terms of physical location, the participants and I were responsible for securing our own safe and confidential setting where outsiders could not hear the content of our conversation to protect confidentiality. I facilitated all meetings by creating the Zoom appointment and sending each participant pertinent details for the interview. If participants were unfamiliar with the Zoom platform, I provided detailed instructions to begin the interview. Once the meetings began, I welcomed the participant and asked the interview questions, and upon completion of all interview questions, I ended the Zoom meeting after closing remarks.

The rationale for this setting selection was due to the often-busy nature of pastoral work, and while convenience is not the only factor in this decision, it was considered. Another reason for using an online video platform as the setting was the method of collecting data through video and audio recording. I also took notes during the interview. With the added component of video and audio recording of the interview, I had complete access to the footage and produced a transcript from the audio file for data collection. Watching and listening to this footage multiple times helped in the data analysis and sorting process. The transcripts from the audio footage were helpful in data analysis as the verbal answers will be transcribed into written form seamlessly.

Participants

Participant selection in this study followed a purposive, criterion sampling method. According to Moustakas (1994), the critical criterion in participant selection was that each participant has experienced the phenomena being discussed and investigated. The participant had to experience the phenomena in a first-person account to accurately depict the experience of the phenomena in a first-person account, which was needed in this qualitative research study. In addition to experiencing the phenomena, the participants must have been willing to participate in the study and be interested in the research (Moustakas, 1994).

Other requirements included being willing to participate in the interview process, answering the interview questions, allowing the interview to be video recorded, and agreeing that the identified data can be shared in this dissertation and other potential future publications (Moustakas, 1994). Additional considerations for participant selection included ethnic and cultural factors, gender, age, race, and religion (Moustakas, 1994). The considerations were relevant to this study as patterns associated with the various factors may have indicate room for more research in specific population areas.

The research participants were from a purposive method of sampling of local evangelical pastors in the GTA. The sampling procedure followed a criterion strategy, which relied on my judgment to determine the inclusion of each participant based on the predetermined criteria outlined below. This sample was be drawn from the population of evangelical pastors who lead churches in the GTA. The sample included diverse individuals from various ethnic backgrounds, ages, and denominations. Using a purposive sample with a criterion strategy, I selected participants to ensure diversity within these demographic criteria. Specifically, the participants

were evangelical pastors in high-level leadership roles within their church organization across multiple denominations. Both female and male evangelical pastors were included in the study.

Each participant was presented with the requirements for participation and were provided informed consent. Pseudonyms were used to protect the evangelical pastors by ensuring their names and church names are not published. The participants were provided with pseudonyms before beginning their session, and they were asked to use these pseudonyms instead of their name and church name throughout the recording. They were also asked to rename themselves on Zoom prior to beginning the recording and interview. The research met face and content validity measures by obtaining the demographic information directly from the participant instead of assuming. I asked each participant to provide an answer for each of the demographic categories: gender, age, ethnicity, denomination, and role. Specifically, the ethnicity category was selected instead of race heritage. Considering their ethnicity, the research may have reflected patterns related to various cultural backgrounds, which could be further investigated in future research.

Moustakas (1994) indicated that in phenomenological qualitative research, there is no fixed number of participants, and the aim is for smaller sample sizes of participants. It was the intensity of the participation and diversity of the participants that should be of focus (Moustakas, 1994). The goal of this research as to develop a rich dialogue and in-depth exploration of the phenomena with data saturation that is comprehensive. Since this research followed Moustakas's (1994) model, his recommendation of using 5-25 participants or until saturation guided the participant selection process. Saturation is met when no new information or themes were emerging, and data collection continued until the point of redundancy to ensure all themes were found (Moustakas, 1994). The target participation number was 15-20 or until data saturation is

obtained to ensure a wide range of diversity among participants. Data saturation was considered after interviewing eight participants and confirmed after interview the ninth participant.

Inclusionary and Exclusionary Criteria

The criterion for selection included evangelical pastors of churches that meet weekly, in person, on Sundays. These churches had dedicated children's, youth, or young adult ministries, and their congregation attendance was over 300 people each week. This did not include all pastors in the GTA who meet this criterion. However, the study was limited to evangelical pastors who meet these criteria. I was committed to understanding more about Christian churches in the GTA, as opposed to other religions or denominations that do not believe the Bible is steadfast. For this reason, only evangelical pastors of Baptist, Pentecostal, and non-denominational churches were selected.

The rationale for interviewing this specific sample was due to the shared religious values, the commitment to teaching and training from scripture, and the effectiveness in growing a community. Additionally, the sample was exclusive to churches that prioritize family church attendance and programs as they may be more committed to meeting the specific age-appropriate needs of all attendees than churches without specialized programming. Further, churches must have focused on younger generations if they sought to impact current generations. Churches that neglect younger generations were part of a global church issue where church attendance was limited to older generations. To continue impacting generations of young people through the church, the church must be open to ministering directly to the age groups they hope to impact.

Recruitment

First, I developed a list of all evangelical churches in the GTA, which reflected the population from which the sample was selected. Second, the churches ere be divided according

to weekly attendance. Churches that did not meet weekly on Sundays were not be included, as were those having fewer than 300 weekly attendees. The remaining churches were further categorized based on whether the church has a children's ministry, an established youth group, or programming specifically for young adults. Churches without these specialized ministries were excluded from the study.

The recruiting process continued with an invitation and introduction to the study sent via email to the evangelical pastors of the churches in the research pool. The email included a description of the background of the study and a request to be included. The study parameters were explained, as well as the time needed for each interview and how the results and data will be used for research. Only evangelical pastors interested in the study, willing to participate in the interview and answer all questions, and who will allow their answers and perspectives to be shared in the data analysis process and the study findings were considered. The number of participants depended on the number of evangelical pastors who met the criteria and were willing to participate, along with the consideration of data saturation (Moustakas, 1994). Once the data collection reached a point of sufficient depth and richness, there was no longer a need to continue collecting.

Potential Limitations of Participant Selection

Denominational and demographic diversity amongst participants was needed, and this was considered in the selection process. For example, I did not select only evangelical pastors under 40. I selected evangelical pastors across a wide range of ages (18-80). Other considerations were considered if participant selection did not allow for a reasonable number of participants; however, this limitation was not experienced.

Procedures

The procedures for this study were outlined in a step-by-step process below. There were seven main steps to follow in this study: (1) identify the phenomenon to study, (2) seek institutional approval, (3) participant selection, (4) pre-interview meeting, (5) facilitate interviews, (6) analyze the data, and (7) data reporting. There were specific procedures for each step in this process, which were addressed in depth in this section. In-depth details for participant selection, interviews, and data analysis were discussed throughout this chapter under the appropriate section. If replicating this study, these steps should be followed in the order they are listed.

Step 1: Identify the Phenomenon

By working through the literature and finding the gaps in the field, the area for study were be determined. When researching the processes of care and training for evangelical pastors working with congregants who have experienced trauma, there was a glaring gap in the literature, which led to the discovered phenomenon of this study. The phenomenon studied was the experience of evangelical pastors when they have interacted with congregants in their church who seek care for their trauma symptoms. TLT guided this research, and a potentially new methods of TIC, were offered to evangelical pastors (Mezirow, 1991). This study focused on pastors' perspectives towards integrating this new method into their practice as leaders seeking to help others in their community and church.

Step 2: Seek Institutional Approval

Before initiating any data collection, I secured approval for research from the Institutional Review Board (IRB), which guided my dissertation chair and required the approval of the dissertation committee before conducting research. When seeking institutional approval, I

sought approval from my Dissertation Chair to begin the application process with the IRB. After approval, I submitted the IRB application.

Step 3: Participant Selection

After being approved by the IRB at Liberty University, I began the steps of participant selection addressed in the Participant section. This selection process was explained in detail in the Participant section above. Participants were selected using criterion sampling in a purposive method.

Step 4: Pre-Interview Meeting

Once the participants were selected, a pre-interview meeting was scheduled between the participant and me. This meeting set the stage for the individual interview. The data collection process involved working individually with participants to collect data. A pre-interview meeting occurred in which I explain the study and develop a relationship with each participant so full transparency and truth can occur during the interview (Moustakas, 1994). In the pre-interview meeting, I concluded the participant to confirm their appropriateness for the study.

The purpose of this meeting was for me to introduce the research study and explain the purpose of their participation in the study. I explained the interview process and shed light on the in-depth, semi-structured interview style. An informed consent document which was previously emailed, addressed confidentiality and was discussed by the participant in this meeting. This form was signed and returned by email before the interview.

Much like building rapport with a new client, this pre-interview meeting was intended to alleviate any concerns from the participants and help me to ensure each

participant was comfortable with the interview. I also discussed the potential risks of participating in the study with the participants. We discussed how I intended to secure their information to prevent a data breech, and we discussed the potential emotional risks involved when discussing trauma. I shared with the participants about a local Christian counselor who agreed to meet with any participants who required or would benefit from debriefing or counseling after the interview. In this meeting, the participant also asked questions about the study, and full disclosure of how the results intend to be used was provided within the informed consent document. A successful pre-interview meeting ended with both the participant and me feeling prepared for the interview, aware of what as expected of both parties, and confident about the data collection, analysis, and distribution methods.

Step 5: Interview

The next step was used to facilitate an individual interview with each participant. These interviews took place in a setting where video and audio recordings were permitted, as these were critical components of data collection. The specific details of the interview processes, including interview questions, the rationale of each question, and the method by which the answers were reported and analyzed, are discussed later in this chapter in the Interview and Data Analysis sections. This section explained the procedures for facilitating the interview and the rationale behind the data collection strategy.

Interviews were the typical method of phenomenological investigation (Moustakas, 1994). When choosing a data collection strategy, the research problem led me towards qualitative methods, specifically individual interviews, as the best method for collecting data. This was the best research method to understand the experiences of multiple individuals who have a shared phenomenon, as perspectives, beliefs, and experiences can be described in considerable detail

during an interview (Moustakas, 1994). Creswell and Poth (2018) listed ten procedures used in conducting interviews: "determine the research questions," "identify interviewees," determine interview type, collect data with recording procedures, design interview guide, "refine the interview questions," locate setting, "obtain consent," follow procedures, and determine transcription logistics (p. 165). These protocols were followed in the set-up of interview procedures and are addressed below.

The phenomenon being researched in this paper as investigating the pastors' experiences to learn more about their methods of pastoral care and their perspectives on TIC. By interviewing them, I expected to learn from their experiences with congregants who have discussed their traumatic experiences while seeking help or counsel. I wanted to understand their training and level of comfort as they try to meet the needs of these congregants. Also, I investigated potential issues or gaps that evangelical pastors felt existed in helping their community in this area.

At the beginning of each interview, I asked the participant for general information to help create a warm and calm atmosphere. By asking simple questions that were easy to answer, I sought to give participants the confidence to continue with the more in-depth questions that followed. Next, I asked each participant more direct, closed-ended questions about their awareness of their church’s programs, policies, and vision for their community.

I assumed that the lead evangelical pastors were knowledgeable about the church's methods of dealing with issues related to mental health within the congregation. This assumption was based on my belief that the lead pastor's role was to oversee the church's operations and the care provided to congregants. The next set of open-ended questions focused on their experience with the phenomenon in question.

Moustakas (1994) developed two questions for interviews, which were asked at the beginning of the open-ended interview section. The questions were broadly worded. By using them, I hoped to gain a fuller understanding of the participant's experience regarding the phenomenon and how their context or situation influenced their experience.

Step 6: Data Analysis

Upon completion of the interviews, the collected data was analyzed through a meticulous methodology discussed later in the Data Analysis section of this chapter. Data analysis aimed to examine the data and organize this content into significant statements or quotes, which reduced lengthy interview answers into specific ideas and comments (Creswell & Poth, 2018). Once these statements and quotes were identified, they were combined into themes identified by textual and structural descriptions of the phenomenon (Creswell & Poth, 2018).

Data analysis involved working with interview transcripts to highlight significant statements through horizontalization (Moustakas, 1994). Specific participant demographic information and answers related to church demographics were analyzed in a method called coding. Coding was a method of clustering data in a "meaning-making process" (Creswell & Poth, 2018, p. 84). Clusters of meaning were then developed from the statements that help identify themes (Creswell & Poth, 2018). The textual descriptions of experiences were then written out using the significant statements and identified themes. The structural descriptions, also known as imaginative variation, were written out using significant statements and themes (Creswell & Poth, 2018). These methods were used in this study: bracketing, horizontalization, coding, and imaginative variation.

Step 7: Data Reporting

The data reporting began after the data analysis, where common themes were highlighted and categorized in a logical and organized fashion. In the results section of the dissertation, I explained the data and discussed some of the implications of the results from this study. After completing the research study, including the dissertation defense, I intend to seek publication in research-based journals related to the topics discussed in this study. Specifically, journals related to trauma, psychology, counseling, Christianity, pastoral care, and TIC are the primary areas of interest for publication.

Researcher's Role

This section explained my role as a human instrument in the data collection process, and it primarily addressed the bias and assumptions that the researcher brings to the study that might influence the data analysis process. My role in this design was to select and interview a set of human participants, collect data, analyze data from the interviews, and present the findings of the study in an organized way. Moustakas (1994) discussed the researcher's role as involving a non-biased position, specifically during the interview, data collection, and analysis procedures. The epoché process guided me in eliminating biases and preconceived ideas before the interview process by pulling out such ideas, identifying them, and intentionally setting them aside (Moustakas, 1994).

The researcher's role also involved a detailed, rigorous data collection process followed by data analysis and reporting (Creswell & Poth, 2018). Phenomenological reduction was the process following data collection, during which the researcher analyzed and organized data by reducing statements into categories or themes based on importance (Moustakas, 1994). The next step for phenomenological research involved imagination variation, during which researchers

interpreted significant statements and themes by bringing meaning to them from different perspectives, positions, roles, and functions (Moustakas, 1994).

The Researcher's Motivation

I aimed to better understand the gap between mental health care and Christian religious settings such as church and ministry programs. Previous research indicated that trauma was a widespread experience that nearly every human will experience. How the church dealt with trauma and the impact of trauma on their congregants impacted their healing process, both negatively and positively. My trauma history and positive experience with TIC in a hospital setting motivated me to investigate the implications of a trauma-informed church setting. I have heard many evangelical pastors in my community assert that the church operates as a hospital, helping to meet the community's needs. If this was so, as I believe it was, I wondered how our local churches could better serve the mental health needs of individuals who were exposed to trauma. I believed there was room for improvement in churches when it came to caring for the needs of individuals who had been exposed to trauma. I was curious about pastors' perspectives towards TIC and their openness to integrating TIC methods into their church.

As a child, my experience with church-based counseling in treating my experienced trauma was not successful, as I experienced treatment focused heavily on the principles of biblical forgiveness with little attention to psychologically processing the experience of the trauma. Treatment later in life with a licensed professional counselor with a Christian worldview helped me to find healing through treatments that addressed psychological pain while also opening the door for forgiveness. Successful healing of trauma was experienced prior to my experience with TIC during my pregnancy and childbirth experience within a hospital setting. Instead of experiencing more profound trauma during a very intense and potentially triggering

experience, I was cared for very intentionally by hospital staff due to their training in TIC and their understanding of basic trauma practices needed by trauma survivors. These experiences revealed that while the church once failed me, others can be helped by the church when proper training in trauma-informed practices exists within church counseling practices.

Philosophical Assumptions

The philosophical assumptions of an individual involved the ontological, epistemological, rhetorical, and axiological beliefs (Creswell & Poth, 2018). One's ontological assumptions were related to the nature of reality, one's beliefs about reality, and how multiple realities may exist simultaneously (Creswell & Poth, 2018). Epistemological assumptions were rooted in knowledge, what knowledge is, and how knowledge is justified (Creswell & Poth, 2018). Rhetorical assumptions were driven by language and how in-depth details of experiences are necessary for understanding the full scope of the experience. Axiological assumptions were rooted in the role of researched values, and these values are brought to light in qualitative research (Creswell & Poth, 2018). Each assumption was broken down with examples in the following sections.

Ontological assumptions

I believed multiple realities are at play, especially in the work of evangelical pastors and those seeking to care for others. I believed that in the role of a care provider, such as an evangelical pastor, counselor, or leader in the church community, one should be aware of the multiple realities that can co-exist at once. When I thought back on personal experiences in church counseling, I identified how a clash of multiple realities can create more chaos than care for survivors of abuse. It is critical for those seeking care and seeking to provide care to understand that multiple realities exist between the caregiver and provider. By acknowledging

these realities, care providers can be more open-minded to the perspectives of others as they seek to offer help. I believed that a network, such as a church leadership team, was filled with multiple individuals living different realities. However, when disseminating information and practice of care, such as TIC, working through a similar reality was essential. For example, operating under the reality that trauma existed in the lives of people in their congregation will better prepare pastors and leaders so that they do not feel blindsided when conversations about trauma come to the surface.

Epistemological assumptions

I believed that using TIC in churches could better enable healing amongst congregants through leaders and evangelical pastors using a framework of practices that help address symptoms of trauma. Instead of leaving the congregation to deal with their trauma alone or scour the internet looking for help, churches could help by becoming trauma-informed and equipped with efficient resources. Research stated that the quality of information about mental health online in Canada may not be accurate, and the implications of false information or faulty treatment are critical (Schaffer et al., 2023). The results of surveying local evangelical pastors across multiple denominations revealed what was currently being done in these church settings to address congregants' needs. Additionally, results revealed where there are deficits within the existing church leadership systems. The results laid a foundation for improvement upon each other, where churches can become better at meeting the needs of their congregants. Proper training and programs in a two-tier framework can then be provided to church leadership to better equip themselves with the necessary tools for becoming a trauma-informed unit.

Rhetorical assumptions

This research was driven by its language, and my rhetorical assumption was that their experiences must be explained in detail to understand pastors' views better. A literary style of answering questions through interviewing was a decision made through my rhetorical assumptions. I believed in-depth, semi-structured interviews would help guide the research without limiting the participants to answering questions inside a box. Instead, many of the questions were open-ended to allow for a full array of answers and explanations to evolve from the participants.

Axiological assumptions

The axiological assumptions in qualitative research were characterized by known and valued values (Creswell & Poth, 2018). I placed a high importance on the participants' values in this study. Specifically, their values helped to understand the implications of integrating TIC within a church program. For example, if the values of evangelical pastors were not aligned with TLT, then future education in TIC may prove to be ineffective in improving church practices for mental and spiritual health. By seeking to understand the views of evangelical pastors better, I hoped to learn more about the potential areas for growth within current implementations of care provided in church settings.

Paradigm

I brought a social constructivism interpretive framework to the research. Such a paradigm aimed to better understand the world around oneself, such as the world in which one works and lives (Creswell & Poth, 2018). The goal of this study as precisely to understand better a part of the world in which the research lives and works, as it investigated the practices of evangelical pastors and church leaders in their churches. I sought to understand the experience of evangelical

pastors better as it related to caring for their community, and I sought to know the pastors' perspectives toward integrating TIC in their church. This interpretive framework recognized one's background as a shaping component of one's paradigm or worldview (Creswell & Poth, 2018). Being positioned both in the counseling field and in church ministry, I understood that my background brings about certain assumptions and ideas into the research, which were identified. The practices of a social constructivism framework involved interpreting participants' explanations of their experience by looking into the deeper meaning of their answers. In this study, this happened through interviewing strategies (Creswell & Poth, 2018).

Minimizing Bias

In constructivist-interpretive research, data collection required close attention to detail to minimize error and bias (Levitt, 2020). One strategy used in phenomenological research was bracketing which prevented the researcher from interpreting data through the lens of their experiences by first acknowledging their experiences prior to data collection and data analysis (Moustakas, 1994). I used a researcher's journal through the data collection and data analysis process to prevent bias through bracketing.

Another strategy I took was providing precise descriptions of mental health-related language used in the interview. When necessary, clear definitions were provided for uncommon terminology that the interviewees might use. For example, before asking evangelical pastors about TIC, they were given a clinical definition of TIC to ensure an informed answer on the topic. The definition used for TIC was "an intervention and organizational approach that focuses on how trauma may affect an individual's life and his or her response to behavioral health services from prevention through treatment" (*Trauma-Informed Care in Behavioral Health Services*, 2014).

Another description of TIC used was:

A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings. (SAMHSA, 2014, p. 9)

Additional strategies for constructivist-interpretive research included "writing in first-person language, reflexively analyzing the influence of their own perspectives on their research, focusing on experiences of ambiguity and conflicting interpretations, and developing understandings that are contextualized by culture, place, and time" (Levitt, 2016, p. 87). These processes fit well into the context of a subjectivist epistemology, as the researcher accepted the inescapable reality of researcher assumptions (Levitt, 2016).

Data Collection

In phenomenological studies, in-depth interviews were the typical method of data collection (Moustakas, 1994). This study used in-depth, semi-structured interviews as its data collection method. I was the instrument in this study, and I asked a series of questions that each participant answered. The first set of data collected was the demographic information from each participant, and this was when I asked each participant to state their age, gender, ethnicity, denomination, and role in their church. While this data was already known from the participant selection process, this data collection was solely for the purpose of getting the data on the record. Each participant was then asked questions about the experienced phenomenon. Questions were asked in the same order, and if there was a need for additional clarifying questions, they were used to ensure the quality of data collected. Moustakas (1994) insisted that two questions must

be asked in transcendental phenomenological interviews. The two questions are "What have you experienced in terms of the phenomenon?" and "What contexts or situations have typically influenced or affected your experiences of the phenomenon?" (Moustakas, 1994). These questions focused on how the phenomenon impacted the participant and others involved and the experience for the participant.

The purpose of interviews was to gain a deeper understanding of the phenomenon experienced by the participants. If a participant provided an answer that did not fully answer the question or needed more detail for me to gain an in-depth understanding of their experience, then clarifying questions were asked. The interview should have been comfortable for the participants, as it was my responsibility to create an atmosphere where participants could share openly.

The sequence of the data collection strategy followed standard interview procedures: an introduction explaining expectations and confidentiality, an explanation of the interview structure (outline below) and asking the interview questions in the designated order. While asking questions and actively listening to the participant, I took a record of any notable observations during the interview in a Word document. Once all questions were asked and the interview was complete, I thanked the participant and ended the interview. The audio file from the recorded interview was then stored for analysis, and they were later transcribed and coded using a Qualitative Data Analysis Software (QDAS), which is explained in the Data Analysis section. The storage procedures for data collection were addressed in detail in the Data Storage section.

Interviews

In-depth, semi-structured interviews were at the core of this study's data collection process, and the data collected in these interviews was used to answer the research questions. A semi-structured approach as critical in interviews for qualitative research as the researcher aimed to remain unbiased and neutral so as not to shape the answers of the participants (Creswell & Poth, 2018). Additionally, I collected data using open-ended questions while listening and observing the participants as they answer questions on a topic that is "emotion laden, close to people, and practical" (Creswell & Poth, 2018, p. 50). I conducted these interviews as the sole data collector in this study. The questions asked in each segment were developed to collect information to help answer the research question of this study. The answers to these questions helped to learn more about the current level of care offered to trauma survivors by the church, the views of evangelical pastors towards trauma care, and their openness to TIC integration in their practices. Each interview included 23 questions, segmented into three categories: basic information, close-ended, and in-depth interview questions.

Interview Segment 1 (Basic Information)

1. Please introduce yourself to me as if we just met one another.
2. Please share your age.
3. Please state your gender.
4. Please state your ethnic background.
5. Please state your church denomination.
6. Please state your title at the church.
7. Please share the time you have been in this role at the church.

The first segment, seven questions, collected identifying information on the evangelical pastor and their church demographics. The information from this section provided identifying details. The validity of any interview questions was in the ability of the interviewer to ask questions that the interviewee could accurately answer, and this category asked questions that the interviewee were easily able to answer (Fontanella et al., 2006).

Interview Segment 2 (Closed-Ended Questions)

1. Does your church have a church counseling model in place for congregants?
2. When a church member discloses trauma, are there standard practices for pastors and leaders?
3. Is there a counselor on staff or volunteering at the church?
4. Does the church use a trauma-informed care (TIC) model with its congregants?
5. Do mental and spiritual health conversations occur amongst the pastoral leadership at the church?
6. Suppose a TIC methodology was modified to align with your church's religious beliefs and ethics. Would pastoral leadership be willing to implement these practices within their congregation?

The second segment, six questions, included closed-ended questions to learn more about the status of mental and spiritual support offered by the evangelical pastor, leadership team, and the church. These interview questions were straightforward and specific to the research study. The role of direct questions was to gain critical information in a methodological approach that would help the researcher learn more about the phenomena (Fontanella et al., 2006). However, these questions were limited in the amount of detail that could be shared, which was why they were paired with the questions in the third segment.

Interview Segment 3 (In-Depth Questions)

1. What have you experienced in terms of speaking with congregants about their experienced trauma?
2. What situations impact your conversations with congregants who've experienced trauma?
3. What does spiritual and mental health mean to you as the pastor of your church?
4. Can you discuss the openness of the church leadership to expand the current level of care available for individuals with primary mental health needs?
5. What is your church currently doing to meet your congregants' mental and spiritual health needs?
6. As a pastor of your church, what is your understanding of trauma and its impact on your congregation?
7. What is your church's perspective on mental health and the impact of trauma?
8. What is your understanding of trauma-informed care?
9. Please describe any protocols in your church that relate to mental health.
10. How do you feel about pastors in your church receiving training in TIC with a modified approach for your congregation and religious beliefs?

The third segment, ten questions, took the discussion deeper with in-depth, open-ended questions about the pastors' perspective on mental health, trauma, TIC, spirituality and healing, and the church's role in mental and spiritual health care. Open questions, such as in this third segment, were critical to phenomenological research in qualitative data, as the interviewee could share their experience in their own words (Fontanella et al., 2006). The third section focused on the pastor's experience working with individuals who had experienced trauma. The data collected in this segment helped to answer the main

research questions, as participants were asked to provide in-depth descriptions of their experiences, drawing on emotion, perception, and worldview.

Question 1 validated the participant's experience as consistent with the phenomenon being researched. Additionally, this question opened the conversation on the participant's experience by allowing them to answer an open-ended question about their experience with no pointed direction. The participants shared experiences in this answer as they expand upon their global experience of speaking to congregants about their trauma. Question 2 required the participant to dig deep and become introspective as they considered their contextual experiences, which might have played a factor in their experiences with congregants dealing with trauma. This question was critical to understanding what the participant found as significant in their own context.

Question 3 helped to understand the basic knowledge of the evangelical pastor when it comes to mental health care and spiritual care. By understanding this level of knowledge, I better understood why the participant holds certain beliefs or values. Additionally, this question helped to discover if there was a greater need for further knowledge or training on these topics. Question 4 spoke to the nature of care offered by the church, not solely of the participant. This question guided me in knowing how the church viewed its responsibility toward congregant care and if the church valued mental health and spirituality. By understanding these views of the church, I better determined the church's willingness to further training or increased information about different care methods.

Question 5 was a direct and open-ended question that helped the participant explain what the church offers for congregants in terms of their mental and spiritual health needs. This question was looking for the facts, and the participant was able to explain in detail the steps

offered by their church. Question 6 asked participants more directly about their understanding of trauma, which helped me understand other questions and how they were answered. For example, if the participant did not understand trauma, they might not understand the value of trauma-informed protocols. However, if the evangelical pastor expressed a deep and clear understanding of trauma, I better understood their view towards mental health care within the church.

Question 7 helped to understand the speech surrounding mental health within the church organization. By learning how the leadership of the church discussed mental health, I gained insights into the narrative surrounding mental health, which staff, volunteers, and congregants hear of the church. This information was critical, as it helps us understand more about the church's openness towards providing care. Question 8 gauged the participant's knowledge of TIC. By asking the participant directly, I sought to find a straightforward answer that either slightly explained or did not explain TIC well. This question helped me to know if the evangelical pastor was knowledgeable about TIC, which was crucial to understanding their inclinations towards integrating TIC. For example, a participant who knew very little about TIC might not have been interested in the integration of TIC into their system.

Question 9 was a follow-up question for question 5 and may not be necessary if the participant answers question 5 in deep detail. However, the difference between question 5 and question 8 spoke to the general process and the specific procedures offered and implemented by the church. This question, 9, allowed the participant to describe any protocols related to mental health that were in place by the church, and this was not limited to trauma-based protocols. Question 10 was a follow-up to question 9 and

helps to understand the climate around TIC in the church. Since the goal of this study was to understand the views of evangelical pastors and to learn of the influence of TIC on the local church, this question guided the participant in explaining the current level of interest or exposure of TIC to the church.

Prior to facilitating interviews with participants from the sample used in this study, I piloted these interview questions with a single sample of an evangelical pastor in the GTA to ensure the strength of the questions and that appropriate wording was selected. Piloting these questions with an evangelical pastor who had experienced the phenomenon helped the researcher to consider the value of bracketing during the data collection process. This step was made possible after approval from the IRB to begin data collection.

Data Analysis

The data analysis process involved using a QDAS called NVivo (Paulus, 2023), a tool that was used for storing, transcribing, coding, and analyzing interviews in qualitative data. The rationale for selecting NVivo as the chosen software was its efficiency with qualitative analysis of in-depth interviews (Paulus, 2023). NVivo was used specifically to help researchers find rigorous human insights quickly while organizing and analyzing qualitative data for dissertation research (Paulus, 2023). The steps of this data analysis included bracketing, horizontalization, coding, and imagination variation. Each step was explained in detail below.

The first step in this process was bracketing, which was a preventative measure taken by the researcher to prevent bias on thematic development and transcript interpretation. I used bracketing to distance my personal experiences prior to data collection and analysis by using a researcher’s journal.

The next step in the data analysis process was to transcribe the data from the recorded audio files from the interviews. Once the data was transcribed, I validated it through member checking, allowing the participants to confirm or alter the researcher's data from their interview to better correspond with their perception of the experience (Moustakas, 1994).

After transcribing the interviews, qualitative data analysis continued through thematic analysis. Moustakas (1994) stated that after transcribing, the data will undergo horizontalizing, in which statements of equal value are taken from the transcripts. These statements were listed meaningfully and clustered by themes (Moustakas, 1994). Horizontalization was used to analyze the data further and triangulate the findings (Moustakas, 1994). Using thematic analysis, I grouped the data found in the interviews according to their similarities (Moustakas, 1994). These groups were described in greater detail in Chapter 4. Some expected themes included the costs of implementing TIC training, the liabilities of using TIC in the church, the logistics of expanding the ministry to include counseling services, and concerns regarding secular psychology in a religious setting. Surprisingly to the researcher, none of these themes presented in any of the data collected, as the participants expressed an eagerness to integrate a TIC model if modified to meet church ethics and religious beliefs.

The next step was to begin coding the data from each segment. I used NVivo to code the transcripts and analyzed data from each section of the interview (Paulus, 2023). Using imagination variation, I developed textual and structural descriptions of the experience from these themes (Moustakas, 1994). From these descriptions, I summarized participants' experiences and provided the meaning and essence of their experiences of the phenomenon (Moustakas, 1994).

Once the data was analyzed and the themes were discovered, more consideration can occur regarding how these themes can be addressed, how the needs and concerns can be met, and how the themes relate to the potential future inclusion of TIC in church settings. While the research questions were the core questions being answered by this study, the following topics are further discussed in:

- If churches have a higher baseline of currently integrated TIC practices, does this mean they are open to integrating full TIC?
- Is there a connection between a church's views toward TIC and its current baseline of TIC practices?
- Can a church's views towards TIC predict their willingness to integrate TIC or point towards their current baseline of integrated TIC?

To summarize, the data analysis process required interpreting answers from evangelical pastors in their interviews. Data collected through the interviews was transcribed upon completion. All verbal answers were converted into a written narrative. Once transcribed, the data was interpreted by organizing answers to questions from all participants. Data organization used horizontalizing, in which answers were arranged on a spreadsheet using columns for each question and rows for each answer. Themes were identified for each question to locate unifying concepts or statements among participants. All themes were presented in a variety of graphics and discussed in Chapter 4.

Data Storage

The only software that received access to the data in this research study was the QDAS called NVivo, which was used for coding the transcribed data for the data analysis process. All data collected throughout this study was stored in the cloud based QDAS. This included Zoom

files, interview notes, transcribed files, coding, and analyzed data. The data collected from the Zoom interviews, including the video and audio recordings of the interviews, were saved on my computer immediately upon completion. These recordings were then transferred directly to the NVivo drive and erased from my computer's hard drive. At that time, these files only existed in the NVivo drive. Security of this NVivo drive was ensured through a two-step authentication process to access this drive, which only the researcher could access. When the audio files were used for transcription, the files were be downloaded to my computer while continuing to exist in NVivo, transcribed, and again erased from my computer upon completion of the transcription process. The files containing the transcriptions were be stored in the NVivo drive and erased from my computer's hard drive.

Trustworthiness

A study's trustworthiness encompassed credibility, dependability, transferability, and confirmability, and it spoke directly to the accuracy of research findings (Creswell & Poth, 2018). These terms were the naturalist's equivalent to internal and external validity, reliability, and objectivity (Creswell & Poth, 2018). Each component of trustworthiness was defined with its importance address and the methods used to achieve its implementation during this study. A study's trustworthiness spoke to the researcher's integrity and was another layer in the ethical approach to qualitative research. The methods used in this study for achieving credibility, dependability, transferability, and confirmability included triangulation, direct quotes, clarifying researcher bias, generating a detailed description, and discovering disconfirming evidence. These methods are described in depth in the sections below.

Credibility

Research was deemed "credible" when it is considered "true" (Creswell & Poth, 2018, p. 278). Credibility was a core value in achieving validity or trustworthiness (Creswell & Poth, 2018). Credibility spoke to all research components, from participants to methods and data collection to analysis. One method by which credibility was achieved in this study is through triangulation and "corroborating evidence" by using multiple data sources with the various participants (Creswell & Poth, 2018, p. 259). Instead of solely using the testimony of a singular participant, I looked for patterns amongst multiple participants. The same questions were asked to each participant in the same manner and order so as not to sway any answers, and the perspectives and views of multiple sources were identified and analyzed for a vast understanding of the perspective of local evangelical pastors on trauma exposure and the potential integration of TIC in the church. Another method was the use of direct quotes when developing patterns amongst interviewee answers. Using direct quotes spoke to the credibility of the research, as the data reflected an authentic form of evidence.

Dependability

Dependable results were reliable (Creswell & Poth, 2018). The importance of dependability lay in its ability to be subjected to change and instability (Creswell & Poth, 2018). One method for dependability is "clarifying the researcher bias or engaging in reflexivity" by the researcher (Creswell & Poth, 2018, p. 260). As addressed in the Researcher's Role, my motivation came from my experiences with trauma and the church and my current role in the counseling field and ministry as an evangelical pastor. These experiences and lenses directly speak to the potential for researcher bias, and dependability was increased by clarifying the assumptions and biases of the researcher at the outset of the researcher (Creswell & Poth, 2018).

Transferability

Transferability was the ability for the results and findings of the research to be transferred to other settings of similar contexts (Creswell & Poth, 2018). The importance of transferability spoke to the relevance of the study. In qualitative studies, research methods and results sought transferability to further analysis (Creswell & Poth, 2018, p.). The method for achieving transferability in this study was "generating a rich, thick description" of the data and evidence from the data collection process (Creswell & Poth, 2018, p. 262). This method required extensive details to be shared in the analysis and explanation of data to allow readers to essentially “transfer information to other settings," such as future research projects (Creswell & Poth, 2018, p. 262). Due to transcendental phenomenology and qualitative research, the interview strategy for data collection allowed me to purposefully integrate this method into the data collection and analysis processes.

Confirmability

Confirmability revealed the collected data's value (Creswell & Poth, 2018). Instead of objectivity, the researcher seeks confirmability within research data and results (Creswell & Poth, 2018). A method used in this study to gain confirmability is discovering and reporting disconfirming evidence. The use of member checking helped to ensure the confirmability of the data which was collected from the interview transcripts. While trends and patterns formed through data analysis of participant answers and perspectives, I also looked for evidence and data that went against the discovered trends and patterns. These "negative or rival evidence" components were critical to maintaining confirmability, as the researcher sought to report on various aspects identified from the data collection process (Creswell & Poth, 2018, p. 259).

Ethical Considerations

Ethical considerations were paramount when working with human subjects in a research study. In phenomenological research, these considerations were essential and extensive. I as committed to minimizing researcher bias, protecting participants during the data collection, ensuring data validity and proper analysis, and adequately disclosing data. Researchers must develop terms of confidentiality and informed consent contracts with their participants (Creswell & Poth, 2018). Moustakas (1994) emphasized the importance of research guided by ethical principles. The first step in the research process for this study involved seeking university and professional research approval through the IRB, and only with approval granted did the research begin.

In addition to these challenges, researchers must work to reduce the potential for bias from their assumptions and preconceived ideas about the phenomenon (Moustakas, 1994). Moustakas noted that this is best prevented by a process of epoché, in which researchers spend time expressing their thoughts and beliefs about the phenomenon before engaging with participants in the interview process. All assumptions were identified and recorded by researchers, and in this study, these assumptions were reported in a previous chapter and addressed once more in this chapter.

To achieve data validity, participants were chosen to ensure they have all experienced the phenomenon in the study (Moustakas, 1994). This helped prevent collecting data based on thought rather than experience. Other considerations for participant selection were confidentiality and informed consent. As the data collected in interviews was analyzed and reported in this dissertation and future publications, I only allowed participation from those willing to have their answers recorded and reported publicly. Data storage was a critical aspect of

ethics in research, and the data collected in this study was stored on an electronic drive with two-step verification and encryption to prevent data leaks or tampering by outsiders.

To ensure safety of participants, considerations for possible triggers during the interview were factored into the questions including a clear description of the study prior to engaging in the interview (Moustakas, 1994). Prior to data collection, I piloted the interview questions with an evangelical pastor to ensure the language is suitable for the participants (Moustakas, 1994). If a participant became triggered during the interview, the participant had the choice to continue with the interview or to end the interview and have their answers removed from the data collection. Accommodations for a referral to a Christian counselor were aligned prior to interviews, and this information was provided to participants before interviewing began to ensure clear and easy access to a necessary resource if needed by the participant.

Summary

In summary, the areas addressed in this chapter included the research methodology conducted in this study. This study used a qualitative research design with a transcendental phenomenological approach. The research questions were outlined, and the setting and participant sampling criteria and process for selection were described as purposive, criterion sampling. The role of the researcher was that of a human instrument, and the expectations were described. The study procedures were outlined in-depth, including a seven-step approach with topic selection and data reporting. The specific procedures of each step ere identified and highlighted the processes of identifying the phenomena, institutional approval, participant selection, data collection, interviews, data analysis, and data reporting. Specific tools and software used in the data collection and analysis processes were described in full detail, with a rationale for each decision. The study's validity, or trustworthiness, was identified by addressing

the study's credibility, dependability, transferability, and confirmability. Lastly, the ethical considerations of the study, research methods, and potential for bias were also addressed with methods described for preventing ethical misconduct.

Chapter 4: Findings

This study aimed to learn about the lived experiences of pastors in the Greater Toronto Area (GTA) when speaking with their congregants about trauma, also considering the challenges pastors face and the strategies implemented. This study also looked at the experiences of pastors related to Trauma-Informed Care (TIC) within their church model. In this chapter, I have presented the results of the study, which involves a thorough description of the analyzed data, beginning by discussing critical information about participants, followed by a section dedicated to the thematic analysis, and ending with a clear answer to each research question and chapter summary. Several themes emerged early in the data collection process, as the participants shared many similar aspects of their experiences when discussing trauma with their congregants, including similar challenges and strategies implemented to address the mentioned challenges.

The data collection process involved bracketing in a researcher's journal, an invitation to participate, a pre-interview meeting providing details about the study and potential emotional risk with provisions in place, signing informed consent documents, and a formal interview. The data analysis involved multiple steps, including transcribing, member checking, coding, and horizontalization. Thematic analysis was achieved through a circular process of coding and horizontalization by reviewing the data and emerging themes until a deep understanding and interpretation of the data were met. The research questions were considered from the beginning of the data collection and analysis process. Themes naturally emerged as each interview transcript was reviewed, question by question. Participants' statements presented imagination variation as pastors shared their unique experiences. Similarities were noted and used to develop themes which supported the literature.

Since the interviews were divided into three segments, there were also three levels of coding that focused on each part of the interview. This guided the analysis by looking at the data chronologically by segment and question order. For example, the data in Segment One, which identified participant and church demographics, was reviewed first, followed by Segment Two and then Segment Three. Each segment was further analyzed, beginning with the first question.

Participants

Following the procedures outlined in Chapter 3, participants were selected and interviewed until data saturation was met. Each participant engaged in a semi-structured interview that had three series of questions. A detailed description of their answers is provided in this section, in the order that the questions were asked. Prior to the interview, all participants were selected based on meeting specific criteria. Pseudonyms were provided to all participants, and these are used throughout this chapter to identify each participant in a manner that does not disclose any identifying information about the participant or their church.

Segment one of the interviews addressed specific demographic details related to the participant and the participant's church. These details were identified to track diversity amongst the participants by age, gender, ethnic background, and denomination. The purpose of asking these questions was to ensure data participation was appropriate for the study by confirming the participant's role at the church and denomination. Criteria for engaging in the study were discussed early on with all prospective participants, from the initial invitation to the informed consent and again in the pre-interview meeting. The graph below reflects the demographic information about the participants and their church.

Table 1. Characteristics of Participants

Participant Name	Gender	Age	Ethnicity	Denomination	Role	Years of Experience in Role
Participant 1	Male	33	Caucasian	Non-Denominational	Pastor	8 years
Participant 2	Male	42	Caucasian	Pentecostal	Pastor	8 years
Participant 3	Female	39	Black	Non-Denominational	Pastor	8 years
Participant 4	Female	62	East Indian	Pentecostal	Pastor	14 years
Participant 5	Male	62	Brazilian	Non-Denominational	Pastor	32 years
Participant 6	Male	58	Italian	Pentecostal	Pastor	19 years
Participant 7	Male	45	South Asian	Non-Denominational	Pastor	3 years
Participant 8	Male	63	Caucasian	Christian Missionary Alliance	Pastor	1. 8 years
Participant 9	Female	33	Caucasian	Non-Denominational	Pastor	.5 years

The data collected in the chart above is relevant in showing the diverse nature of pastors across the Greater Toronto Area (GTA). This range reflects the diversity of the GTA population, which was a goal of the research and participant selection process. These demographics indicate that both male and female participants were selected. A wide age range from 33 to 62 was met with this sample. This is important as it reveals perspectives from multiple generations of pastors, which helps gain a rich understanding of the various perceptions of this population. The ethnicities of participants include Black, Brazilian, Caucasian, East Indian, Italian, and South Asian. Each participant was required to be a pastor in a leadership role at their church, and all participants met that criterion and confirmed this role in their interview. The range of experience in this role varied from 6 months to 32 years, adding various perspectives based on their time at the church in this role. Though open to three specific denominations within the evangelical church umbrella, only two from the criteria were reflected in this sample. These two denominations include Pentecostal and Non-Denominational churches, along with Christian Missionary Alliance.

Participant 1

Participant 1 disclosed that he is a 33-year-old Caucasian male who has been a lead pastor at a Non-Denominational church in the GTA for eight years. This participant shared an extensive knowledge of his church's position on mental health and his experiences discussing trauma with church congregants. When asked about the church's counseling model, he shared a model in place, though not one with a TIC approach. While there is not a counselor on staff or volunteering at the church, there are standard practices around mental health and trauma that pastors and leaders use. The participant noted conversations regarding mental health and spiritual health amongst the leadership team, and he acknowledged a willingness to integrate a TIC model that was modified toward his church's beliefs and ethics.

The participant identified a range of trauma issues amongst congregants and noted the importance of community and small groups in helping to offer support. This participant expressed a desire for the church to help congregants feeling lonely or isolated. He did not express any concerns about the lack of training on staff or lack of resources within the church. Instead, he shared multiple times about the list of resources available outside of the church that are often used to assist congregants with trauma. This participant noted the church's openness towards expanding the level of care offered within the church. Current strategies implemented by this participant when discussing trauma with congregants involve basic levels of pastoral care, outsourcing to professional counselors when trauma needs are beyond his capacity, and offering resources when necessary. He explained that his church is equipped with many outreach partners committed to mental health, including professional counselors who can absorb cases of congregants with extensive trauma needs. The church regularly provides resources to

congregants faced with trauma symptoms, and this is the primary protocol in place, as there is no formal training for staff regarding trauma care.

This participant expressed a basic understanding of TIC, and he recognized the need to create a safe space for trauma survivors where specialized care is offered to meet any trauma needs. While he did not address a staff-wide approach towards TIC integration, he did highlight the church's position on the importance of community. He shared the methods for creating a safe, supportive community for all congregants. The participant expressed a basic to high level of trauma knowledge and noted the impact of trauma on the congregation. He also noted the importance of mental and spiritual health, and this participant drew a correlation between the two, highlighting their significance to each other. This participant did not specifically acknowledge the need for TIC within his church. However, he expressed a deep level of interest and willingness to integrate a modified TIC approach to caring for congregants with trauma needs if one was presented to his church.

Participant 2

Participant 2 disclosed that he is a 42-year-old Caucasian male who has been a lead pastor at a Pentecostal church in the GTA for eight years. This participant shared their experience with trauma conversations in the church and expressed a thorough understanding of his church’s stance on mental health care. Although this participant’s church does not have a formal church counseling model in place, there are standard practices and protocols in place for when congregants disclose a trauma situation. Pastoral care is the primary method of care provided to congregants directly by the lead pastor or pastoral team member, as there is no counselor on staff or volunteering at the church. This participant shared that mental and spiritual health

conversations occur amongst the pastoral team and that there is an openness to integrate a new model of care for the trauma needs of congregants.

This participant explained his experience talking to congregants about trauma scenarios where they can come to him with a range of concerns and that he can offer biblical wisdom and advice. When discussing his perspective on spiritual and mental health, this participant shared about a recent personal journey of self-awareness and how this has helped to shape his understanding of personal trauma and the importance of mental health care. He mentioned an openness to expanding the current level of care available at his church and highlighted standard protocols. In doing so, he shared challenges related to discussing trauma needs with congregants. He discussed some strategies he currently uses, such as outsourcing congregants whose needs are more extensive than what he is trained to address.

Participant 2 had a basic understanding of trauma, as he identified some specific scenarios of addressing trauma with congregants and how it impacted the individual and others within the church. This participant drew a clear connection between mental and spiritual health. He also provided a basic understanding of TIC, sharing about the importance of creating a safe space for people who have experienced trauma. He also mentioned that when it comes to protocols around mental health, his church leadership and staff are trained to report disclosures upward to prevent information from spreading and highlighted the importance of confidentiality. He also mentioned referring cases to professional counselors when needed. Lastly, this participant expressed an openness to integrating a modified TIC within his church, sharing that much like we would offer first aid in an emergency, we should be offering care for trauma situations.

Participant 3

Participant 3 disclosed that she is a 39-year-old black female who has been a lead pastor at a Non-Denominational church in the GTA for eight years. This participant disclosed a deep understanding and background in caring for trauma needs, and she spoke well of the church's current infrastructure for trauma care and attention to mental health. This participant stated there is a current model in place for church counseling, including a protocol and standard practice for when trauma is disclosed. There is no professional counselor on staff at the church. However, a TIC model is in place. Mental health conversations occur amongst the pastoral leadership, and there is an openness for TIC integration in addition to what already exists at this church.

This participant shared that in her experience, there is a concern for the level of support available in the congregant's life when they disclose trauma. This participant is keenly aware of the impact of support and a team dedicated to proper trauma care. She highlighted the importance of community when addressing spiritual and mental health, explaining that her church had multiple opportunities for congregants to connect with others and find the support they need. She shared that her church is open to expanding the current level of care available to congregants and that there is a variety of programming available for the church to continue learning about mental health.

Participant 3 had a primary to high level of trauma knowledge and shared various scenarios of trauma. This participant also highlighted the impact of trauma on the congregation and how it is essential to offer both spiritual and mental health care when these issues arise. This participant mentioned the importance of creating a safe space when describing TIC and disclosed that this healthy environment is something they aim to create within their church. When addressing protocols, this participant described the training they offer leaders at all levels to

handle situations and offer care when trauma is disclosed. This participant expressed a solid openness for integrating a modified TIC model and shared the importance of people talking about their trauma and receiving training on how to care for trauma needs.

Participant 4

Participant 4 disclosed that she is a 62-year-old East-Indian female who has been a lead pastor at a Pentecostal church in the GTA for 14 years. This participant shared her experiences when discussing trauma with church congregants and spoke about the needs and challenges involved. She also disclosed the church's perspective on mental health and TIC integration. Participant 4 stated that there is no church counseling model in place at this church. However, there are regular discussions about mental health amongst the staff. Also, there are protocols and standards involved when trauma is disclosed. There is a counselor on staff or volunteering at the church. While no TIC model is currently in use at the church, there is an interest in integrating a modified TIC model into the church's current infrastructure.

This participant's experience with congregant trauma disclosure has often been connected to very public traumas like issues related to death, accidents, or loss of a relationship. She did highlight that some cases she works with involve more people and less known scenarios. This participant focused on spiritual and mental health connectedness and mentioned how they strongly impact each other. She expressed a solid openness to expanding the level of care offered from within the church. She mentioned that there is not much of a current infrastructure as most cases of trauma counseling are outsourced to professional counselors.

Participant 4 discussed her understanding of trauma and explained how it can be processed. She also shared that she did not believe she knew enough about trauma. This participant also mentioned that there is a greater awareness of mental health in the church now

than there has been in the past, which has increased congregants' ability to receive the care they need. This participant described TIC as an essential model and should be available in churches. She highlighted some of the current protocols involved in the church and welcomed the idea of integrating a full TIC model for staff training.

Participant 5

Participant 5 disclosed that he is a 62-year-old Brazilian male who has been a lead pastor at a Non-Denominational church in the GTA for 32 years. This participant offered a wide range of experiences about discussing trauma with congregants and shared many examples of how the church has responded to trauma disclosures. This participant's church does not have a counseling model, but there are standard practices and protocols for trauma disclosures. There is no counselor on staff or volunteering at this church. There is a trauma-informed model in place at this church, and conversations around mental health occur among the leadership. The participants said they would be willing to integrate a modified TIC model with practices to serve their congregation.

This participant shared how 32 years of experience in this role has led to a variety of trauma issues being discussed. He mentioned issues related to abuse, house fires, unexpected deaths, near-death experiences, and tragic accidents. This participant counts it as a privilege to care for congregants through these situations but addressed the toll it takes on him and the pastoral staff at times. He shared that the current reality involves significant issues with mental health and that spirituality is impacted. This participant expresses a sensitivity to mental health needs, when speaking in the pulpit and in meetings with staff, always using a lens that recognizes mental and spiritual health. He welcomed the idea of expanding the level of care offered by the church and expressed a profound openness to further training in all areas of ministry.

Participant 5 described trauma as a building collapsing and highlighted the impact of trauma on a congregation. This participant spoke about the connection between spiritual and mental health, specifically highlighting the importance of taking the time to care for the needs of congregants. When asked about TIC, this participant shared that there is much for the church to learn and was very open to collaborating with other professionals and networking with partners to expand the way care is offered to congregants. He shared some protocols at the church and amongst the staff. He welcomed any opportunity to integrate TIC training, offering to do whatever it takes to integrate this model.

Participant 6

Participant 6 disclosed that he is a 58-year-old Italian male who has been a lead pastor at a Pentecostal church in the GTA for 19 years. This participant shared a deep understanding of trauma needs along with his experiences with trauma in the church. He also spoke to the impact of trauma and the desire for better training on all levels of leadership from within his church. This participant's church does have a current counseling model in place, along with standard practices and protocols for pastors when trauma is disclosed. A counselor is on staff and available to congregants at this participant's church. This is not a TIC model at this church. However, conversations about mental and spiritual health occur with the participants and staff often. They are willing to integrate a modified TIC model at their church.

This participant mentioned the heartbreak of caring for the trauma needs of congregants and addressed a variety of topics disclosed by congregants, some being more personal or private than others. He also expressed the frustration and anger associated with traumas that could have been prevented, specifically with issues of abuse involving children. This participant noted the connection between spiritual and mental health, and he mentioned that, at times, mental health

issues are spiritualized instead of cared for. He specifically noted that his church tries to address the needs as they are instead of ignoring the impact of mental health-related issues. This participant expressed an openness to expanding the level of care available at the church and shared a deep appreciation for the training and development of ministry teams. He spoke to the current protocols of the church, highlighting the use of outside resources when needed.

Participant 6 had a high level of trauma knowledge and described various aspects of trauma, including types, symptoms, and impact. This participant expressed the importance of mental health conversations amongst church leadership and congregants, sharing that the church discusses these topics regularly without minimizing the needs of those with issues related to trauma and mental health. This participant expressed a high level of TIC understanding and mentioned that he felt his church implemented some of the practices without knowing the correct terminology. He welcomed the idea of a model formatted explicitly for his church's religious and ethical beliefs.

Participant 7

Participant 7 disclosed that he is a 45-year-old South-Asian male who has been a lead pastor at a Non-Denominational church in the GTA for three years. This participant shared a range of experiences regarding trauma and trauma disclosures from congregants. He highlighted some previous needs for development within his church and some methods of improving current systems surrounding trauma care. This participant's church has a current model of care and counseling along with standard practices and protocols to use when trauma is disclosed. Though resources are available, there is no counselor on staff or volunteer at this participant's church. This participant said there is a TIC model in place at this church but that they would be open to

the full integration of a TIC model for the church. This participant also said conversations about mental and spiritual health occur frequently amongst the leadership.

This participant shared that his experience with congregants is one of empathy and understanding, as he disclosed several instances where he has personally experienced trauma. He mentioned the impact of his experiences on caring for others as they walk through the trauma-healing process. This participant shared how mental and spiritual health are connected and impact one another. This participant also highlighted the importance of both equally. He shared a willingness of the church to expand the current care model through more training, and he mentioned some ways that he has experienced this in other church settings. This participant also spoke about how care has been offered at the church where he currently pastors and mentioned some areas where he has been actively working to improve mental health care.

Participant 7 had a medium level of trauma knowledge and spoke specifically of the impact of trauma on the whole person, including physical, emotional, and spiritual impacts. This participant discussed determining if needs are spiritual, physical, or emotional and how sometimes they are interconnected and impact other areas of the person's life. This participant understood TIC well and explained the model exceptionally well. He shared about trauma-informed practices and protocols already in place at the church and welcomed the opportunity for further training in TIC, insisting that it is imperative.

Participant 8

One participant, "Participant 8" was selected for the study based on the impression that the criteria were met. Additional checking on criteria occurred during the informed consent signing and in the pre-meeting interview, where the participant agreed to have met all criteria. Once the interview began, one of the questions asked was, "What is your church denomination?"

the participant answered with a statement that eliminated this participant from the study. At the time of the interview, I was unsure if the denomination that the participant stated was under the umbrella of one of the criteria denominations required: Baptist, Pentecostal, or Non-Denominational. The interview continued, and I carefully researched the denomination of the participant, Christian Missionary Alliance, to find that although it is an evangelical denomination, it is not under the umbrella of one of the three required denominations. This participant's data was destroyed, and the results were not included in the data analysis.

Participant 9

Participant 9 disclosed that she is a 33-year-old Caucasian female who has been a lead pastor at a non-denominational church in the GTA for six months, though she served on staff for seven years prior. While only serving as a lead pastor for a short time up to this point, the participant still had much to share about her experiences as a lead pastor addressing the trauma needs of congregants, disclosing that these conversations are frequent. She also spoke about her church's perspective on mental health and how conversations about mental health and trauma begin from the pulpit and occur in all areas of the church's ministries. The church of this participant has a current model for counseling at the church, as well as standard procedures and protocols for when trauma is disclosed. While pastoral care and referrals to professional counselors are available at this participant's church, no counselor is on staff. This participant stated that the church does operate through a trauma-informed lens, and conversations about mental health often occur among staff. This church is also open to integrating a complete and modified TIC model within its framework.

This participant shared that her experiences involve walking alongside congregants through their trauma and finding the best resources available to help support their needs. She also

highlighted the benefit of multiple outreach partners dedicated to caring for trauma needs. This participant highlighted the importance of spirituality on mental health and identified how they are interconnected. She also addressed how trauma healing can open a pathway for more significant spiritual development. She shared an openness about her church's willingness to expand the care they currently offer congregants and expressed an appreciation for all training.

Participant 9 had a basic understanding of trauma and explained how it dramatically impacts the church. She stated that her church is a very safe space where people can come as they are and share about the issues they are dealing with. She felt confident in her church's proactive approach to addressing mental health needs from the ground up. This participant shared that she had a limited understanding of TIC but explained that she felt it could benefit someone who was expressing symptoms or issues related to trauma exposure. She mentioned it would be helpful to have more training and to be equipped with tools to help congregants when they disclose trauma. She also mentioned that her church was always open to trading and welcomed an opportunity to apply practical steps when caring for trauma needs.

Results

This purpose of this transcendental phenomenological study was to learn about the lived experiences of pastors in the GTA with their congregants regarding trauma TIC. The findings from the participant interviews revealed four major themes among participant experiences related to trauma and TIC. These themes were consistent with the literature from Chapter 2. Connections to the literature are seen throughout the description of themes in the sections below. The first segment of interview questions focused primarily on church and pastor demographics. The second was direct, short-ended questions surrounding the church's current level of care available for congregants who disclose trauma and the openness towards expanding this level of

care. The chart below provides participants' "yes" and "no" answers for each question in the second segment of interview questions.

Table 2. Segment 2 Responses

	Does your church have a church counseling model in place for congregants?	When a church member discloses trauma, are there standard practices for pastors and leaders?	Is there a counselor on staff or volunteering at the church?	Does the church use a trauma-informed care (TIC) model with its congregants?	Do mental and spiritual health conversations occur amongst the pastoral leadership at the church?	Suppose a TIC methodology was modified to align with your church's religious beliefs and ethics. Would pastoral leadership be willing to implement these practices within their congregation?
Participant 1	yes	yes	no	no	yes	yes
Participant 2	no	yes	no	no	yes	yes
Participant 3	yes	yes	no	yes	yes	yes
Participant 4	no	yes	yes	no	yes	yes
Participant 5	no	yes	no	yes	yes	yes
Participant 6	yes	yes	yes	no	yes	yes
Participant 7	yes	yes	no	yes	yes	yes
Participant 8	This participant was removed, as he/she did not meet the Denomination Criterion.					
Participant 9	yes	yes	no	yes	yes	yes

These results began to reveal patterns amongst the sample of participants, including a nearly even split between churches having a current counseling model in place. Three of the participants revealed that there is no model in place at their church, while five revealed that there is a model currently in place. There was a unanimous consensus surrounding the use of standard practices within churches for leaders and pastors concerning the disclosure of trauma by congregants. Most of the participants revealed that there is no counselor on staff or volunteering services at their church. However, two participants confirmed having a counselor on staff or volunteering. There is an even split between this sample regarding implementing a TIC model currently at their church. However, one should note that based on the level of understanding by the participants surrounding TIC, which was revealed in the interview, it may be the case that a TIC model is not fully integrated into all four churches, as noted here in this graph. All participants acknowledged that mental and spiritual health conversations occur amongst their

pastoral leadership teams. Additionally, all participants agreed that their church would be willing to integrate a modified TIC model into their church.

Theme Development

Theme developed during all segments of interview questions and developed more depth specifically in the third segment, as participants began to provide answers in rich detail, explaining very openly their experiences with discussing trauma with congregants. Themes also presented as participants discussed their church's protocols when trauma is disclosed, and the potential integration of a TIC model modified to reflect their church's religious beliefs and ethics. Initial trends emerged and were first identified using a horizontalization technique of organizing the data by question. Once the answers were horizontalized, a coding system began and continued in a circular approach, further horizontalizing various themes as they presented.

There are four themes from the participant interviews that reflect the interpretation of results. These four themes are the experiences with trauma, understanding of trauma and TIC, challenges faced by pastors, and strategies implemented by pastors and churches. Statements from the participants' interviews helped develop these themes, which are identified in the sections below. Each theme reveals examples of statements from every participant in the study.

Theme 1: Experience with Trauma

As participants described their experiences discussing trauma with congregants, it was clear that people are coming to the church for help related to issues around mental health. This supports the literature on the historical overview of the role of church as it relates to mental health (Costello et al., 2021; Hardy, 2014; Hill & Yancey, 2022; Kane & Green, 2009; Weaver et al., 2019).

The Toll of Congregant Trauma Disclosure on Pastors

It is evident that the impact of trauma extends beyond the congregation and onto the pastoral staff. Participants expressed how this toll ranges from bearing the emotional weight of discussing trauma needs to facing the challenges related to being the employer of staff members who struggle with trauma symptoms. The literature reflects that the overall social fabric of a religious center is impacted when traumas occur (Herman, 1997; van der Kolk, 2014). While other participants did not reveal the emotional impact of trauma on themselves, some chose to disclose some personal traumas that they have experienced, noting the impact of their trauma on their experiences relating to congregants who discuss trauma.

Participants discussed the toll these trauma conversations can take on the pastoral team. Three of the participants highlighted the difficulties involved in addressing the trauma needs of congregants. Participants were not asked to discuss the toll of their work, and these conversations emerged naturally as pastors described what their experience feels like when discussing trauma with congregants. The example below reveals how this contributes to this theme.

Participant 5 stated, “I bear the privilege of being about to be involved. It is hard, but I also count it as a privilege to be involved when people need help that way.”

Participant 6 made multiple references to the difficulty and emotional impact of caring for the trauma needs of congregants. He stated, “I think we're very heartbroken for people that have gone through very painful experiences. It's not something that you can just easily dismiss or even forget about depending on.” This participant went on to say, “it's a very difficult and very stressful. It's very heartbreaking to hear some of the stories and, you know, the things that people have gone through.” His last references to the toll of trauma on pastors stated,

> It is, as I mentioned before, it's very difficult not to take these. I will take these things home per say. I wouldn't say that they've traumatized me, but there is an impact. There's no question you are. If you're human in any way, it is impactful.

Participant 7 also addressed the impact of addressing trauma needs of congregants but from a different angle. This participant stated,

> Now everything is mental health, so people don't want to work because it's mental health. There's one little trigger things like, Oh, you can have mental health, they can't work, right? And so, it becomes almost hard as a leader. Yeah, because you're always walking on edges because this person is going to suddenly say, this is affected my mental health. Because you gave them, you know, a talk about performance review and you're like, you're not doing well, now you're traumatize me, you know?

Disclosure of Personal Trauma from Pastor

While this study focused on pastors' experiences when discussing the trauma congregants have experienced, it might not be a surprise that some pastors would feel a need to share some of their traumas. These were comments that surfaced when asking about the situations that have impacted their experiences when discussing trauma with congregants. Three of the participants disclosed their experience with personal trauma. It is relevant to note that these pastors were not asked to disclose their trauma. However, they felt that it was relevant to the interview to share their experiences. These experiences were shared as they explained the type of care they offer.

It seems that pastors' exposures to trauma make them feel more equipped to help congregants deal with their experienced trauma as they come from a place of understanding what it feels like to experience trauma. As the trauma experiences of pastors ranged from abuse to exposure to war environments, a trend was also noticed regarding the range of trauma topics

discussed with congregants. The meaning behind these statements reflects an essence of empathy and a sense of understanding what their congregants are experiencing due to their personal experiences. One may deduce that their desire to help comes from a place of knowing how it feels to experience trauma through these personal experiences.

Participant 2 stated, “my dad abused me.”

Participant 5 stated, “I'm coming from an abusive home, you know, sexual abuse, you know, from 7 to 11 years old.” This participant also stated, “I went through some experience in life,” when discussing how he relates to congregants who are dealing with trauma exposure.

Participant 7 stated, “I've gone through a lot of trauma myself, probably more than a lot of people I know,” before going on to disclose multiple scenarios of experienced personal trauma throughout his life.

Range of Trauma Topics Discussed with Congregants

When sharing their experiences of discussing the trauma of congregants, 7 of the participants spoke about the range of trauma conversations with their congregants. Some participants noted a wide range, while others were more specific with examples of traumas they discussed with their congregants. Participant statements reflect the wide range of trauma topics that pastors discuss, and this trend reflects the many types of traumas discussed in Chapter 2. Researchers have identified a wide range of the types of experiences that can cause trauma (Chu, 2011; Bloom, 2013; Sanderson, 2015). The meaning behind these statements reveals a closeness with the congregation, as pastors are keenly aware of what is happening in their congregants' lives. A level of care to attend to these needs is also seen. By being able to highlight specific types of traumas that their congregants have experienced, the participants show a sense of

understanding of the topic of trauma. The examples below point to discussing various trauma topics with congregants.

Participant 1 stated that trauma conversations are

> Definitely wide ranging. Some people are very surface level and just looking for, you know, some prayer and to more in depth, looking for more structured counseling and others are very open with some of the struggles that they've gone through in the trauma.

Participant 2 stated, “Mental health can be a variety of things that people are going through and could be because of relationships, could be because of career, all of these things.”

Participant 4 stated that her experience discussing trauma with congregants usually involved, “Mostly like a death in the family or, you know, breakup of a relationship for marriage or something like that.” She also stated, “there have been cases where they've gone through a traumatic experience that no one knew about and where they have, you know, come and opened up and had conversations with me about it.”

Participant 5 shared that trauma conversations, “varies from, you know, house being burned and people dying in it and then, you know, being involved with the family, sexual abuse and things of that matter, loss, you know, tragic accident.”

Participant 6 stated, “People describe traumatic situations where they have been victimized, they've been abused, they have experienced something that is beyond their emotional mental capacity to deal.”

Participant 7 stated, “when someone does share, depending on the trauma, you know, sometimes it could be legal, illegal trauma, it could be, you know, emotional.”

Recognized Importance of Empathy, Compassion, or Community

This theme highlights how participants mentioned the need or importance of empathy, compassion, or community when discussing their experiences with congregants about their trauma. The literature highlights the importance of empathy in trauma recovery and healing, along with other methods like active listening, trauma-informed approaches, developing trust, understanding triggers, and promoting self-care and additional resources (Courtois & Ford, 2009; Harris et al., 2001; Herman, 1997; Njavits & Walsh, 2012; Roth et al., 1997). Four participants made statements in their answers that reflected this theme of empathy and compassion. Some of the participants specifically used these terms, while others described empathy and a need for sensitivity to the trauma needs of congregants. The statements below reflect how this theme emerged.

Participant statements not only reveal the participants' compassion but highlight their understanding of the impact of empathy and careful consideration of the trauma needs of congregants. Without this awareness, their care is stunted beyond the limitations of a lack of resources. Participant 5 highlighted the importance of compassion and again address the connection between a pastor's personal experience with trauma and how they care for their congregants who have experienced trauma. This understanding and offering of empathy and compassion reveal a desire to meet the congregants where they are and to tailor care to the specific needs of the congregants.

Participant 5 stated, "We try to be very sensitive and very self-aware of as we minister to people." He also said, "you know, extending compassion, things like that" when talking about caring for congregants with trauma needs. This participant also said, "And I'm not trained, you

know, I went through some experience in life that I can I can, you know, sympathize and have compassion and all that."

Participant 6 addressed empathy from a different approach asking, "How do we show compassion and yet and empathy and yet not take it to such a degree that you know that it impacts us?" which again points to the toll of trauma conversations on pastors.

Participant 7 was quick to reference empathy when describing his experience with congregants disclosing trauma, as he stated, "So what's my experience? I think one with empathy and understanding." He then went on to disclose his experiences with personal trauma and why he felt that these two components were critical. This participant also stated, "it's empathy, understanding and an ability is to try to help you know."

Participant 9 stated that small groups and community in church is "a place where people can receive prayer from others, where they can do life with each other. They can form really strong friendships where they can again walk alongside them and support them."

Expressed Desire to Help Mitigate Trauma Needs

When sharing their experiences, pastors highlighted their desire to help mitigate the impact of trauma on their congregants from within the church. Offering support to communities and helping with a variety of needs are a core roles pastors, according to the literature (Allen et al., 2014; Anshel & Smith, 2014; Barnes & Curtis, 2009; de Oliveira Maraldi, 2020; Sklar & Goldman, 2023). The desire to help congregants was mentioned by all 8 participants. Before one can help, the desire to help must exist, and this desire was noticeable among all participants.

As participants discussed their experiences when talking to congregants about trauma, it was almost immediately noticed that they all had a desire to help. The participants all expressed how they care for their congregations and want to see their congregants heal and grow from their

trauma. These noticeable trends in pastoral experiences are shaped by a lens of a desire to offer care, which can be challenging. The trending challenges mentioned by pastors are mentioned in the next section.

When commenting on church protocols related to trauma and mental health, Participant 1 stated

> We are very big on community as well. We don't want people to be isolated. We don't want people to suffer on their own. And so we really highly encourage people to get into the community, whether that's through a small groups of the best way to do that, even through volunteering, even different events that we post by trying to get people to get into communities so they can know that they are struggling alone.

When discussing TIC, Participant 2 stated, “I want this to be the place where people want to come for that kind of care.” When considering a willingness for TIC training for church staff,

Participant 3 stated, “I think everyone needs to be aware of any type of trauma that's in their life, or even special leadership, how to how to help other people.”

Participant 4 clearly stated, “There's a desire to help people” when asked about care for trauma and mental health needs.

Participant 5 asked, “How can we be of help? So, what do we do?” and followed up, saying,

> We try to be very sensitive and very self-aware of as we minister to people to really reach not only this spiritual need, but the emotional need of a person. So, we try to do that in, you know, as we talk or preparing messages to address both of those things that are really very important.

When discussing how the church leadership converses about mental and spiritual health, Participant 6 stated, “we always have discussion on ‘how do we help people?’.”

Participant 7 shared a proactive way in which they offer help and stated

> We put a slide with the pastor's name, telephone number, email. After the end of every service, it's always there and said, Hey, you want to care and follow up? And then we also have prayer teams every Sunday at the front. And so people go and talk to them and then if there's a need, can follow through with each other. So we're trying to do those kind of things to be proactive to the people's needs.

When discussing the church's response to the impact of trauma, Participant 9 said, "these emotions come out and we want that because we do believe that obviously the best place to heal is at the feet of Jesus. And that's what we try to offer through our Sunday worship experiences."

Theme 2: Understanding Trauma and Trauma-Informed Care

This next section discusses the participants' understanding of trauma and the TIC model. Each participant expressed a level of trauma knowledge and understanding of mental health. This section also mentions the church's perspective on mental health. Participants expressed a basic to a high level of trauma understanding, noting the impact of trauma on the church, revealing the importance of mental health, drawing a connection between spiritual and mental health, and discussing a stigma around mental health. As participants were asked to express what trauma, mental health, and spiritual health mean to them and the church's perspective on mental health, they discussed these topics in a way that was very consistent amongst the sample.

Basic to High Level of Trauma Knowledge

As themes developed, a shared understanding of trauma and mental health was revealed. Participants acknowledging the importance of TIC, recognizing the need for a safe space, noting the need for specialized care, and recognizing the importance of staff-wide training. By having a basic understanding of these topics, participants reflected a basic understanding of TIC, even

without formal training. These conversations developed during the third segment of interview questioning when participants were explicitly asked to share their understanding of TIC.

When asked to explain their understanding of trauma and its impact on the congregation, all eight participants expressed a basic to high level of trauma knowledge. As participants defined trauma in their own words, they alluded to many of the same descriptions of trauma. Some highlighted various types of traumas, while others focused more on the impact of trauma. As the participants revealed a basic to a high knowledge of trauma, the importance of their understanding was noticed. When pastors understand trauma, even at a basic level, they are more empowered to help their congregants.

Their awareness of trauma needs and prevalence can help to create a greater awareness within the church community, possibly even preventing future trauma instances with education on the topic. Some studies reveal how congregants do not always feel supported by their church about mental health issues (Guiking & Jacobs, 2022; Hipp et al., 2019; Streets, 2015; Zauzmer, 2017). Mentioned in a different section but relevant to this theme is how an awareness and understanding of trauma can impact the elimination of stigmas attached to mental health conversations and trauma disclosure. When pastors understand trauma, they can offer enhanced support or make decisions from a position of knowledge instead of an uneducated perspective. The statements below reveal how this basic to high understanding of trauma developed.

Participant 1 stated

> Most people probably experience some sort of trauma at some point in their life, and it can be over a variety of different situations, a variety, different topics, and it affects different people in different ways. But it definitely is something that probably should be talked about more often and dealt with more openly or like.

Participant 2 mentioned, “Mental health can be a variety of things that people are going through and could be because of relationships, could be because of career, all of these things.” This participant also described trauma by saying

> It's like someone going through a situation that they have not necessarily put themselves through, but it's been like, brought upon them. Yeah. And now they’re like having to, whether they're reliving it or whether they're just acting as a result of what happened. That's how I would define trauma.

Participant 3 shared

> My definition of trauma is any. It can be inherent. Bad things happen to someone that they're not. Because sometimes you don't realize they've been traumatized because they don't know the definition of it. Or also someone that's been actually emotionally, physically, emotionally, emotionally, physically, or spiritually abused by a certain person or a community by negative thoughts or even physically being harmed.

Participant 4 said, “I do think that it can manifest in so many ways. And sometimes the impact of trauma can be seen, you know, months or years later. But. And each individual process that processes it differently.”

Participant 5 mentioned, “when I think about a trauma, I always think about this building that is, you know, collapsing. And, you know, that affects not only, you know, that particular person, but it affects everyone around.” This participant also said

> Yeah. So, it impacts in every level. You know, it's not only, you know, spiritually and of course, we are a spiritual entity. We try to, you know, we minister, you know, try to reach people's hearts as far as the spiritual concerned. But we are not only that, we are experts in body. So, you know, I am we our understanding is that it impacts the whole person.

> Yeah. So, you know, we have to be able to reach somehow and trying to help people to minister that and so it impacts.

Participant 6 shared

> I think I have a high level of understanding, particularly. You know, we are very aware of the lyrics in the industry, for example. And so, in many cases. People describe traumatic situations where they have been victimized, they've been abused, they have experienced something that is is beyond their emotional mental capacity to deal, to deal with things that literally it has paralyzed them in some ways, whether that's spiritually. Emotionally and mentally.

Participant 7 said, “I think trauma can be something that. A life experience that we go through. Physical, emotional and even spiritual that continues to linger and resurfaces at trigger points.”

Participant 9 said

> My understanding of trauma is anything that has caused pain and hurt to a person. And it it impacts their life in some sort of way. So, it's something that they can't forget. They can't just shake off, but something that's deeply impacted them in the way that they respond to the world to make connections to other people.

Noted Recognizable Impact of Trauma on Congregation

Participants also shared perspective on the impact of trauma on the congregation. Participants were asked to share their understanding of trauma and its impact on their congregation. All 8 participants noted a recognizable impact of trauma on the congregation. Their answers offered insights into how this impact can range from one individual to specific groups and even the entire congregation. There is a profound meaning behind these statements,

as pastors are responsible for the care of their congregants. These participants all acknowledge that trauma does impact the individual who has experienced the trauma, and some participants highlighted how the experience of one person with trauma can cause a ripple effect that impacts the entirety of the congregation. Examples were given by participants of cases where trauma, such as an accident or a death, left a lasting impact on a youth group and the church.

Understanding the impact of trauma fosters a space where support and care can exist to help improve trauma symptoms and lessen the impact of these trauma experiences. This concept of developing a safe space is a core value of TIC (Arthur et al., 2013; Ely et al., 2017). Research reveals a need for care to mitigate the impact of trauma on church congregations (Costello et al., 2021; Williams et al., 2014). By addressing this ripple effect of the impact of trauma, participants can improve the church's overall health and strengthen the relationships of those within the network of the church. A collaborative approach among counseling professionals and church leaders can help to meet the needs of the community (Costello et al., 2021; Williams et al., 2014). This all begins with an understanding of trauma's impact. The statements below reveal these perspectives and highlight this understanding.

Participant 1 stated, “The congregation is experiencing it. And they are, you know, as as they're trying to move further on their faith and move forward in life. I think a lot of times people come to the realization that they need to deal with the trauma that they're experiencing, and they need to find out ways to get past that and to get through it.”

Participant 2 mentioned, “it can be as simple as it affects one person because it's something unrelated to church. Or it can really get the whole thing off.”

Participant 3 shared, “Oh, like so huge. A lot of people's responses in most things is from a lens of their trauma and their past experiences by decision making, by just so many things. Why they do certain things from a lot of times from a lens of their past experiences.”

Participant 4 said

> Sometimes the impact of trauma can be seen, you know, months or years later. But. And each individual process that processes it differently. So. I know that as a congregation we've gone through, you know. A couple of things that affected us together. We grieved together as a congregation.

Participant 5 mentioned, “So it's never just a person. It's whoever has a relationship there. You know, in that in the case that I previously told you about this girl, you know, it was a whole youth group that was impacted.”

Participant 6 shared

> And I am aware of people that have have been, you know, impacted. Affected. Some people have taken a leave of absence. Some people have gone to therapists. Trauma is very it's evident. People recognize they they go through it. And and sometimes the the outcome of it can be long lasting and some ways can be can be worse than the sense of they're experiencing nightmares, memories, inability to function. And so, they are Yeah, they are. They're deeply impacted by what has occurred.

Participant 7 stated

> I do think the effect of trauma affects the church world, because the church is to be a place of community. If trauma affects an internal family between the traditional family, and it's going to affect the parent’s trauma affects how they raise their kids or how their marriage comes out.

Participant 9 said

> Trauma definitely has a huge impact on the church congregation. At different times, our pastor will preach on different things that you can see trigger people and they need to go and talk to somebody about it because it could bring up maybe a past memory of something or a past hurt. And so, it can bring up a lot.

Acknowledge Importance of Mental Health

Pastors acknowledging the importance of mental health is crucial to the study since understanding TIC is improved by understanding mental health and trauma. Seven participants specifically acknowledged the importance of mental health. Participants were not explicitly asked to disclose if mental health was necessary. However, they were all asked to share their church's perspective on mental and spiritual health.

By recognizing that mental health is essential, these participants understand the complexity of humans and have a deeper understanding of how life's experiences impact a person than someone who does not value mental health conversations. This awareness of mental health's importance can influence pastors in addressing congregants' needs, especially trauma needs, discussing specific topics during sermons or workshops, and how the church perceives mental health care and counseling. Acknowledging the importance of mental health by pastoral leadership can help to destigmatize both trauma and mental health conversations and promote healing in instances where trauma exists.

Participant 1 stated, “it's very important both spiritual and mental health.” Participant 2 mentioned, “It is important because I also see it tied to spiritual health.”

Participant 3 shared, “knowing their awareness of their mental health and says a lot about their, their journey or challenges.”

Participant 4 said, “I think mental health affects your health in both ways. I think it is important, obviously, to grow strong spiritually. But I do know that sometimes a lot of the times are poor mental health affects their spiritual progress.”

Participant 5 mentioned, “People are affected by, you know, by both of those things.” Participant 7 stated

> The convergence of the gifts, experiences and the disciplines are very important to the formation of who you are and your relationship to God. And that relationship informs how we handle our emotional, physical and mental health. And so mental health is also a very important aspect. And so, as our spiritual health is thriving, our mental health.

Participant 9 said

> It's important to be prioritizing spending time with God, reading scripture, praying, putting on worship music, getting around people that can encourage you not doing life by yourself. And those things are all vital to spiritual and mental and mental health. And again, if you ever experienced a trauma or something, ensuring that you are getting professional counseling so that somebody is able to help you heal and give you what you need so that you can continue to do everything God has called you to do.

Drew Connection Between Spiritual and Mental Health

Pastors also drew a connection between spiritual and mental health. This connection is critical to the study and supported in the literature, as research reveals a connection between mind, body, and spirit (Helmke et al., 2017; Hill & Yancy, 2022; Pargament et al., 2000; Vazquez et al., 2023). Pastors acknowledged that mental health is essential and expressing how it is connected to spiritual health and vice versa. Seven participants drew a strong connection between spiritual and mental health. This is relevant because historically, the church has been a

place where mental health conversations were taboo and mental health issues were seen as a lack of faith. As participants reveal how they see the connection between mental and spiritual health, this historical perspective from the church could shift.

The meaning behind understanding that mental and spiritual health are intertwined and connected is that participants are aware that multiple aspects of the human are at play when dealing with trauma needs. For example, these answers below reveal how trauma can impact both mental and spiritual health. Participants also reflected on how mental health and spiritual can impact each other. Awareness of the multiple components at play reflects a holistic perspective of the human framework, promoting a holistic approach towards care and healing, including addressing trauma symptoms. A holistic perspective opens the door for collaborative approaches to healing from trauma which considers both psychological and spiritual aspects of trauma. This points to integrating care from the counseling community with the spiritual care commonly offered within the church for a holistic approach.

Participant 1 stated, “Yes. it's very important both spiritual and mental health. I think they definitely go hand in hand as well. I think especially when you're talking about mental health, you have to include the spiritual aspect as well.” When discussing mental health,

Participant 2 said, “I also see it tied to spiritual health.”

Participant 4 said, “Poor mental health affects their spiritual progress.”

Participant 5 mentioned, “we try to be very sensitive and very self-aware of as we minister to people to really reach not only this spiritual need, but the emotional need of a person. So, we try to do that in, you know, as we talk or preparing messages to address both of those things that are really very important.”

Participant 6 shared, “I do believe that in some cases they are intertwined. In other words, the root cause of some mental health issues can be spiritual and need to be dealt with.”

When talking about spiritual health and one’s relationship with God, Participant 7 stated, “that relationship informs how we handle our emotional, physical and mental health.” Participant 9 said

> Just like we work at our bodies physically to keep ourselves healthy. It's important to be prioritizing spending time with God, reading scripture, praying, putting on worship music, getting around people that can encourage you not doing life by yourself. And those things are all vital to spiritual and mental and mental health.

Mentioned Stigma Related to Mental Health

The research also acknowledged how participants addressed stigmas related to mental health and trauma. The literature reflects that churches can help reduce the stigma around mental health when they offer support for these issues (Simpson, 2013). Four participants made comments about a stigma related to mental health, and the perspectives which were shared came from two different angles. All four of these participants reference a mental health stigma, yet two of the participants in this group revealed an existing stigma within their church. In contrast, two others revealed no stigma despite the historical issues regarding mental health stigma in the church. It is interesting to note that the interview questions did not address a stigma. However, talks about stigma arose when asked about the church’s perspective on mental health.

The pastor’s awareness of the church’s perspective on mental health reflects the essence of stigma awareness around mental health and trauma. It also reveals a possible deeper need for integration and training on trauma topics to reduce the challenging misconceptions. Another meaning could be related to the extent of pastoral care available to congregants, to the point of

congregants possibly feeling that the church meets their needs. Where the pastors discussed no stigma towards mental health, this reflects an essence of a safe place currently existing within the church which happens with intentionality on behalf of the church staff and leadership. Safe spaces are not accidentally created, and this lack of stigma surrounding mental health can be perceived as a good thing. This environment promotes inclusivity and an opportunity for those struggling to reach out and receive the care they need or be provided with resources to help with that care.

Participant 2 said, “I think that title mental health kind of scares people.” He also said

> But like the older generation, it's kind of like so we have older Italians that were the original founding members of the church, and that was like my grandparent’s era. That generation was like, What's wrong with you? Like, just. Just like, get up, get ready, Let's go to church. Move on. It wasn't very helpful. And so, there's a bit of that still lingering, I would say, when we were talking about the church as a whole.

Participant 4 stated, “there is maybe a stigma attached to mental illnesses or anything for that matter that's falling short of the normal what.”

Participant 6 took a different approached and mentioned, “We we don't minimize it in any way, shape or form. We don't stigmatize it per se. And it is it is something that is discussed openly within within the congregation from the pulpit with leaders and and honestly on an individual basis.”

Participant 7 also took the approach of Participant 6 and shared, " We talk about spiritual direction counseling. So, it's not a taboo here. It's it's, you know, almost everyone is involved.”

Acknowledged Need for Specialized Care of Trauma Needs

Participants acknowledged a need for specialized care when addressing trauma needs. Seven participants acknowledged that there is a need for specialized care when it comes to treating or managing the trauma needs of congregants. This is relevant as participants were not specifically asked if specialized care is necessary. Instead, they expressed the essence of TIC integration by acknowledging the importance of different models of care depending on the congregants' specific needs.

By recognizing that specialized care is needed, participants understand the limitations of care that do not involve special attention or training in trauma. This awareness may represent a willingness or desire for collaboration, further training, and building an infrastructure within the church to fully support congregants facing trauma. The essence of this willingness reveals a commitment to helping congregants heal and promoting overall well-being using resources from within or outside of the church.

Participant 1 stated, "I think it is definitely something that's needs to be addressed and more of a well-rounded approach to spiritual mental health."

Participant 2 mentioned, "I'm taking into account what this individual has expressed to me. Yeah. And that needs to influence, then, how I lead them."

Participant 4 acknowledge this need by mentioning, "Cases that, you know, really actually needed professional help are more detailed in-depth help." When discussing specialized care, Participant 4 said

> I think there is a lot more to learn. You know, I think. I think there needs to be a greater partnership, a greater understanding, a greater exchange of information and really

networking, more particularly in the faith community. You know, I my understanding is that, you know, we are we need more.

Participant 6 mentioned, “I believe that they understand the need for it. They understand the need for training.”

Participant 7 shared

Because yes, I would say yes in the sense that we encourage our side pastors to create care teams from the congregants that would respond to the need. So, when there's some because a pastor can't handle everyone. So, if there was a good model that could help equip people to do deal with trauma, I think definitely there would be openness to it.

Participant 9 said

I think that. So many people carry trauma, and they don't know how to deal with it. And they do come to church looking for it. And I do believe that it is found through our faith. But you do need practical steps at the same time. I believe that it really works together.

Acknowledge Importance of Trauma-Informed Care

All participants had the opportunity to explain TIC in their own words and express their understanding of this model, and while defining TIC, they expressed the importance or relevance of such a model for working with individuals who have experienced trauma. Five participants specifically highlighted or acknowledged that a TIC model is essential when working with congregants who are experiencing the impact of trauma. This speaks to the perspective of participants regarding the importance of using a TIC model with congregants who have trauma exposure and points to the openness of integrating this type of model.

The study reveals pastors’ perspective on how a TIC model could integrate effectively into their church framework. The meaning here is further impacted by the awareness of the

benefit of new systems and infrastructure specifically designed to meet the needs of trauma survivors. These perspectives were shared after a clinical definition of TIC was presented at the beginning of this study. Though some participants expressed that they did not have a deep enough understanding of the model, their answers reflect that their perspective was favorable regarding something they would welcome into their church.

Participant 2 mentioned, “I think, it's the same way we would want CPR and first aid. Yeah. You know, and that's important.” This participant described using TIC by stating that it is like, “I'm taking into account what this individual has expressed to me. Yeah. And that needs to influence, then, how I lead them.”

Participant 3 shared, “I think would be really great resources to churches.”

Participant 4 said, “It seems like it's something that's very necessary.” This participant also said, “trauma informed care seems like it is the right way to go. Like it's a knowledgeable and it's educated care that, you know, we can give people so we can all learn at whatever stage.

Participant 7 stated, “I would see trauma informed care as multifaceted approach, personal community and touching a kaleidoscope of care, I would say, as and and kind of catered towards different people's needs.

Participant 9 said, “I think that. So many people carry trauma, and they don't know how to deal with it. And they do come to church looking for it. And I do believe that it is found through our faith. But you do need practical steps at the same time. I believe that it really works together.”

Acknowledged Need for Trauma-Informed Care within the Church

Participants also acknowledged the need for or value of a TIC model within the church. Seven participants specifically acknowledged the need or the value of a TIC model which could

be modified to meet the church's needs while being sensitive to religious and ethical standards of the church. This awareness emerged throughout the interview as participants discussed the challenges faced when discussing trauma with congregants and shared about the strategies they currently use to meet the needs to the best of their ability. As discussions formed around a modified TIC model, participants acknowledge the relevance of such a model. The statements support the literature on the need for TIC in church models (Cashwell & Swindle, 2018).

By recognizing the value of a modified TIC model, participants may be more willing to integrate this type of model into their church's practice, as noted in the next theme. The meaning behind these statements reveals a deep desire to help, to use available resources, and to make changes where needed. This points back to the participants understanding the impact of trauma on the church, the need for appropriate care, and the value of integrating professional training for better care of congregants when dealing with trauma needs. It highlights the perspective that pastors understand trauma healing to be one of an ongoing process, not one of a lack of faith or dependent solely on spiritual healing. This is deeply connected to many of the other points addressed above. However, particularly, it lays a strong foundation for the next aspect of pastors being willing to integrate TIC within their current church framework of care.

Participant 2 mentioned, "I think, it's the same way we would want CPR and first aid."

Participant 3 shared, "I think would be really great resources to churches."

Participant 4 said, "I myself, I know, will benefit from it, but more so because it's not just one person or the lead passed and knowing, I think if the the leadership is trained, I think our approach would be very different."

Participant 5 mentioned, "we need to be equipped. You know, it's no longer I'll pray for you. Cut it out. Prayer. Absolutely. We got to pray. We've got to believe God completely for that.

But I think if we're going to really be in the business of helping people, we got to be able to offer what people need."

Participant 6 shared, "I believe that the more that we can expose people, educate people, train people. And I would just say pastoral stuff because they're a very capable people. Maybe they don't need to be trained, you know, to the same degree. But I would, I would involve as many people as possible, including, for example, youth leaders, pre-teens."

Participant 7 highlighted this theme as by stating the importance of, "making sure that we have good language and teaching around understanding the concepts."

Participant 9 said

> I think any training is great anyway that we're able to better ourselves and better care for the people that come to our church is always going to be beneficial. And I think that. So many people carry trauma and they don't know how to deal with it. And they do come to church looking for it. And I do believe that it is found through our faith. But you do need practical steps at the same time. I believe that it really works together.

Recognized Need for Safe Space or Community Support

A safe space is a critical element of TIC, and it was interesting that participants discussed a safe space by either using the verbiage "safe space" or describing scenarios within their church that represent a sense of safety. These comments emerged as participants shared their experience with caring for congregants, whether by using TIC or simply using the tools they have within their church. TIC models highlight the need for a safe space to reduce the impact of trauma and to help prevent retraumatization (Ely et al., 2017). Six of the participants either described a safe space or expressly stated that a safe space was necessary for congregants.

The meaning behind participants knowing the importance of creating a safe environment for congregants expressed how pastors offer care and support without retraumatizing trauma survivors. The essence of this understanding depicts the awareness of trauma needs and the willingness to create environments where those with trauma can still thrive. By giving special attention to these details of the church community, participants reveal a proactive nature in their approach to care for the trauma needs of their congregants. The statements below express the understanding of a safe space and the awareness of its value.

Participant 1 stated, “We are very big on community as well. We don't want people to be isolated. We don't want people to suffer on their own.”

Participant 3 shared about TIC that, “it's creating a space, a safe place for people that can unpack some of their triggers or issues or think they've had in the past in a healthy environment.”

Participant 5 described a safe space by stating, “I think for particularly spiritual leaders, you know, to it's important to stop. It's important to pay attention, important to care, eye to eye. You know, it takes time. A lot of times messes up our schedules and all that kind of stuff. But I think it's important if you want to minister to people. So that's how we view it.”

Participant 6 also described a safe space as he mentioned, “And, you know, obviously we are in a very caring or we should be in a very caring, sympathetic. You know, family environment. Right. And so, we we try to to the best of our ability to express. That sort of care, whether it's to the level of. You know, to the level that you're describing and probably not. It's probably more within that support family community.”

Participant 7 shared how they create this safe environment by stating, “So we have a ministry called Restoration Prayer. And so, it particularly it's quite well known externally and internally where people can come and have a safe space of really dealing with their past.”

Participant 9 said, “So I find that our church, our church is a very safe space. People can come as they are no matter what, no matter what they're dealing with, There's always a place for them. But then these emotions come out and we want that because we do believe that obviously the best place to heal is at the feet of Jesus. And that's what we try to offer through our Sunday worship experiences.”

Noted Importance of Staff-Wide Approach

Participants also noted the importance of a staff-wide approach towards trauma care when discussing how the church meets trauma needs, not only by the lead pastor or through pastoral care. The literature states that efficient integration of TIC models involves training across all levels of an organization (Harris & Fallot, 2001). Five of the participants discussed a staff-wide approach to integrating TIC or considering congregant trauma needs. This is important as it highlights the impact of church culture on the community and how a collaborative approach to care is relevant to addressing the impact of trauma at all levels of leadership. These participants shared a perspective of community awareness and highlighted the need for trauma understanding at all levels of church infrastructure, including those not on staff. The essence of these statements and this theme show a deep understanding of the impact of a community-based approach to trauma care and how special training in all areas, at all levels, is a great way to implement change within an organization. This core component of TIC reveals a vital pathway for church integration.

Participant 3 stated, “I think everyone needs to be aware of any type of trauma that's in their life, or even special leadership, how to how to help other people. If you don't know, you can't help people appropriately. If you don't have the right, the right information or resources, I think would be really great resources to churches.”

Participant 4 shared, “It seems like it's something that's very necessary. It should be available to all. You know, pastors and church leaders and churches.” This participant also said, “I think it'll be great, actually, because I myself, I know, will benefit from it, but more so because it's not just one person or the lead passed and knowing, I think if the, the leadership is trained, I think our approach would be very different. Yeah . Because it it's possible that there are situations in different homes.”

Participant 6 mentioned, “We're a development house. I believe that the more that we can expose people, educate people, train people. And I would just say pastoral stuff because they're a very capable people. Maybe they don't need to be trained, you know, to the same degree. But I would, I would involve as many people as possible, including, for example, youth leaders, pre-teens.”

Participant 7 said, “We're always happy to train and equip our pastors. So, if you know if it's yourself or someone who said, Hey, I have an opportunity to train your pastor, your staff team and how to deal with trauma. We do have staff development every month for our staff. We bring them together and we do our coaching.”

Participant 9 said, “I think any training is great anyway that we're able to better ourselves and better care for the people that come to our church is always going to be beneficial.”

Confirmed Openness to Integrate Trauma-Informed Care in Their Church

Lastly, participants confirmed their openness and willingness to integrate a TIC within their church framework for trauma care. Participants were asked in various ways about making changes to their current model. At the end of the interview, they were asked to share the openness toward integrating TIC. All 8 participants agreed to integrate a modified TIC model within their church’s trauma care infrastructure. This willingness to change existing models

reflects a humility amongst the participants as they can admit there is room for improvement and are willing to bring new strategies to better care for congregants.

The essence of these answers reveals a deep desire to help, to grow, and to serve. This openness is critical in pastoral work and seeing that participants are very open and eager to bring in new strategies can encourage the community. This concept was a core consideration of this study, and seeing how participants were all in favor of receiving this type of training speaks to their understanding of trauma, their experience with discussing trauma with congregants, and their understanding of the benefit of TIC. The statements below show how the participants responded to integrating a modified TIC model.

Participant 1 stated, “Yes, I definitely think we’re open.”

Participant 2 mentioned, “Yeah, I'm very interested.”

Participant 3 shared, “That's great. I think everyone needs to be aware of any type of trauma that's in their life, or even special leadership, how to how to help other people. If you don't know, you can't help people appropriately. If you don't have the right, the right information or resources, I think would be really great resources to churches.”

Participant 4 said, “I think it'll be great!”

Participant 5 mentioned, “Amazing! That is available? Wow, we would love that. Going completely open putting money into it. Whatever it takes.”

Participant 6 shared, “I would say it is very high. I believe that they understand the need for it. They understand the need for training.”

Participant 7 stated

> I think they would, and they would appreciate it. We're always happy to train and equip our pastors. So, if you know if it's yourself or someone who said, Hey, I have an

> opportunity to train your pastor, your staff team and how to deal with trauma. We do have staff development every month for our staff. We bring them together and we do our coaching. You know how to deal with conflict resolution, communication, all these other stuff. So, this would just be another thing that would be helpful for our staff and also for cheerleaders. If it's something that we like and it's workable, definitely we can bring all of our care leaders or prayer teams together and have that back coaching. Yeah."

Participant 9 said

> Definitely very opened. We don't have too much of a structure in place right now of kind of how to really handle these conversations. There's definitely been times where there are things that people have gone through that I haven't gone through. So being able to ensure that I am providing a good standard of care would be incredibly helpful."

Theme 3: Challenges

This next theme focuses on the challenges pastors and churches face surrounding trauma with congregants. There are four examples identified in the interview transcripts, and these describe a lack of training for pastors and staff, a lack of internal resources within the church, an increase in trauma disclosure or awareness since the COVID-19 pandemic, and a deep desire to expand the current level of care as needed. It might be interesting to note that pastors were not explicitly asked to identify any challenges they face, even though this is one of the research sub-questions under Research Question 1.

Lack of Training

This theme emerged as participants discussed the challenge related to a lack of trauma training or training around topics of mental health for pastors and those involved in offering care from within the church. This highlighted challenge is supported in the literature, as research

reveals a lack of training and a need for more mental health education for pastoral leadership (Costello et al., 2021; Guiking & Jacobs, 2022; Williams et al., 2014). A total of 6 participants made mention of a lack of training or limited understanding or knowledge. Notably, these participants were not asked about areas where they could improve or to discuss the challenges they are facing. Instead, these comments occurred naturally as participants discussed how they try to help using resources from within their church. This also revealed a sense of wanting more training to be better equipped for their work.

In addition to a lack of training for pastors and their teams, a lack of internal resources from within the church was a highlighted theme among pastors. The statements below reflect how the participants' answers revealed a theme of a lack of training received by pastors when it comes to mental health and trauma. The meaning behind these statements reveals a keen self-awareness of pastors and the limitations of their work with congregants.

Participant 2 shared,

> This is something like in Bible school I never was trained in. Yeah. Like I remember in pastoral care class or whatever it was called, it was like, this is how you do a hospital visit, you know, sit down at their level, and relate with them and speak gently. But like the whole mental health and how it affects spiritual. Like that was never a discussion.

Participant 3 spoke on the lack of training for the entire pastoral team, stating

> So when people like they want to schedule meetings with any pastoral team, our teams know they are equipped to know that there's only a certain level that they can express to or share or help the participant or attendee.

Participant 4 spoke to her limited knowledge and training, stating,

> So apart from some basic, you know, teaching from the Bible college, you know, way back many years ago. But part of my training, nothing in-depth. But sometimes I've attended like a one day, you know, like grief counseling seminar or, you know, trauma management, whatever, like here and there. Not really anything in-depth or detailed.

This participant also stated, “I think I don't know enough about about trauma.”

Participant 5 stated, “I think if we're going to really be in the business of helping people, we got to be able to offer what people need. And I'm not trained.”

Participant 6 stated, “I'm very quick to tell people, you know, listen, I'm not a psychotherapist. I'm not a counselor.” This participant also said, “the frustrations can be that we are either not equipped or that people's lives have become incredibly complex. It is just not simple.” He discussed pastoral trauma knowledge as,

> a level that perhaps we're not we're not trained. And in some ways, to be honest with you. We have had to tell people we could not help them because we're not able. We don't, we can't speak to the situation from an educational standpoint.

Participant 9 said, “we're not fully trained and equipped to handle all areas of trauma.”

Lack of Internal Resources

There were multiple statements about a lack of resources based inside the church for congregants dealing with trauma symptoms. Six participants spoke to this lack of internal resources when addressing their experiences caring for the trauma needs of church congregants. This is different from the previously mentioned lack of training, as this directly references a lack of resources beyond training, such as not having counselors in the church. The statements below reveal how this theme developed and identify the experience of pastors facing this challenge of a lack of internal resources.

Participants indicated that while spiritual support and resources are readily available, internal resources related to mental health care and trauma care are not readily available within the church. This alluded to a sense of helplessness when unable to care for the church's needs. The essence derived from these statements was different from the perspective that churches do not want to have resources. Instead, resources seem welcome, but there is uncertainty on how to integrate or develop these resources from within the church.

When naming the resources available in his church, Participant 2 stated, “Yeah, so really it's just pastoral care.”

When addressing how there is no counselor on staff, Participant 3 said, “we send them with referrals because currently we don't have anyone on staff that is qualified to go beyond a spiritual like normal conversation but beyond expertise we refer out.”

Participant 4 said

> I think there's a lack of maybe resources or lack of understanding.” This participant also said, in reference to what the church is doing to meet mental health needs of congregants, “with regards to mental health. There isn't much.

Participant 4 also commented, “we haven't actually ever really had a program in our church specifically for that” when speaking about counseling resources within the church.

Increased Trauma Disclosure Since COVID-19 Pandemic

Another challenge mentioned by pastors was the increase of mental health needs since the COVID-19 Pandemic. The literature discusses how the church was utilized to help support the community during the COVID-19 pandemic through offering support, deliver practical information, and mitigate the symptoms of anxiety (Nche & Agbo, 2022; WHO, 2020). Two participants spent time addressing this challenge. This study did not specifically review the

impact of COVID-19, and pastors were not asked to discuss the nature or impact of this pandemic. This theme emerged naturally as participants highlighted the impact of COVID-19 on the church's mental health.

This reflects a new awareness of trauma needs and mental health within the church. It is possible that the mental health and trauma needs of congregants existed prior to COVID-19 but that the extensive impact of this pandemic brought these needs to the forefront of pastoral care conversations. With new attention to mental health from a global perspective, these conversations may be emerging as community awareness of mental health needs increases. These challenges led to participants expressing a desire or openness to expand the current level of care from within the church. The statements below include answers to the questions on this topic. Participant 2 stated

> Someone who was coming back to church after Covid, they they just they were locked up in their home and in a really bad state that they're like, 'I just need to get out of my house while things are still locked down there.' Like, 'can I just come and sit in the church sanctuary?'."

This participant also highlighted a desire to learn more about trauma care stating, "I'm very interested, especially coming out of Covid. Like I see the needs."

Participant 7 addressed challenges during the COVID-19 Pandemic and the continued impact by stating

> I think part of the challenge is and very frankly speaking, I think one of the areas that we failed during the pandemic was the care for the people. You see, I mean, we can we can believe something and we can have the opportunities for people. But unless we guide people in it, that's a different story. Right." This participant went on to say, "hearing and

seeing like how the church kind of responded during the pandemic and the feedback from the congregation that one of the things that we lack, and we don't do as well is actually community care as as well as we should.

Desire to Expand Current Level of Care

Participants also expressed an overall desire to expand the current care offered by their church. This led to the development of the next theme of strategies which are in place to mitigate these challenges. All participants expressed a desire to extend the current level of care offered from within their church to congregants who are facing issues related to trauma exposure. The participants were asked about this directly, and they all responded in favor of a higher level of care. Each participant said that they wanted to improve upon the current level and offer more care to congregants dealing with the impact of trauma.

The meaning behind this is critical, as the participants show an understanding of the issues at hand and a deep willingness to improve current systems to help mitigate the impact or solve these issues. From within the church, the care offered to congregants is lacking, and participants recognize this and want to improve upon their current systems to offer better care. The statements below show direct examples of the participant's desire to expand care.

Participant 1 stated, “Definitely very open. We're always looking for more opportunities to care for our congregants better.”

Participant 2 stated, “I do believe on our end there's there's definitely an openness. So like, I want this to be the place where people want to come for that kind of care.” This participant also said, “I'm very interested, especially coming out of Covid.”

Participant 3 stated

> I think everyone needs to be aware of any type of trauma that's in their life, or even special leadership, how to how to help other people. If you don't know, you can't help people appropriately. If you don't have the right, the right information, or resources, I think would be really great resources to churches.

Participant 4 stated, “I think there is a great level of openness.”

Participant 5 said the church is, “Very open. Very open.”

Participant 6 spoke to the interest level stating, “I would say it is very high. I believe that they understand the need for it. They understand the need for training.”

Participant 7 stated, “I think there's always an openness to to hear, you know, particularly at the church.” This participant also said, “I would like to see it expand a little more and be a little bit more broader and open to new ideas and new things, personally speaking.”

Participant 9 said

> Definitely very opened. We don't have too much of a structure in place right now of kind of how to really handle these conversations. There's definitely been times where there are things that people have gone through that I haven't gone through. So being able to ensure that I am providing a good standard of care would be incredibly helpful.

Theme 4: Strategies

While pastors addressed many challenges, there was also mention of strategies implemented to help congregants dealing with trauma, which are addressed in this section. This theme emerged from the participant's answers include participants doing what they can with current resources, offering pastoral care, outsourcing cases beyond their capacity, making referrals to professional counselors, offering outside resources to congregants, using small groups to promote community, and providing specialized training to staff and pastoral teams.

Participants were asked to share their church's protocols around mental health, and this theme developed from that question.

Using Available Resources to Best of Ability

This theme discusses how pastors use their resources to the best of their ability. Five participants discussed using what was available and alluded to doing their best. While participants continue to allude to areas where growth could exist, many took the time to share what is available and how they are trying to do their best with what they have. Participants reveal an effort towards utilizing the readily available tools and making the most efficient use of what they have at their fingertips. These participants have expressed a desire to help. Their comments highlight how they are helping, specifically by reaching within the church and trying to support people from inside their community. The statements below reveal the experience of pastors trying to help to the best of their ability.

Participant 2 stated, “I'll do my best to meet with someone like as the first pass. And then after that, if I feel like, okay, this is bigger than what I know how to help.”

Participant 5 shared, “So as leaders, we kind of go to a point with a person and then we always try to make sure that that person gets the care and the help that they need.” This participant also said,

> Once we identify that it is mental health. Second thing, okay, what can we do? What is within our scope to be to help? And it varies from, you know, from you know, a conversation or a counseling or you know, directing people somewhere.

Participant 6 stated

> We are in a very caring or we should be in a very caring, sympathetic. You know, family environment. Right. And so, we we try to to the best of our ability to express that sort of

> care, whether it's to the level of. You know, to the level that you're describing and probably not. It's probably more within that support family community.

Participant 7 shared

> Now we encourage our pastors to set up block the time during the in their calendar and put out, you know, Google or calendar to invites and let congregants know you can choose this time I'm available any time this this this for a phone call and follow up so we are training our pastors to be more effective in their care and be more proactive.

Participant 9 stated

> We also do provide, if there is an outreach need, if people can't afford it and we do cover, we do subsidize a session or two for them depending on their circumstance. We also again, we are we have a prayer chain so people can submit their prayer requests and one of our staff members can reach out and help them. And groups are really our main way that we that we do it. So, our group leader is the one that if anything does come up with somebody in their group, they're able to communicate with myself or my husband and we're able to step in if there is a need.

Offering Pastoral Care

Participants highlighted the specific role of pastors as they offer care to their clients one-on-one. Pastoral care is a common term within the church community. The literature revealed that pastoral care can mean working through everyday issues like marital struggles and issues with depression (Abbott, 1988; Bernau, 2021). All 8 participants shared answers where they described pastoral care work or specifically mentioned using pastoral care with their congregants dealing with trauma. Each of the eight participants highlighted how they offer pastoral care, whether they specifically used the verbiage “pastoral care” or simply described components of

pastoral care. The meaning derived from their statements reveals the work that pastors are doing. Beyond having protocols in place and training available, these statements reflect the real experiences of pastors when offering care to their congregants and how they all understand that this is part of their role as pastors.

Participant 1 described his role as, “Being able to walk people through seasons of trauma.”

Participant 2 explained, “I'm a pastor who can give biblical wisdom and advice.” This participant also said, “Yeah, so really it's just pastoral care.”

Participant 3 said, “I have experienced their personal experience like they share about their personal experience, what they are currently going through, or they've gone through in their past, who their support system is, but [I am] who they currently talking to if they don't have support.”

Participant 4 stated, “I can talk to first let me talk about the spiritual needs. You know, as a church and as a pastor, it's it is our primary, you know, responsibility.”

Participant 5 said

> We try to be very sensitive and very self-aware of as we minister to people to really reach not only this spiritual need, but the emotional need of a person. So we try to do that in, you know, as we talk or preparing messages to address both of those things that are really very important.

This participant also described the care he offers stating, “it varies from, you know, from you know, a conversation or a counseling.”

Participant 6 shared

> Well, on the spiritual side of things, it's much easier. We have different ministries that will pray with people, counsel people, mentor people, because a big focus on community and fellowship because I believe that's a big part of mental health, because people suffer with whether it's rejection or isolation, loneliness, etc.

Participant 7 mentioned, “we actually follow them through through a process of restoration, prayer, through listening, prayer, renouncing confession and prayer for deliverance.” Participant 9 stated

> It depends on the individual and the relationship that I have with them. Everyone's been a little bit different, but I find that every time that I do talk to somebody, and we offer prayer, we talk about the resources that are available, specifically Christian counseling that we have and the different recommendations that we have. We really try to walk alongside them. So, there's a lot of follow up with them and we try to care for them just as they're going through the journey or the healing process or whatever they're walking through.

Outsourcing Cases Beyond Capacity

Participants revealed the strategy of outsourcing cases of trauma care when pastors reach a limitation with the congregant’s needs. All 8 participants shared about outsourcing cases with congregants whose needs are more extensive than the level of care the pastors can manage. Participants acknowledge the need to outsource when cases are beyond the capacity or expertise of the pastoral team. The meaning behind these statements reflects an awareness of their skill, limits, and respect for professional counselors. These participants reveal an understanding of the need for professional counseling, and making these referrals shows a willingness to get the best help and care for the congregant instead of practicing outside of their scope. This is critical to the

ethical standards of church practices, as it highlights the understanding that trauma needs require very specific and specialized help from trained professionals. The literature is supported by this decision of pastors to outsource beyond their capacity, as it reflects their willingness to make referrals for cases beyond their scope of expertise (Guiking & Jacobs, 2022).

Participant 1 stated, “So we have a list of counselors that we are able to refer out. So when people are, you know, raise it, raise tasks that they're struggling with mental health, we're able to provide resources with that.”

Participant 2 mentioned, “I do make a point of saying that I'm not a professional counselor. But I'm a pastor who can give biblical wisdom and advice. And more often than not, if if the need seems like it would need it, I would actually refer them out to a counselor.”
This participant also said

> I see the needs. And I also know that. I don't know how to handle all of the situations. And so oftentimes that's why I say I'll I'll do my best to meet with someone the first like as of the first pass. And then after that, if I feel like, okay, this is bigger than what I know how to help, then I'll usually refer out.

Participant 2 also said, “if I feel like , okay , this is bigger than what I know how to help , then I'll usually refer out.”

Participant 3 stated, “we don't have anyone on staff that is qualified to go beyond a spiritual like normal conversation but beyond expertise we refer out.”

Participant 4 said, “when we have had cases that you know really actually needed professional help or more detailed in-depth help, we had no issues referring them to trusted Christian professionals.”

Participant 5 shared, “We have you know, lots of counseling that we can refer people to.”

Participant 6 mentioned, “So probably start with the leader, depending on the scenario, it goes up to a pastor eventually comes to me and then ultimately we may we may have to outsource the individual to outside counselors.”

Participant 7 said, “a lot of times that's why we rely on our counseling partners to help because as pastors, we're not fully trained and equipped to handle all areas of trauma.”

Participant 9 stated, “Currently, whenever somebody has a need, we outsource to a to a bunch of different people that we found either through their congregation or through recommendations from other people.

Offering External Resources to Congregants

Findings also indicated that resources are available outside the church, and using these resources is another strategy of pastors. Comments on what the pastor and churches have to offer regarding resources outside the church were made including making these referrals. While many pastors did not go into detail about the available resources, they spoke confidently about offering resources to congregants facing trauma. The literature reveals that the use of outside resources can benefit trauma survivors as their needs may demand immediate assistance, and this strategy supports this method of trauma care (Levine, 1997).

Participants expressed a realization that what exists within the church is not currently enough to meet the variety of trauma needs experienced by the church. Instead of leaving congregants to manage symptoms independently, the participants unanimously disclosed methods of offering outside resources, connections with outside networks, and ways to refer congregants when their needs cannot be met in the church. The importance of this is seen in the way participants are not afraid to connect with outside networks and professionals for a community-based approach toward trauma care and wellness. The essence of these statements

and the meaning reflect a proactive nature and approach toward finding the necessary resources for congregants when they cannot provide them from within the church.

Participant 1 stated, “We're able to continue to like meet them in that and provide resources to help them.”

This participant also said

> We're always looking for more opportunities to care for our congregants better. Whether it's resources that we have on hand that we can give to the individuals or for resources or services we can provide or things that we can refer to. We're always looking to expand that and continue to care for our own center.

Participant 2 mentioned, “And again, like it comes down to if we can be of assistance, we're always going to be that first level. Yeah. And then if we feel it's something that's greater, we would refer out.”

Participant 3 shared, “Yeah, that's kind of and then we send them with referrals because currently we don't have anyone on staff that is qualified to go beyond a spiritual like normal conversation but beyond expertise we refer out.” This participant also said, “We normally have a list of referrals that they can do.”

Participant 4 said, “we are well-connected with outside sources.”

Participant 5 mentioned, “We kind of go to a point with a person and then we always try to make sure that that person gets the care and the help that they need, you know, even, you know, offering financial support and things like that. So, we are very, very open to that.”

Participant 6 shared, “But we want to be honest and upfront and say, hey, we just here's a basic level of, you know, counseling that we provide. And then beyond that, we would have to get other resources.”

Participant 7 stated, “And so that's why if it's medical, we encourage people to go and see a doctor. If it's emotional, take it further to a counselor.” This participant also said, “a lot of times that's why we rely on our counseling partners to help because as pastors, we're not fully trained and equipped to handle all areas of trauma.”

Participant 9 said, “we talk about the resources that are available, specifically Christian counseling that we have and the different recommendations that we have.” This participant also said, “We have a huge focus on outreach. So if there's ever any outreach partners that we can refer to to also step in and help. That's another way that we try to provide support and care.” Participant 9 also stated

> Our biggest one would be our counseling resources and is the biggest one that we point people to. We also do provide, if there is an outreach need, if people can't afford it and we do cover, we do subsidize a session or two for them depending on their circumstance.

Referrals to Professional Counselors

Another strategy mentioned is the use of professional counselors outside of the church. There are a variety of resources available to help manage trauma symptoms. However, it is essential to highlight that all 8 participants mentioned a direct connection to local professional counselors and referrals to these counselors to support their congregants. Unlike pastors outsourcing cases beyond their capacity, this theme addresses a church-wide approach to making counseling referrals.

The following statements reflect the participants' experience making referrals and describe how staff make these referrals. The essence of these statements is rooted in the awareness that professional counselors can be partners in caring for congregants and offering support. Instead of being afraid of outsourcing or making referrals outside of the church, all 8

participants welcomed the ability to refer congregants to offices where their trauma needs are best supported. A sense of humility is recognized here, as well as a community-based approach and a teamwork mentality when supporting congregants.

Participant 1 stated, “I would say we have counseling resources on on hand. So we have a list of counselors that we are able to refer out.”

Participant 2 mentioned, “I would actually refer them out to a counselor.”

Participant 3 shared, “Yeah, that's kind of and then we send them with referrals because currently we don't have anyone on staff that is qualified to go beyond a spiritual like normal conversation but beyond expertise we refer out.”

Participant 4 said, “We had no issues referring them to trusted Christian professionals.”

Participant 5 stated, “We have, you know, lots of counseling that we can refer people to.”

Participant 6 shared, “we may have to outsource the individual to outside counselors.”

Participant 7 stated, “a lot of times that's why we rely on our counseling partners to help.”

Participant 9 said, “we outsource to a to a bunch of different people that we found either through their congregation or through recommendations from other people.”

Utilizing Small Groups for Community Support

While referrals and outside resources are some of the strategies implemented by the church, another example mentioned in the interviews was how the church uses the support of the church community and small groups to help foster healing for congregants. Five participants addressed small groups and the community, mentioning how this strategy supports the congregants. The meaning behind these statements shows a genuine desire from pastors to foster community amongst congregants, as they value the impact of experiencing life together. By identifying the struggles of loneliness and isolation and then highlighting the positive impact of

community support, these participants reveal a deep understanding of the role of support groups.

As referenced in Chapter 2, the church has historically been where the local community finds support, and the pastors spoke to a continued theme within church culture. This strategy represents resources from within the church that help congregants mitigate the impact of their trauma symptoms. The following statements reveal how this strategy was discussed and reflect the pastor's views on community support from within the church.

Participant 1 stated

> Getting into small groups really kind of helps guide the discussion a little bit deeper, allows even the trainings that we do with our small group leaders to be able to provide, resource them, provide them with, you know, lists of counselors or how to how to. Care for somebody."

This participant also said

> We are very big on community as well. We don't want people to be isolated. We don't want people to suffer on their own. And so, we really highly encourage people to get into the community, whether that's through a small groups of the best way to do that.

Participant 4 mentioned, "So we have things in our discipleship programs in place, you know, like outreach programs, Bible studies, prayer."

Participant 6 said, "We have we have different ministries that will pray with people, counsel people, mentor people, because a big focus on community and fellowship because I believe that's a big part of mental health, because people suffer with whether it's rejection or isolation, loneliness, etc.".

Participant 7 stated, "We believe, you know, we, we share about care in multiple ways in which they get care from community. So, we encourage people to be in a connect group."

Participant 9 shared

> We offer small groups which meet during the week, and they discuss the sermon and how it practically applies to your life. It's also a place where people can receive prayer from others, where they can do life with each other. They can form really strong friendships where they can again walk alongside them and support them.

Offering Special Training to Staff

While all participants shared an openness to receiving training and expanding the level of care offered within the church, only 1 of the participants mentioned the current or previous use of training for staff regarding mental health and trauma. The literature on TIC integration describes the training process as something that can occur with at least one day filled with a series of teachings on trauma and trauma care (Herman et al., 2020). While only one participant made statements regarding offering specialized training to staff, all participants mentioned that they are open to receiving training. It might be interesting to highlight that only one church currently trains its staff in mental health and trauma training. The meaning behind this statement from Participant 7 is that their motivation to help goes beyond a willingness to implement changes and extends to a change in practices through training. Awareness is step one, willingness to change is step two, and change through training is step three. This participant is the only one who revealed change at the level of integrating new practices and training within their church care model. This reveals a start in equipping churches with TIC integration, and this reflects how training can exist within a church model when pastors take that next step of engaging with professionals who offer training to their staff.

Participant 7 stated, "we do encourage and train pastors here to make sure how they best respond and know what to do in those circumstances." This participant also said, "we've been

trying to record things that we can provide them as onboarding training for them and say, 'Hey, watch this, and this is how you handle trauma or this this need and this is the steps you do'." Participant 7 also said, "We do have staff development every month for our staff. We bring them together and we do our coaching. You know how to deal with conflict resolution, communication, all these other stuff."

Research Question Responses

This study set out to answer 2 research questions and 2 research sub-questions regarding the experiences of pastors in the GTA when speaking with congregants about trauma and with TIC. Challenges and strategies implemented by pastors and churches were also considered from the start of this study. The answers to these questions have taken shape from the collected and thoroughly analyzed data. In the next 4 sections, these answers are provided with attention to thematic analysis and data interpretation. Meaning and essence from answers related to themes are also summarized and provided.

The following graphs present the four themes in a visual aid with each element of the theme listed. Theme 1 addressed pastors' experiences with trauma and Research Question 1. Theme 2 addressed pastors' understanding of trauma and Research Question 4. Theme 3 addressed the challenges faced by pastors around trauma conversations with congregants and Research Sub-Question 1. Theme 4 addressed the strategies implemented by pastors to help congregants with trauma needs and Research Sub-Question 2. In the next sections, the research questions are answered using components of each theme with specific aspects addressed under each question or sub-question.

Figure 1. Theme 1 & Theme 2

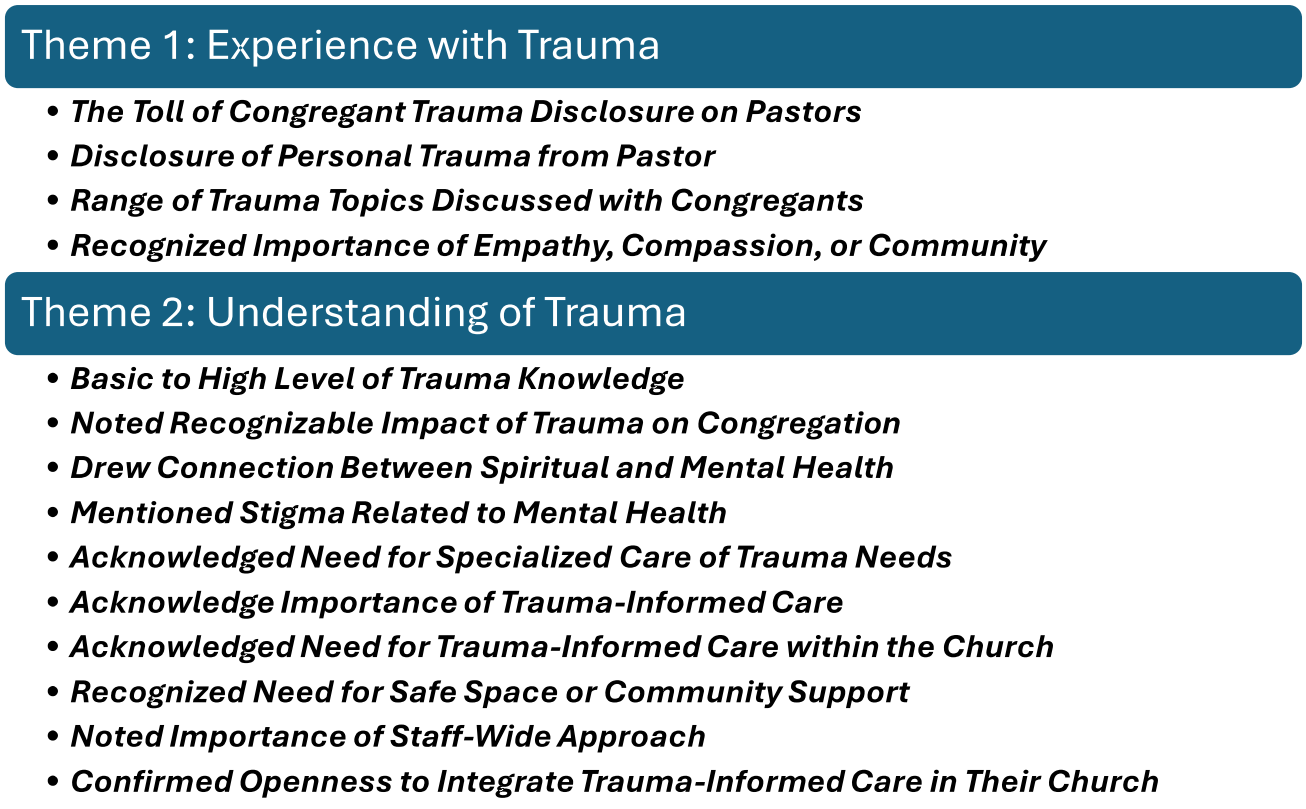
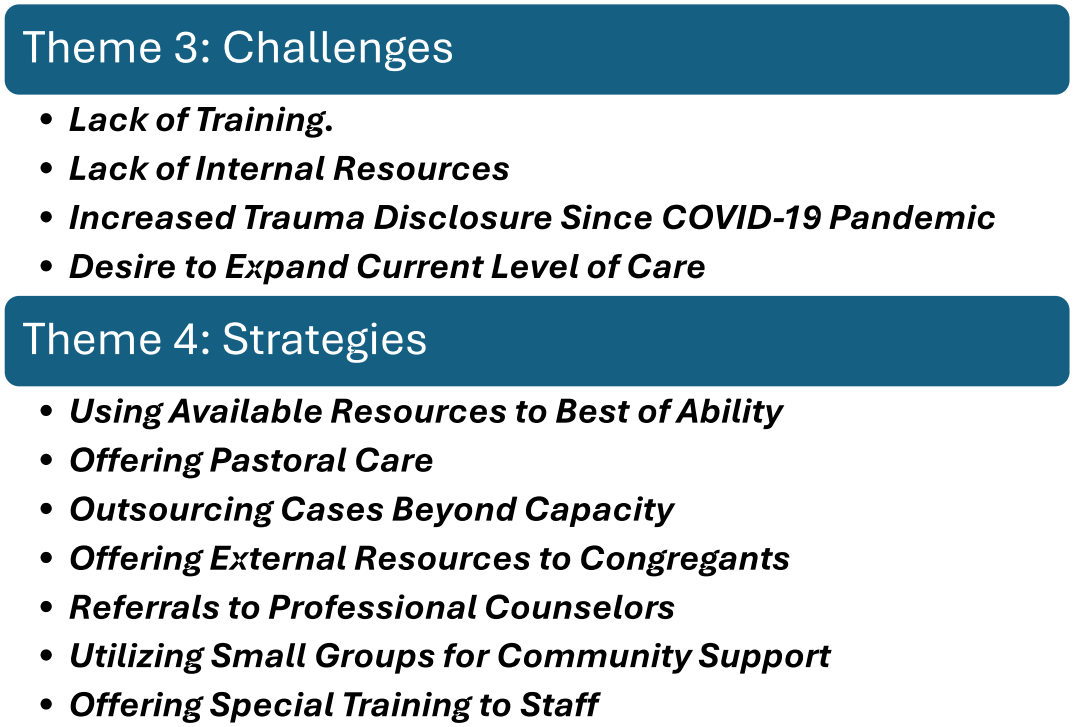


Figure 2. Theme 3 & Theme 4



Research Question 1: How do evangelical pastors in the Greater Toronto Area describe their experiences ministering to congregants who have experienced trauma?

The experiences of pastors in the GTA when speaking with congregants about trauma share commonalities amongst participants. Theme 1, experiences with trauma, helped to address the range of experiences by pastors related to trauma. The graphs above show the various examples of how this theme developed and relate directly to answering the research question. Three participants expressed a toll of congregant trauma disclosure on pastors. Three participants disclosed of personal trauma prior to their role as a pastor. Six participants highlighted a range of trauma topics discussed with congregants. Four participants recognized importance of empathy, compassion, or community. All eight participants expressed a desire to help mitigate trauma needs. The experiences of pastors are well-rounded with discussions on a variety of trauma topics with congregants and a deep desire to help mitigate their trauma symptoms.

Research Sub-Question 1: How do evangelical pastors in the Greater Toronto Area describe the challenges faced when ministering to congregants who have experienced trauma?

Participant interviews highlighted some of the many challenges pastors face when discussing trauma with congregants. Theme 3, challenges, addressed the variety of challenges described by participants. Six participants noted a lack of training for pastors and church leadership. Six participants highlighted a lack of internal resources available for congregants. Two participants acknowledged an increase in trauma disclosure since the COVID-19 pandemic. All eight participants expressed an openness and desire to expand the current level of care offered to congregants with trauma exposure. Acknowledging these challenges indicates a high-level awareness amongst pastors of an area in the church where the opportunity for growth and an improvement of trauma care exists.

Research Sub-Question 2: How do evangelical pastors in the Greater Toronto Area describe the strategies implemented when ministering to congregants who have experienced trauma?

Recognizing the strategies implemented by pastors is equally important as highlighting the challenges they face, and participant answers depicted specific strategies used when discussing trauma with congregants. Theme 4, strategies, addressed the various strategies described by pastors. Five participants expressed that they were using available resources to best of ability. All eight participants acknowledged that they offer pastoral care. All eight participants mentioned outsourcing cases outside of the scope of practice. All eight participants shared the strategy of offering external resources to congregants. All eight participants referenced using referrals to professional counselors. Five participants mentioned the utilization of small groups for community support. One participant noted offering staff special training to help mitigate trauma's impact on the congregation. These strategies give the essence that pastors, while challenged by the task of discussing trauma with congregants, are committed to offer care to the best of their ability and providing alternative resources when they cannot meet the needs of trauma survivors from within the church.

Research Question 2: How do evangelical pastors in the Greater Toronto Area describe their experiences with trauma-informed care?

This study's results reveal a deep understanding of the experiences of pastors about TIC. Five participants acknowledged the importance of trauma-informed care. Theme 2, understanding of trauma, addressed how pastors describe their experiences with TIC. Six participants recognized need for a safe space or community support. Seven participants acknowledged the need for specialized care of trauma needs. Five participants noted the importance of staff-wide approach towards trauma care. All eight participants reflected a basic to

high level of trauma knowledge. All eight participants noted a recognizable impact of trauma on congregation. Seven participants acknowledged the importance of mental health. Seven participants drew connections between spiritual health and mental health. Four participants mentioned a stigma related to mental health. Seven participants acknowledged the need for trauma-informed care within the church. All eight participants confirmed an openness to integrate trauma-informed care in their church. Understanding the experiences of pastors when it comes to TIC is relevant to the current level of care available in the church and to the future of trauma care in the church. These responses reflect a positive experience of pastors with TIC and a favorable perspective of pastors towards TIC integrations in the church in the future.

Summary

This chapter focused deeply on the findings and results of the study with attention to participant experiences, highlighting theme development, and a thorough look at each theme represented in the participant answers. Thematic analysis of 27 different examples helped to shape these experiences into four themes. These themes included experiences with trauma, understanding of trauma and TIC, challenges, and strategies. This chapter addressed and answered the research questions based on the interviews where participants shared their experiences with discussing trauma with congregants and their experiences with TIC. While answering research questions, the accounts from participants regarding their experiences were used. The specific examples of each theme helped to answer the questions focusing directly on the experiences of pastors speaking with congregants, the challenges they face when offering care, the strategies implemented to mitigate these challenges, understanding of TIC, trauma knowledge, and the integration of TIC.

Chapter 5: Discussion

This study aims to understand evangelical pastors' experiences in the Greater Toronto Area (GTA) when discussing trauma with congregants and to learn about their experiences with Trauma-Informed Care (TIC). This is the final chapter of the study, and its purpose is to discuss the study's findings as they relate to existing literature, provide research perspectives on the findings, address research implications, and provide recommendations for future research. In this chapter, I share my views and interpretation of the data. The main sections of this chapter provide a summary of the findings, a discussion of empirical and theoretical literature, and an explanation of theoretical, empirical, and practical implications of the findings. I include recommendations for counselors and ministers based on these implications, a section on the delimitations and limitations of the research, and recommendations for future research.

Summary of Findings

This section will summarize the research findings of this study and provide an answer to each of the research questions. This development and organization of findings and how the research question findings were interpreted are also discussed. The purpose of this transcendental phenomenological study was to describe evangelical pastors' experiences ministering to congregants who have experienced trauma in the GTA. This study sought to understand the challenges faced by evangelical pastors during these experiences and the strategies implemented.

The theory guiding this study was transformative learning theory (Mezirow, 1991), as it supported education as a progressive method of moving an individual from one perspective to another without the risk of regression to an outdated or earlier perspective. Since change is difficult, this theory helps spur changed perspectives through educational methods. The connection between education, mental health, and the church was rooted in practices of TIC and

how the fundamental teachings of trauma-informed practices shift the perspective of a community-based approach towards care. This study followed the methodology framework developed by researcher, Clark Moustakas (1994) working through his four stages of preparation, data collection, organization, and analysis. Moustakas' (1994) methodology was the best option for this study as it aims to learn about lived experiences, which was the focus of the research questions. An in-depth, semi-structured interview was the method of data collection used in this study, and a total of 9 participants were interviewed to help answer these questions.

Research Question 1 sought to learn about the experiences of evangelical pastors in the GTA when discussing trauma with congregants. The goal of this question was to add to the existing literature on pastoral work. There was a recognizable gap in the literature on pastors' experiences when discussing trauma, and a need for more research was highlighted. This research question aimed to better understand these experiences by asking the pastors directly.

Research Sub-Question 1 asked about the experienced challenges of pastors related to their experiences discussing trauma with congregants. The goal of this research question was to better understand the current challenges of pastors in hopes of learning where the needs are within trauma care in the church. Learning about challenges from the pastors having these critical trauma conversations, the assumption was that the information would accurately reflect the needs of pastors related to better trauma care in the church.

Research Sub-Question 2 addressed the strategies implemented by the pastors related to congregant trauma. The purpose of this question was first to learn what is being done to mitigate the impact of trauma. The second goal was to understand how challenges are being overcome and specifically what efforts are being made by pastors to care for the trauma needs of congregants.

Research Question 2 aimed to understand the experiences of evangelical pastors with TIC. The goal of this question was multi-faceted, as I wanted to understand the level of TIC knowledge by pastors. The glaring gap in the literature on TIC in churches led to the development of this question. The goals were to add to the literature, to begin critical conversations about trauma, and to bring awareness about a topic not commonly discussed in the church.

Development and Organization of Findings

The development of research findings began after completing the steps of bracketing experiences in the researcher's journal, conducting interviews, transcribing audio files from the interviews, and member checking the data. The organization of findings was managed through Moustakas's approach to thematic analysis beginning with reviewing interview transcripts, using methods of horizontalization and coding to find themes and then synthesize the findings.

To best express the data when aiming to answer the research questions, the findings were horizontalized and then coded meticulously and thoroughly in a circular manner until themes were clear. This process allowed for multiple examples of each theme to be presented with equal representation of participants across all themes. The four themes of this study were the experience of pastors with trauma, the understanding of trauma, the challenges faced by pastors, and the strategies they implemented.

Theme 1 was the experience of pastors, and this was addressed by pastors discussing the toll of having trauma conversations with congregants, the disclosure of personal trauma by pastors, the range of trauma topics discussed with congregants, and recognizing the importance of empathy, compassion, and community. Theme 2 was related to the participants understanding of trauma and understood that pastors reflected a basic to high level of trauma knowledge, noted

recognizable impacts of trauma on congregants, drew connections between spiritual and mental health, mentioned the stigma related to mental health. Related to theme 2, pastors also acknowledged the need for specialized care of trauma needs, the importance of TIC, the need for TIC within the church, the need for a. safe space, the benefit of a staff-wide approach, and all confirmed an openness toward integrating TIC into their church. Theme 3 was related to the challenges faced by pastors, and they mentioned a lack of training, lack of resources, increase in trauma disclosures since the COVID-19 pandemic, and a desire to expand the current level of care for trauma needs in their church. Theme 4 addressed the strategies used by pastors and churches, and participants shared about how they use the available resources they have to the best of their ability. Pastors also shared how they use strategies like pastoral care, outsourcing cases outside of the scope of their professional expertise, offer external resources, referrals to professional counselors, small groups for community support, and offer special training to staff.

Research Question 1 Findings

Theme 1 addressed Research Question 1 which asked how evangelical pastors in the GTA describe their experiences discussing trauma with congregants. Findings revealed that the conversations with congregants about trauma take a toll on the pastors. These conversations affected pastors emotionally, and it was clear that the pastors who expressed this toll cared deeply for their congregants. Findings also revealed that some of the pastors have a personal trauma history, which I believe impacts the way they discuss trauma with their congregants through a greater openness to have trauma conversations and offer care. Findings reflect a wide range of trauma topics discussed, and I believe this is consistent with the literature and related to the prevalence rates of trauma within society (Benjet et al., 2016; Dennis et al., 2022; Karstoft & Armour, 2022). The data revealed that pastors recognize the importance of empathy,

compassion, and support, and I understand this points directly to how they care for congregants. By being willing to have tough conversations, despite the toll it takes on pastors, they desire to help their congregants. This was the final theme noted around pastors' experience with congregants discussing trauma. My overall understanding of pastors' experiences is that pastors have trauma conversations with congregants because they understand the impact of trauma, sometimes based on their lived experiences, and are willing to offer care due to their desire to lead and help their congregation.

Research Sub-Question 1 Findings

Theme 3 related to Research Sub-Question 1 which aimed to understand how evangelical pastors in the GTA describe the challenges when discussing trauma with congregants. Findings highlight a lack of training for pastors and their staff. I learned that pastors' training is mainly focused on theological teachings as they are trained for ministry. Although there is a level of teaching related to pastoral care, there is little to no teaching on mental health and trauma care. With pastors having regular conversations with congregants about trauma, I find it interesting and alarming that they are not provided with more formal education on how to care for the trauma needs of congregants. I also understood that there is a desire to know more, but it may be unclear to pastors how to obtain this training and education. Findings also mentioned the lack of available resources inside the church for congregants regarding trauma care. My view on this is that due to the number of available resources outside of the church, churches have been able to manage congregant trauma disclosures up to this point. As these needs increase and pastors become more aware of the amount of care needed from the congregation, this may open the door for more resources to become available from within the church. Again, I did not suspect a lack of interest in expanding this resource; instead, I noticed a need for conversations surrounding the

infrastructure of developing programs within the church. Although unexpected, it was not surprising that pastors noted the increase in trauma needs and conversations after the COVID-19 pandemic compared to trauma conversations prior to the 2019 lockdowns. I interpret this as pastors gaining a deeper understanding of their congregants' trauma needs, and I wonder if this is due to the global conversations on trauma and mental health becoming more common throughout society. Lastly, pastors revealed a solid openness to expanding the level of care available from within the church for congregants dealing with issues related to trauma. I believe they want to increase the resources available within their church. Instead of sending congregants away, it seems that pastors hope to become equipped to care for trauma needs efficiently from within the church.

Research Sub-Question 2 Findings

Theme 4 addressed Research Sub-Question 2 which asked how evangelical pastors in the GTA describe the strategies they use related to trauma care for congregants. The findings noted seven strategies pastors and churches implemented to mitigate congregant trauma needs. Participants gave the impression in their interviews that they were doing their best with their current resources, which is true. It is clear to me that pastors want to help their congregants, do what they know, and try to improve the system of care. Participants mentioned two specific strategies pastors used offering pastoral care to aid in the healing process of congregants with trauma needs and outsourcing cases when they are beyond the expertise or level of training of the pastor. These trends reflect the first theme of using the available resources and reaching outside the church for help when needed. I recognize the awareness of limitations by the pastors as they indicated their level of training for trauma care is not always enough to help their congregants complete the healing journey. This awareness is critical to reducing the re-traumatization of

congregants due to a lack of understanding or training. When outsourcing, churches often make referrals to professional counselors or offer a range of other outside resources. This strategy of a community-based approach towards trauma care reveals to me the openness of pastors to collaborate with other professionals to offer the best care for congregants. Another strategy the church uses is building supportive communities with small groups. Participants mentioned how sometimes these groups have leaders with specialized training to guide trauma conversations to proper leadership when trauma disclosures are made. This reveals to me the understanding of a group effort towards offering care, which is related to TIC methods of an organizational approach towards trauma care.

Research Question 2 Findings

Theme 2 answered Research Question 2 which asked how evangelical pastors in the GTA describe their experiences with TIC. Eleven unique elements relate to pastors' experiences with TIC, their understanding of TIC and trauma, and their openness to integrate a modified TIC model into their church. When pastors discussed TIC, they highlighted its importance, recognizing the need for a safe space by acknowledging the impact of community and the support offered in small groups where care and safety are considered. Pastors acknowledged the importance of specialized care for trauma survivors, noting the impact of trauma can lead to a wide range of issues for the congregant. Pastors realized the need for a staff-wide approach for effective TIC integration and highlighted the importance of trauma care at all levels of an organization.

These concepts discussed above are essential to this study because they help to gauge pastors' awareness of TIC and their understanding of the value of a specialized model for congregants facing trauma. I was very encouraged by the pastors' perspectives on TIC, as I

wondered if they might be skeptical of a professional counseling model. This was encouraging because it revealed to me that there is room in the church for more informed care and a desire to bridge the gap between the church and the counseling community.

As pastors explained their understanding of trauma, they expressed a basic to a high level of trauma knowledge by describing types of traumas and prevalence of trauma issues reported by their congregants. Pastors noted the impact of trauma on congregants and the church explaining that it ranges from the impact on the individual with trauma to an overall impact on the entire church. Pastors recognized the importance of mental health and confirmed a belief that mental health is a crucial part of the whole person. This led to pastors drawing a connection between mental and spiritual health as they identified a key aspect of spirituality and mental health around the impact they have on each other. Pastors also addressed the stigma around mental health, with some stating that the stigmas continue to exist within their congregation and others reporting a positive shift towards mental health awareness and destigmatization within their church.

Again, I was encouraged by the awareness of pastors and their level of trauma knowledge. While there is room for more education and training, their current level of knowledge lays a proper foundation for expanding this knowledge base. I was able to have conversations about trauma that went beyond the surface level, as the pastors understood the impact, prevalence, and effects of trauma. Lastly, pastors showed great awareness of the need for TIC in the church and a confirmed interest and willingness to integrate a modified TIC model within church systems. This last element is critical to the church community and the counseling field, and I view this as a tremendous discovery. Pastors responded to this concept of a modified TIC model as though they had never heard of such a program or considered this type of

integration. While they understood trauma and the benefit of TIC, they collectively expressed a deep desire to have a TIC model integrated into their church.

Discussion

In this section, I will state how the study confirms and corroborates previous research, highlighting connections to the reviewed literature in Chapter 2. This section also reveals how the study extends previous research and adds to the field and knowledge base of trauma, trauma care, TIC conversations, pastoral experiences, and church practices. Lastly, this section will show how the study sheds new light on this topic.

Empirical Literature Discussion

Previous research on trauma care highlighted four themes, which were confirmed by this study's findings. The literature revealed that the church is a place where people go to have their mental health needs met (Costello et al., 2021; Hardy, 2014; Hill & Yancey, 2022; Kane & Green, 2009; Weaver et al., 2019), and this is supported by the study through Theme 1 where pastors discussed their experience with trauma and how congregants come to them for help with trauma needs. The literature also pointed to some of the challenges of offering trauma care when there is a lack of training (Hipp et al., 2019; Zauzmer, 2017), and this was supported by Theme 3 as pastors outlined some of their challenges including the lack of training, they have received on trauma care. The literature reflected many strategies used across disciplines to aid in trauma care, including TIC and an increase in trauma training for churches (Crosby et al., 2020; Guiking & Jacob, 2020). The need for specific strategies was supported by Theme 3 as the pastors shared their strategies, many of which aligned with TIC concepts despite a lack of formal training on this model.

The findings also went a step further and extended the current knowledge base on TIC in the church, as the current literature lacked extensive research on this topic (Costello et al., 2021; Guiking & Jacob, 2022; Williams et al., 2014). The study makes novel contributions to the field and adds value to counseling and church communities. I will focus the next sections a discussion related to the main topics reviewed in the literature, including trauma, the church, and TIC.

Trauma

The literature revealed several defining qualities regarding trauma, which were also addressed by the participants in this study (APA, 2022; Brewin et al., 2000; Kartstoft & Armour, 2022; Lazarus & Folkman, 1984; McEwen, 1998; SAMHSA, 2012). These qualities looked at types of traumas, the impact of trauma, the prevalence of trauma, and the connection between trauma and spirituality. The literature revealed a wide range of trauma categories and types of traumas (Bloom, 2013; Chu, 2011; Sanderson, 2015). This range was confirmed in the interviews with pastors as they also highlighted a wide range of trauma topics discussed with congregants, including abuse, accidents, disasters, loss of relationships, and experiences related to death or near-death experiences.

The literature revealed the impact of trauma extending beyond psychological impacts to biological, sociological, and spiritual parts of the human experience (Saad et al., 2017; Sulmsay, 2002; Van Dened et al., 2022). This was supported in the study's findings as pastors addressed the impact of trauma. Each area of the whole person, from a biopsychosocial spiritual perspective, was mentioned by at least one participant throughout the study, and specific statements were made related to how trauma impacts all four areas.

As the literature highlighted the biological impact of trauma, research discussed how trauma is not only a psychological experience (Ogden et al., 2006; van der Kolk, 2014). The

physical impact of trauma was discussed by the participant who mentioned congregants disclosing issues with sleeping and eating related to their trauma. This connection between trauma and physiological experiences points to the understanding of trauma on a biological level. Additionally, a participant discussed the need for medication when mental health needs are related to chemical imbalances. This understanding of mental health and the connection to physical health is critical and was recognized by participants.

The literature also explained the impact of trauma on psychological functioning (Herman, 1997). Impacts of trauma on psychological function include symptoms of anxiety, issues related to sleep disorders, and avoidance (Entwistle, 2021; Foa et al., 1987; Litz et al., 2000; Luik et al., 2019). Participants supported these findings in the literature as the explained the symptoms described by their congregants relating to their trauma experiences. The discussions included topics of anxiety, depression, and grief related to loss.

Research has shown the impact of trauma on sociological aspects of a person, highlighting that the effects of trauma go being the person who experienced the trauma (Entwistle, 2021; Herman, 1997; van der Kolk, 2014). This is corroborated by the study as pastors noted the impact of trauma extending to entire congregations. Pastors also highlighted the importance of cultivating a safe space to mitigate the social stressors involved in trauma exposure. Additionally, pastors mentioned a community approach towards care and spent time discussing the positive impact of social support on trauma healing.

Lastly, literature revealed that biopsychosocial spiritual model highlighted the need for more research on the spiritual impact of trauma care (Anim et al., 2022; Engel, 1997; Saad et al., 2017; Sulmsay, 2002; Van Dened et al., 2022). Pastors agree with this literature and support the findingds by sharing how their experiences involve spiritual care and guidance for congregants

dealing with trauma. Participants highlighted the need for spiritual advise and wisdom with congregants expressing trauma needs. The literature shows an impact of trauma on the spiritual facet of a person (Levine, 1997; Lifton, 1993; Ogden et al., 2006). Pastors referenced this impact revealing that one's involvement in ministry can be impacted by trauma. Specifically, a pastor shared that the excitement around serving and being involved can be impacted when an individual has experienced a trauma. Other pastors indicated a lack in church participation completely when trauma occurs.

The literature also discussed high prevalence rates for trauma exposure, detailing that most individuals will experience some trauma during their lifetime (Armour, 2022: Benjet et al., 2016; Kessler et al., 2017). The findings supported this as participants discussed the prevalence of trauma conversations in their churches and their awareness of the prevalence of trauma. The literature was extensive on the connection between spirituality and trauma (Herman, 1997; Hill & Yancy, 2022; Hipolito et al., 2014; Levine, 1997; Litz et al., 2009; Park, 2013; Piggot & Anderson, 2023). All participants revealed in their statements a connection between mental and spiritual health and the impact of trauma on both.

While topics of trauma have been extensively explored by researchers and professionals in the field, there is more to learn. This study did not produce new findings regarding trauma specifically. However, it did provide data that speaks to the experiences of pastors when addressing trauma and adds to the previous research on trauma discussions outside of professional counseling circles. The current literature lacked in terms of information on pastoral perspectives on trauma, experiences with trauma, and beliefs about trauma. This is addressed more in the next section. However, it is critical to note that there is a gap in the literature on trauma and the experiences of pastors discussing trauma with congregants, which was addressed

in this study. The results of this study and the data collected help to begin filling this gap by providing findings that indicate a pastoral understanding of trauma.

The Church

The literature on the church and pastors as it relates to trauma revealed many themes, such as the historical and contemporary roles of the church, the roles of pastors and church leadership, pastoral support for mental health, pastoral training, and the connection between spirituality and trauma (Heward-Mills et al., 2018; Nche & Agbo, 2022; World Vision International, 2021). The literature defined the church's historic role as a source of hope and healing, a place for social and religious gatherings, a space for religious principles and strategies, and an avenue for education, connection, and volunteering (Bouchard et al., 2020; Fields et al., 2016; Schieffler & Genig, 2021; Trueman & Gould, 2017; Walker et al., 1985). The literature identified that the contemporary roles of the church are consistent with historical roles and have extended to health and security as an instrument for stability and a resource for outreach opportunities (Bouchard et al., 2020; Cnaan & Newman, 2010; Stroope, 2011; Wilcox, 2000).

All of these roles were highlighted within the findings of the participant data, as pastors mentioned the roles of their teams and strategies implemented, especially concerning trauma care. Some of the roles of pastors and leadership mentioned in the literature include that of a leader, caregiver, teacher, pastoral, or marriage counselor (Keller & Keller, 2013; Keller, 2015; Loritts, 2009; Peterson, 2011; Sanders, 2017). These roles were all confirmed through the interviews with pastors. Participants addressed their experiences leading, offering care, teaching, and providing pastoral care related to counseling and addressing relationship and marital conflicts with congregants through pastoral care.

The literature addresses the responsibility of pastors to include support for mental health (Sande & Johnson, 2015; Weaver et al., 2019). Pastors corroborate the literature as they explained a wide range of strategies implemented to help mitigate the impact of trauma and negative symptoms related to mental health. The literature presented evidence to indicate pastors lack the necessary training and resources to provide a high level of care for trauma survivors (Cadge et al., 2020; Costello et al., 2021; Guiking & Jacob, 2022; Williams et al., 2014). Pastors confirmed this by sharing the limited education they receive on pastoral care, also mentioning that they receive little to no education on mental health or trauma care. The literature highlighted the connection between spirituality and trauma (Hill & Yancy, 2022; Hipolito et al., 2014; Moran et al., 2020). Pastors paid particular attention to the connection between mental health and spirituality. Pastors also corroborated the impact of trauma on spirituality with examples from their experiences when speaking with congregants who have experience with trauma.

The literature reflected that pastors set the church's tone regarding the narrative and perspective of mental health (Simpson, 2013). While many pastors corroborated this, two pastors mentioned that a stigma around mental health continues to exist despite their efforts to eliminate misinformation about trauma and mental health. The study extends this conversation by revealing that a potential cause of stigmas could be generational perceptions of mental health and the inability to change the minds of older generations despite efforts to inform better. This problem might be mitigated through an organizational approach to TIC integration.

This study adds to the literature by expressing the interest of pastors in implementing more avenues of trauma care for congregants from within the church. While the literature was clear that there is a need for better care from within the church (Costello et al., 2021; Guiking & Jacob, 2020; Guiking & Jacobs, 2022), it was not clear on the desire of pastors to expand their

current level of care offered from within the church. Additionally, there was a lack of information regarding the actual lived experiences of pastors when it comes to offering care to congregants who have experienced trauma. Findings indicated that pastors offer a basic level of care for congregants with trauma exposure and outsource cases to professional counselors when needed. These findings need to be better represented within the current literature. Also, the current literature did not reflect the current desire of pastors to integrate TIC within their church model or identify the current models and protocols in place within the church, where this study reveals this desire and outlines some of the protocols and standard practices within the current church regarding strategies for trauma care.

Trauma-Informed Care

The literature on the benefits of and use of TIC in organizations such as hospitals, schools, and welfare programs is extensive (Cafaro et al., 2023; Forrest et al., 2018; Isolbel & Edwards, 2017; Kramer et al., 2015; Morton & Berardi, 2018). However, the research on TIC in church programs was limited yet highlighted how TIC could aid in positive coping and trauma healing (Crosby et al., 2020). I found less than three articles on a TIC church model, which is why this study is crucial to counseling and church ministry. However, literature was filled with reports on how people can feel their trauma needs are underserved by the faith community (Guiking & Jacobs, 2022; Hipp et al., 2019; Streets, 2015; Zauzmer, 2017). With little to no known knowledge or understanding of how TIC models operate within church settings, there is little to go on for pastors hoping to implement these programs within their churches. The findings from this study indicate a deep desire to integrate a modified TIC model within their church, yet this model does not exist. The implications of these findings are significant, and they are discussed in a section further below.

The literature review in Chapter 2 revealed a gap in the research, indicating that TIC models are either not currently in place in church settings or that there is simply little to no research to reflect the existence of these models in church settings (Costello et al., 2021; Guiking & Jacob, 2022; Williams et al., 2014). This study may be the first to engage directly with church leaders and pastors to discuss TIC and the willingness to integrate a modified TIC model, essentially opening the conversation for future discussions on TIC models in the church. The contribution of this study to the current literature is significant, and the contribution to the counseling field is significant as this concept of TIC in church settings appears to be fairly new despite TIC being well-researched in other settings.

Theoretical Literature Discussion

The theory driving this research is the Transformative Learning Theory (TLT) (Mezirow, 1991). This theory addresses the shift of perspective with new information and how, as one's knowledge base increases, one progresses to a place of greater enlightenment (Mezirow, 1991). The theory's position on education is that as one learns, one essentially evolves into a more informed version and does not revert to previous, less-informed levels of understanding (Mezirow, 1991). During the participant interviews, I recognized participants alluding to this theory naturally as they discussed how the stigma of mental health was changing with new information and awareness on mental health topics becoming more prevalent in society and within the church. I also saw this connection as participants discussed the shift towards mental health awareness and trauma care after the COVID-19 pandemic when conversations about mental health were brought to the forefront of media outlets. These trends in new information increasing awareness and decision-making within church systems were seen as participants revealed the challenges and strategies they are working through in their care systems.

I saw this theory in action as I offered definitions for trauma and TIC and then listened to the participants offer definitions of these two topics. Participants referred to my statements and descriptions of these terms when describing them in their own words. Seeing how education of a terminology impacted their understanding of trauma and TIC in action during the interviews revealed the impact of increased education on mental health topics and the impact of increased trauma knowledge. The participants favored TIC training for their church, and all alluded to the benefit of more training, education, and resources. Participants' openness to receive training and expand their current level of care revealed a trusted pathway for improving the current systems of care available in the church. This pathway can look like presenting TIC integration as an option and a solution to help with an identified problematic area in an existing system within the church. Specifically, to help churches better care for congregants with trauma, TIC training can be an option to train and equip pastors and leaders for these conversations about trauma. Participants saw the value of training and indicated a level of trust in education and training.

Implications

This section will discuss the study's theoretical, empirical, and practical implications. I will also include specific recommendations for counselors and ministers regarding the topics discussed and the identified themes. As this study was focused on a ministry setting, it clearly connected to the Christian worldview, and spiritual health was at the core of it. This worldview is considered throughout each phase of the research process and discussed in this implications section.

Theoretical Implications

Theory development is one of the implications of this study, as the findings contribute to the theory of community-based care, community care and counseling, and TIC integration into

settings outside of the counseling field. The specific implications of this study related to theory development surfaced when pastors consistently welcomed the idea of an integration of TIC into a setting where it does not currently exist. The value of integrating care into settings where spiritual impacts of trauma are considered is discussed in the literature (Blakey, 2016; Hill & Yancey, 2022; Klan, 2018). This study confirms not only the impacts of trauma on spirituality but also the potential benefits of TIC on the spiritual healing of individuals who have experienced trauma.

A deeper contextual understanding of the lived experiences of evangelical pastors when discussing trauma with congregants is presented in this study. Research on these types of conversations between pastors and congregants is lacking in the literature, and the implications of this study provide a deeper understanding of the context of these discussions and the level of care available and offered within church programs. Further, the complexity of pastoral care and trauma management discussed by pastors is an implication of the study which adds to the current literature. Research reflected the workload of pastors and the impact of church ministry on pastors and pastoral families. However, specific textual dialogue needed to be better represented within the literature. Seeing how the lived experiences of pastors are crucial to understanding the implications of pastoral experiences, this dialogue on the complex nature of pastoral care and trauma care from within the church is relevant.

Empirical Implications

The empirical implications of this study are apparent from the findings. The research reflected a need for trauma care programs within the church to address the trauma needs of congregants and mitigate the impact on the congregation. A TIC model currently exists outside of the church and is readily modifiable to meet the complex trauma needs of congregants, including

a modification to address the spiritual needs of congregants as well. The development of a modified TIC model for evangelical churches could not only help solve this problem within the church but also open the door to other modified versions of TIC.

Another implication of this study is policy recommendations for churches. Now that pastors are aware that a TIC model exists that can be modified to meet the unique trauma needs of church congregants, policies around trauma care should shift. The pastors interviewed in this study reflected good ethical standards and practices within their churches. As new knowledge presents a potential solution to an incredible problem, there is an ethical responsibility to consider practically integrating a solution.

Further knowledge dissemination related to TIC in church programs is another empirical implication of this study, as there is already a favorable response to the initial conversations around TIC with evangelical pastors. The awareness of TIC can lead to curiosity about the implementation of its model. As pastors shared their willingness to be involved in teachings and training to improve current church models, the implication is that they would also be willing to receive further knowledge on trauma care from the TIC model.

Practical Implications

The practical implications of this study are directly related to pastors sharing their experiences with congregants disclosing trauma, the challenges when addressing these situations, the current strategies in place for trauma care, and their openness to integrating TIC into their current model. The enhancement of pastoral care and improvement of congregant support is implied when TIC integration is considered.

The expressed understanding of trauma and TIC by pastors in this study implies that there is already a basic to high level of knowledge in place at churches. However, there is still a lack of

training in this area for pastors. The recommendation for counselors and educators is to make this type of training more easily accessible for pastors so that deeper dissemination of trauma care information is available church wide. The recommendation for pastors and ministers is to steward the opportunities to expand the level of care, increase awareness, and receive knowledge and training concerning mental health and trauma topics. My recommendation to both the counseling community and the Christian community is to collaborate to expand community-based care and approaches for trauma care. By having collaborative conversations, the knowledge base on trauma needs, spiritual needs, challenges, strategies, and best practices can increase across disciplines. A final implication from this study is the impact of a multi-faceted approach toward trauma care in a multi-disciplinary plan that includes religious communities.

Delimitations and Limitations

In this section, I will cover the delimitations and limitations of the study. The delimitations described focus on the necessary criteria involved in shaping this study which limited the results to a specific demographic. These criteria were useful to the study as it helped to gauge results in a particular target group. The limitations discussed in this section describe the potential weaknesses of the study that could not be controlled. Examples were given on how the study could be use in other settings to increase more in-depth knowledge of trauma in other settings including different denominations and other religious groups.

Delimitations

The specific criteria of the participant selection process are a delimitation of the study in which all decisions for criteria can be rationalized. The sample criteria included participants who were exclusive evangelical pastors of Baptist, Pentecostal, and Non-Denominational churches in the Greater Toronto Area with a congregation of at least 300 people that meet in person weekly,

on Sundays every week, and a focus on children, young adult, or youth ministry. These criteria were selected specifically to highlight the experiences of pastors in thriving evangelical churches in a specific area.

Since trauma impacts the younger generations tremendously, the participants needed to be involved in churches where ministries existed to reach these generations specifically. This was reflected in the data as participants noted the impact of trauma on younger generations, but the discussion was not limited to the impact on these generations and considered children and older generations, as well. The rationale for selecting pastors of churches that meet weekly and in person was due to the level of responsibility of the pastor, attention to congregant needs, and closeness to congregants regularly. This regular access to congregants helped to ensure participants had the opportunity for regular exposure to trauma disclosure from congregants.

Limitations

Since participants were only selected if they pastored churches in a specific geographical location, there were limitations related to culture. However, this sample reflected the culture of the population served by this sample. Limitations regarding diversity were not an issue, as findings reflected a wide range of age, gender, and ethnic backgrounds among participants. This study was limited to the experiences of religious leaders in the evangelical Christian community. It did not explore the experiences of other religions or leaders of other social or cultural groups.

While half of the pastors in the study confirmed that their church currently operates with a TIC model in place when asked to answer "yes" or "no" on this topic, the remainder of the interview revealed that their lack of understanding of TIC at the beginning of the interview may have impacted the results of this answer. As these pastors continued to discuss the topic of TIC, their understanding of TIC, and the church's openness to integrate this type of model, their

answers alluded to the opposite of their initial answer. This might be due to a limited understanding of TIC when initially answering the question or the belief that awareness of trauma and available resources for trauma care is equivalent to an implemented TIC model.

The data analysis was limited to the data collected within the participant interviews. However, the lived experiences of pastors were the focus of this phenomenological study. I felt the best way to understand these experiences was by interviewing pastors in a way where they could openly and confidentially share their experiences through rich dialogue.

Recommendations for Future Research

This research lays the foundation for tremendous future research on TIC in church and religious settings. As the church is often viewed as a hospital for the spiritual and emotional needs of the community, it is no surprise that pastors are open to integrating more practices to better serve the trauma needs of congregants. This study highlighted a clear need for the development of training specific to pastors, and future research could work to develop evidence-based training for pastors. I recommend that professionals lean into these conversations with pastors and religious leaders to see how better dissemination of information can happen, how more training can be facilitated, and how collaborative approaches toward congregant care can exist. Specifically, researchers should continue to investigate how churches are offering care and develop strategies to increase this level of care. A modified TIC model should be developed that can easily integrate into church settings across denominations.

This study aimed to answer four questions related to the research, but the findings are not limited to the main research questions. The implications of this study lead to further questions and more discussions on this topic. Researchers should be asking more questions on this topic.

For example, there are three questions for future consideration that were not explicitly answered in this study, and these are discussed below.

- If churches have a higher baseline of currently integrated TIC practices, does this mean they are open to integrating full TIC?
- Is there a connection between a church's views toward TIC and its current baseline of TIC practices?
- Can a church's views towards TIC predict their willingness to integrate TIC or point towards their current baseline of integrated TIC?

Regarding the first question in the list above, this study's findings reveal an openness to TIC integration regardless of current TIC practices in place in churches. This study indicates that a higher baseline is not needed for an openness of TIC integration, but it also reveals that yes, a baseline of trauma knowledge and current trauma care does point to the openness of TIC integration. All participants reflected an interest and willingness to expand the current level of care offered at their church and an openness to integrating a modified TIC model within their church. However, more research should be done on this question to see if this is accurate across denominations and other religious groups and locations.

Related to the second question, this study reflects that when pastors have a basic to high level of understanding of trauma, they favor an integrated TIC model. This connection is seen, and yes, the findings indicate that a baseline of existing trauma care is connected to the church's views on trauma care.

The third question discusses a prediction on future integration of TIC in churches, and I believe this study reveals that when pastors are aware of trauma and the option for TIC, they are inclined to integrate. Because all the pastors in this study were already having trauma

conversations with congregants, the findings in this study reflect a connection. However, future studies could see if this is true across all churches or only churches where pastors share the experience of trauma conversations with congregants.

Better questions can be asked on this topic, and more research should be conducted to develop the best-modified approach of TIC for church models. Variations of this model should be considered to meet the specific needs across denominations, and researchers should not stop at integrating this type of care in Christian religious circles but should consider how to integrate TIC in other religious settings. Additionally, as TIC can be modified and tailored for specific programs, demographics, and communities, researchers can work to implement TIC approaches far beyond the extent they have already been considered and investigate integrations within systems across all disciplines where people exist.

The argument for continued integration, continued development, and further research on religious settings comes from a place of seeing the impact of trauma, the value of TIC., and the importance of spiritual integration in current TIC. Between the literature review in Chapter 2 and the findings in Chapter 4, there is extensive information related to the impact of trauma, the need for trauma care, and the benefit of TIC which have been identified in throughout this chapter. Suppose TIC is a viable solution to mitigating trauma needs and can be used in various organizations across disciplines. In that case, I wonder why it has not already been integrated into community infrastructures like churches.

Summary

This chapter included a summary of the study's findings, a discussion of the researcher, a highlight of the study's implications, delimitations, limitations of the research, and recommendations for future research. The answers to the research questions were discussed in

detail, and the development of these findings was summarized. A deeper discussion on empirical and theoretical literature was also discussed, drawing the connection between the existing research and highlighting the corroboration of this research to the existing literature. The value of this study was referenced, including how it adds to the existing literature on trauma, TIC, and pastoral experiences. Theoretical, empirical, and practical implications were discussed. Some of the key takeaways from this study highlight the challenges and strategies pastors use when addressing trauma conversations with congregants.

Additionally, findings revealed the current knowledge base of trauma and TIC by pastors and found that pastors are willing to integrate a modified TIC model into their churches. Recommendations were made for counselors, ministers, and future researchers, including topics to explore and other angles on these research questions. This chapter concluded as the researcher considered why TIC has not already been modified to meet congregants' unique spiritual and mental health needs and why it has not already been integrated into the current protocols of churches aiming to mitigate the impact of trauma on the congregation.

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Appendix A

IRB Approval Letter

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

April 10, 2024

Lindsay Knox
Debra Perez

Re: IRB Exemption - IRB-FY23-24-1352 A Phenomenological Study Exploring Evangelical Pastors' Experiences Ministering to Congregants with Trauma in the Greater Toronto Area

Dear Lindsay Knox, Debra Perez,

The Liberty University Institutional Review Board (IRB) has reviewed your application per 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 described in your IRB 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.(iii). 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 can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

For a PDF of your exemption letter, click on your study number in the My Studies card on your Cayuse dashboard. Next, click the Submissions bar beside the Study Details bar on the Study Details page. Finally, click Initial under Submission Type and choose the Letters tab toward the bottom of the Submission Details page. Your information sheet and final versions of your study documents, **which you must use to conduct your study,** can also be found on the same page under the Attachments tab.

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 B

Recruitment Script

Dear Pastor:

As a graduate student in the School of Behavioral Studies at Liberty University, I am conducting research to better understand the experiences of evangelical pastors ministering to congregants with trauma in the Greater Toronto Area. The purpose of my research is to understand the experiences of pastors, the challenges faced, and the strategies used when ministering to congregants with trauma. The study seeks to understand the pastoral experience with trauma care in the church, and I am writing to invite eligible participants to join my study.

Participants must be 18 years of age or older, the lead pastor of an evangelical church (Baptist, Pentecostal, or Non-Denominational) in the Greater Toronto Area where congregants meet in person, weekly on Sundays, their church must have a weekly attendance of 300 people as well as a child, youth, or young adult's ministry, and they must have experience ministering to congregants with trauma. Participants, if willing, will be asked to meet for an audio- and video-recorded Zoom interview for an estimated 45-60 minutes to answer a series of research questions. Prior to the interview, participants will be asked to complete a pre-interview phone call with the researcher, which will take approximately 10 minutes. Upon completing the interview, the researcher will transcribe your answers, and you will be asked to review your answers for validity. It should take approximately 1 hour to complete the review of the transcript. Names and other identifying information will be requested as part of this study, but the information will remain confidential.

To participate, please reply to this email confirming that you would like to participate and to obtain more information about scheduling your interview.

A consent document is attached to this email. The consent document contains additional information about my research. If you choose to participate, you will need to sign the consent document and return it to via email, as a scanned attachment, prior to your interview.

Sincerely,

Lindsay Knox McVety

Graduate Student, Liberty University

Appendix C

Consent Form

Consent

Title of the Project: A Phenomenological Study Exploring Evangelical Pastors' Experiences Ministering to Congregants with Trauma in the Greater Toronto Area
Principal Investigator: Lindsay McVety, Doctoral Candidate, School of Behavioral Studies, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must be 18 years of age or older, the lead pastor of an evangelical church (Baptist, Pentecostal, or Non-Denominational) in the Greater Toronto Area. The church where you pastor must meet weekly, in-person on Sundays, and your church must have a child, youth, or young adult's ministry. Your congregation must include an attendance of 300 people each week. You must have experience ministering to congregants with trauma. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

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

The purpose of the study is to understand the experience of pastors when addressing the needs of congregants who have experienced trauma, and this study seeks to understand the attitudes of pastors towards the integration of Trauma Informed Care practices within their church practices.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following:

1. Participate in an interview. This interview will take place via Zoom, with audio and video recording, and should take between 45-60 minutes.
2. Complete a review of your interview transcripts to ensure the accuracy of your responses. This should take approximately 1 hour to complete.

How could you or others benefit from this study?

The direct benefits participants should expect to receive from taking part in this study include a basic knowledge of Trauma Informed Care (TIC). There is an opportunity for future training in TIC that would benefit both the participant and those impacted by their work in their church.

Benefits to society include more open dialogue about mental health and TIC procedures in a church setting, potential for integration of TIC methods in church settings, and increased understanding of the current experiences of pastors in the GTA as they face mental health related topics with their congregants.

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. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be kept confidential by replacing names with pseudonyms.
- Interviews will be conducted in a location where others will not easily overhear the conversation. This is both the responsibility of the interviewer and the participant, and both will need to ensure their end of the conversation is in a confidential environment.
- Data collected from you may be used in future research studies or shared with other researchers. If data collected from you is reused or shared, any information that could identify you, if applicable, will be removed beforehand.
- Data will be stored on a password-locked computer in an electronic drive with two-step verification and encryption. Data will be retained for a minimum of three years after the completion of this study, and after seven years, all electronic records will be deleted.
- Recordings will be stored on a password-locked computer in an electronic drive with two-step verification and encryption. Recordings will be stored for a minimum of three years after the completion of this study, and after seven years, all electronic records will be deleted. The researcher will have access to these recordings.

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 without affecting those relationships.

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

If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

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

The researcher conducting this Lindsay Knox McVety. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at [redacted] and/or [redacted] You may also contact the researcher's faculty sponsor, Dr. Debra Perez, 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

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio-record and video-record me as part of my participation in this study.

_____
Printed Subject Name

_____
Signature & Date

Appendix D

Interview Questions

Interview Segment 1 (Basic Information)

1. Please introduce yourself to me as if we just met one another.
2. Please share your age.
3. Please state your gender.
4. Please state your ethnic background.
5. Please state your church denomination.
6. Please state your title at the church.
7. Please share the time you have been in this role at the church.

Interview Segment 2 (Closed-Ended Questions)

1. Does your church have a church counseling model in place for congregants?
2. When a church member discloses trauma, are there standard practices for pastors and leaders?
3. Is there a counselor on staff or volunteering at the church?
4. Does the church use a trauma-informed care (TIC) model with its congregants?
5. Do mental and spiritual health conversations occur amongst the pastoral leadership at the church?
6. Suppose a TIC methodology was modified to align with your church's religious beliefs and ethics. Would pastoral leadership be willing to implement these practices within their congregation?

Interview Segment 3 (In-Depth Interview Questions)

1. What have you experienced in terms of speaking with congregants about their experienced trauma?

2. What situations impact your conversations with congregants who've experienced trauma?
3. What does spiritual and mental health mean to you as the pastor of your church?
4. Can you discuss the openness of the church leadership to expand the current level of care available for individuals with primary mental health needs?
5. What is your church currently doing to meet your congregants' mental and spiritual health needs?
6. As a pastor of your church, what is your understanding of trauma and its impact on your congregation?
7. What is your church’s perspective on mental health and the impact of trauma?
8. What is your understanding of trauma-informed care?
9. Please describe any protocols in your church that relate to mental health.
10. How do you feel about pastors in your church receiving training in TIC with a modified approach for your congregation and religious beliefs?