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Article

Adverse Childhood Experiences, Religious Coping, and Congregational Support among Black Clergy and Religious Leaders

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Abstract: Limited studies have empirically investigated the impact of adverse childhood experiences (ACEs) among Black clergy and religious leaders despite their status as helping professionals who are implicated in times of crisis. In light of cultural considerations that position African American churches as trusted institutions linking local communities of color with various social services, African American religious leaders are particularly implicated during crisis situations such as the COVID-19 pandemic. Accordingly, the present study investigates the relationships between adverse childhood experiences, religious coping, and social support from one's congregation among a sample of Black religious leaders within Christian churches. Compared to a national sample of Black Americans, we observed significantly higher prevalence rates for four forms of adverse childhood experiences: emotional neglect, parental separation or divorce, mental illness in the household, and an incarcerated family member. The results from two moderated moderation statistical models indicated that higher adverse childhood experiences predicted greater endorsement of PTSD symptoms and that negative religious coping strengthened this relationship. Furthermore, this moderation effect was itself moderated by greater perceived emotional support from one's congregation, such that greater support mitigated this moderation effect. Conversely, we also found that positive religious coping has the potential to compensate for the lack of emotional support from the congregation. Implications for caring for clergy and religious leaders both within the church and in seminaries are provided.

Keywords: black clergy; African American pastors; adverse childhood experiences (ACES); religious coping; congregational support



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1. Introduction

It has been said that when America gets a cold, Black America catches pneumonia. The year 2020 brought to the fore many experiences of racial trauma, racial health disparities, and structural oppression that the Black community in the U.S. has lived with for decades (Cokley et al. 2022; Williams and Vermund 2021). The killing of Black bodies that went viral on social media, a disproportionate number of Black deaths during COVID-19, and the greater vulnerability of Black persons to COVID-19 resulting from Black people holding more service jobs during the pandemic highlighted the numerous traumas that Black Americans live with on a daily basis (Cokley et al. 2022; Williams and Vermund 2021). The conflation of these factors has led some scholars to call 2020 the year of the syndemic within the Black community (Cokley et al. 2022; Williams and Vermund 2021).

All of these stressors within the Black community were experienced within Black religious communities (DeSouza et al. 2021; Goldblum et al. 2023). The Black church remains the most prominent Black institution for the spiritual, mental, and social well-being of Black Americans, with Pew Research studies finding that Black Americans remain the most religious and church-engaged demographic of any major racial group (Hankerson et al. 2018; Mohamed et al. 2021). This has meant that the Black church, along with its religious leaders, played a prominent role in the well-being of many Black Americans through the traumatic experiences of 2020, as they have over the past 400 years of anti-Black racism in the U.S. (DeSouza et al. 2021; Harmon et al. 2018). Despite the critical place that Black religious leaders occupy within the Black community, very little research has focused on the trauma symptoms of this group of clergy (Roggenbaum et al. 2023).

2. Literature Review

2.1. Role of Black Clergy in the Black Community

Black clergy have a long history of playing many prominent roles in their communities, including de facto social workers, community leaders, and advocates for justice (Avent et al. 2015; Scott 2023). Numerous studies have shown that Black Americans are more likely to go to their clergy than a mental health professional (MHP) and that Black clergy often act as gatekeepers to mental health services for their congregants (Anthony et al. 2015; Bolger and Prickett 2021; Harris and Wong 2018). Recognizing the role that Black religious leaders have within their communities, scholars have recently taken an increased interest in their well-being and risks for vicarious stress responses. For example, Wimberley (2016) found that a group of 31 Black clergy reported numerous symptoms of clinical depression, including loss of energy, disruption of sleep, fatigue, agitation, and self-criticalness, as indicated on the Beck Depression Inventory. In contrast, Roggenbaum et al. (2023) found that the mean score on the PHQ-9 (measure for depression) for Black religious leaders indicated that while they were not clinically depressed, on average, their endorsement of secondary traumatic stress (STS) symptoms was moderately high.

2.2. Black Religious Leaders and Negative Religious Coping

That Black religious leaders may be susceptible to STS is not surprising given the numerous ways that Black persons encounter potentially traumatic experiences, including race-based stress (Williams and Vermund 2021). Secondary traumatic stress refers to the reactions and symptoms observed among individuals who have been indirectly exposed to the trauma of others—often due to their line of work (Wang et al. 2014)—and there is empirical evidence that religious leaders represent a population at high risk for developing symptoms of secondary traumatic stress through multiple vocational risk factors (Ruffing et al. 2021). Black Christian leaders, like many Christians, are likely to rely on religious interventions to deal with traumatic material (American Bible Society 2020) regardless of whether they endorse seeing a mental health professional (Roggenbaum et al. 2023). Bryant-Davis and Wong (2013) noted that although some forms of religious coping have been found to be protective against trauma symptoms, this is not always the case; negative religious coping may hinder trauma recovery as it is positively associated with PTSD symptoms (Gerber et al. 2011). Negative religious coping (Pargament et al. 2011) includes responses to hardship and distress that may include “doubting God’s love, perceiving negative life events to be a form of punishment, and feeling abandoned by God and his/her/their community of faith” (O’Brien et al. 2018, p. 55). Negative religious coping has also been found to be indirectly related to PTSD symptoms through a lack of social support from one’s religious community (Wood et al. 2021). These findings fit within a large literature showing religiosity can have positive, negative, or mixed effects on mental health depending on the psychological dynamics involved in religious coping strategies.

Park et al. (2018) found that negative religious coping in African Americans was associated with depressive symptoms, lower self-esteem, and less meaning in life and that such symptoms persisted in a longitudinal study over 2.5 years. This may have implications

for the work of Black religious leaders, as they are often tasked to provide spiritual and emotional guidance for Black parishioners suffering from adverse life experiences, such as the syndemic of 2020, alongside the many forms of grief and stress that continue to linger within the Black community (DeSouza et al. 2021). Furthermore, the stress placed on Black religious leaders may be compounded due to their own personal symptoms of depression, trauma, and negative religious coping, as found in a study of 102 Black church leaders (Roggenbaum et al. 2023). Roggenbaum et al. (2023) found that at high levels of negative religious coping, the impact of ACEs on PTSD symptoms of these Black religious leaders later in life was significantly more prominent than among those with lower levels of negative religious coping. Furthermore, Roggenbaum et al. (2023) noted that negative religious interactions (e.g., feelings that the congregation either made too many demands of you and/or were critical of you or the way you do things) were significantly correlated with higher rates of STS. These findings align with Rogers and Tinsley's (2023) study of 218 Black pastors during COVID-19, where 39% indicated that their pastoral work was either very or extremely stressful.

As noted above, research has begun to focus on the external stressors that exacerbate the work of Black church leaders (i.e., racism, pastoral pressures, etc.). Yet very few studies have examined the ways that the events that occurred during the Black leader's own childhood development may affect their present well-being (Roggenbaum et al. 2023). In the above sample of 102 Black church leaders, Roggenbaum and colleagues found that the rate of adverse childhood experiences of participants (2.27) was significantly higher than that of a national sample of Black persons (1.67) (Roggenbaum et al. 2023; Merrick et al. 2018). We suggest that the adverse childhood experiences of Black religious leaders in the past may, in fact, be a significant, underrated contributor to their occupational well-being and mental health distress.

2.3. Adverse Childhood Experiences

In the mid-1990s, the Center for Disease Control identified 10 childhood experiences that they labeled adverse childhood experiences (ACEs), which can have detrimental physical, mental, emotional, and relational effects (CDC 2023; Felitti 2019). ACEs have been categorized by scholars into three categories, (1) abuse (e.g., emotional, physical, sexual), (2) neglect (e.g., emotional, physical), and (3) household challenges (e.g., mother abused, family member with mental illness, addiction in household). Numerous studies, some longitudinal, have shown that ACEs have effects lasting well into adulthood and later life (Assini-Meytin et al. 2022; CDC 2023; Deighton et al. 2018; Felitti 2019). Physical illnesses associated with ACEs include diabetes, cardiovascular disease, obesity, pulmonary issues, and cancer, to name a few (Felitti 2019). Research has also shown that ACEs have detrimental effects on one's psychological and emotional well-being, as persons with multiple ACEs are much more likely to suffer from depression, anxiety, PTSD, suicidal ideation, and suicidal behavior (Felitti 2019). Roggenbaum et al. (2023) found that the rates of ACEs of Black religious leaders were significantly and positively associated with depression, anxiety, and PTSD.

In a national sample of Americans, Merrick et al. (2018) discovered that Black persons, on average, had higher rates of ACEs than White or Asian individuals. Furthermore, scholars have noted that persons who live in lower socio-economic communities have significantly higher rates of ACEs than those from higher-income neighborhoods (Giano et al. 2020; Merrick et al. 2018). This may have important implications for the well-being of Black clergy as they are often ministering within Black communities, some of which are embedded in financially impoverished areas with multiple ecological stressors (Hankerson et al. 2018).

Currently, the literature lacks research that identifies factors that may ameliorate the negative effects of ACEs for adults outside of what has been termed positive childhood experiences (Crandall et al. 2019). Furthermore, scholarship that speaks to the prevalence rates of ACEs, as well as the protective factors for trauma symptoms among Black reli-

gious leaders, is particularly scant; yet there is reason to believe that a potential source of psychological comfort and resilience may be social support from congregations, as well as certain forms of religious coping (Wood et al. 2021). Chatters et al. (2015) found that among a group of 686 Black adults, those who experienced social support from church members were significantly less likely to suffer from depressive symptoms and psychological distress. Accordingly, the purpose of this study was twofold. First, we examined the prevalence rates of ACE endorsements and compared them to a national sample. Second, we tested two moderated moderation statistical models. The first tested the hypothesis that the relationship between adverse childhood experiences and PTSD symptoms would depend on two factors: perceived emotional social support from one's congregation and negative religious coping. The second model tested the hypothesis that the relationship between adverse childhood experiences and PTSD symptoms would depend on perceived emotional social support from one's congregation and positive religious coping.

3. Methods

3.1. Methods

3.1.1. Participants

A total of 124 clergy and church leaders (e.g., deacons, Sunday school teachers, etc.) from a network of Black or African American-identifying churches in Texas were invited to complete a battery of psychological measures related to a trauma-informed mental health initiative designed to address social inequalities among religious congregants. Twenty-two respondents had greater than 30% of missing data; thus, 102 participants were included in this study. Table 1 provides demographic information for this sample. For ease of reference, this sample will be referred to as the clergy sample in the rest of the paper.

Table 1. Demographic information for African American clergy who participated in 2022 trauma-informed mental health initiative in Texas ($N = 102$).

Demographic Label	<i>N</i> (Percent Total Sample)
Gender	
Male	31 (30.4%)
Female	70 (68.6%)
Age	
18–34 years	11 (10.8%)
35–44 years	15 (14.7%)
45–54 years	25 (24.5%)
55–64 years	28 (27.5%)
65–years or older	23 (22.6%)
Leadership Position	
Head Pastor, Associate Pastor, or Worship pastor	25 (24.5%)
Elders and Deacon/Deaconesses	11 (10.78%)
Children/youth ministry leaders and administrators	10 (9.8%)
Small group leaders	16 (15.7%)
Counseling/Prayer team members	7 (6.9%)
Other volunteer positions	5 (4.9%)
No current leadership position	26 (25.5%)
Missing	2 (2.0%)

Table 1. Cont.

Demographic Label	N (Percent Total Sample)
Education Level	
Bachelor's Degree	11 (10.0%)
Master's or Higher Degree	12 (11.7%)
Missing Information	79 (77.5%)
Marital Status	
Yes	68 (66.7%)
No	33 (32.4%)

Note: To protect the confidentiality of participants, cells that contain < 5 individuals are either (1) not reported in this table or (2) collapsed with another category. Consequently, percentages reported in the table may not total 100 percent.

3.1.2. Matched National Sample of African American Respondents in the Behavioral Risk Factor Surveillance System (BRFSS) Study

Following the methodology of [Holleman et al. \(2023\)](#), as a comparison sample for one of our analyses, this study utilized data from the 2022 Behavioral Risk Factor Surveillance System (BRFSS), a national survey administered by the Centers for Disease Control and Prevention (CDC). This survey collects state-specific data on health-related risk behaviors, chronic health conditions, healthcare access, and use of preventive services among non-institutionalized adults (≥ 18 years of age) in the United States. In 2022, a total of 12 states (88,280 respondents) administered items derived from the Adverse Childhood Experience Questionnaire ([ACE 2024](#); [Dube et al. 2001](#)): Arkansas, Florida, Iowa, Nevada, North Dakota, Oregon, South Dakota, Virginia, Arizona, Ohio, New Jersey, and Oklahoma.

To provide a matched comparison sample, we limited participants to BRFSS respondents identified as African Americans in the dataset ($N = 5333$). Because of the complex nature of stated-based data collection procedures, we created a single unified dataset from three datasets (i.e., one core module and two optional modules) provided by the BRFSS. Because these datasets included weights to help make the sample data more representative of the U.S. population, weights were adjusted according to recommended steps by the [CDC \(2023\)](#) when the datasets were combined. For ease of reference, this sample will be referred to as the matched national sample in the rest of the paper.

3.2. Measures

3.2.1. Adverse Childhood Experiences Questionnaire (ACEs)

The Adverse Childhood Experience Questionnaire is a brief survey on the respondent's exposure to several types of traumatic and/or stress-related events in the first 18 years of life ([Dube et al. 2001](#)). Events in this measure included exposure to verbal abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, a battered caregiver, household substance abuse, mental illness in the household, parental separation or divorce, and an incarcerated household member. The clergy sample was administered a version of the measure that asked for dichotomous (1 = yes, 0 = no) responses. The national sample was administered a version of the measure that asked for a mixture of dichotomous and polychotomous responses. Prior to raking (i.e., sample balancing; [Lumley 2004](#)) and comparison with the clergy sample, the national sample's responses were recoded into dichotomous responses. Table 2 provides further details of the item responses in each version of the questionnaire. After recoding, a total ACE score was calculated for each respondent in both datasets by summing the number of ACEs experienced, with values ranging from 0–10. Because of the heterogeneity of domains covered by the ACEs, internal consistency of the ACEs appeared to be within reasonable range for both datasets (matched national sample, $KR-20 = 0.688$; clergy sample, $KR-20 = 0.781$).

Table 2. Adverse childhood experience (ACE) item comparison across clergy and national sample.

Domain	Clergy Sample	Matched National Sample
1. Verbal abuse	Did a parent or other adult in the household often swear at you, insult you, put you down, or humiliate you? OR Act in a way that made you afraid that you might be physically hurt?	How often did a parent or adult in your home ever swear at you, insult you, or put you down? ^a
2. Physical abuse	Did a parent or other adult in the household often push, grab, slap, or throw something at you? OR Ever hit you so hard that you had marks or were injured?	Not including spanking (before age 18), how often did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way? Was it— ^a
3. Sexual abuse	Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way? OR Try to or actually have oral, anal, or vaginal sex with you?	How often did anyone at least 5 years older than you or an adult, ever touch you sexually? ^a OR How often did anyone at least 5 years older than you or an adult, try to make you touch them sexually? ^a OR How often did anyone at least 5 years older than you or an adult, force you to have sex? ^a
4. Emotional neglect	Did you often feel that no one in your family loved you or thought you were important or special? OR Your family didn't look out for each other, feel close to each other, or support each other?	For how much of your childhood was there an adult in your household who made you feel safe and protected? ^b
5. Physical neglect	Did you often feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? OR Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	For how much of your childhood was there an adult in your household who tried hard to make sure your basic needs were met? ^b
6. Parental separation or divorce	Were your parents ever separated or divorced?	Were your parents separated or divorced?
7. Battered caregiver	Was your mother or stepmother: Often pushed, grabbed, slapped, or had something thrown at her? OR Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? OR Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?	How often did your parents or adults in your home ever slap, hit, kick, punch, or beat each other up? ^a
8. Household substance abuse	Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	Did you live with anyone who was a problem drinker or alcoholic? Did you live with anyone who used illegal street drugs or who abused prescription medications?

Table 2. Cont.

Domain	Clergy Sample	Matched National Sample
9. Mental illness in the household	Was a household member depressed or mentally ill or did a household member attempt suicide?	Did you live with anyone who was depressed, mentally ill, or suicidal?
10. Incarcerated household member	Did a household member go to prison?	Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?

Note: All ACE items in the clergy sample had dichotomous (1 = yes, 0 = no) responses. On the other hand, ACE items in the matched national sample had a mixture of dichotomous and polychotomous responses. Polychotomous responses in the national sample were transformed (and reverse coded where relevant) to yield dichotomous responses facilitate comparison with the clergy sample. ^a Prior to transformation, original item responses were: 1 = Never, 2 = Once, 3 = More than once, 7 = Don't know/Not sure, 9 = Refused. ^b Prior to reverse coding and transformation, original item responses were: 1 = Never, 2 = A little of the time, 3 = Some of the time, 4 = Most of the time, 5 = All of the time, 7 = Missing = Don't know/Not sure, 9 = Refused.

3.2.2. Religious Social Support—Emotional Subscale

Emotional support received from the congregation was measured using the emotional subscale of the Religious Social Support Measure (Krause 1999). The emotional support subscale comprised two items: (1) How often do the people in your congregation make you feel loved and cared for? (2) How often do the people in your congregation listen to you talk about your private problems and concerns? Respondents provided responses on a 4-point Likert-type scale ranging from 1 = Never to 4 = Very often, and items were summed to provide a total emotional support score. Krause (1999) reported that these items represented minor revisions of indicators that have been psychometrically tested with a nationwide sample of older adults in the U.S. (Krause 1995, 1997). For our African American clergy sample, internal consistency for this two-item measure was $\alpha = 0.643$, which appeared to be in the undesirable (0.60–0.65) but above the unacceptable (>0.60) range for internal consistency (DeVellis 2017).

3.2.3. Brief—Religious Coping Scale (Brief RCOPE)

Positive and negative religious copings were measured using the Brief RCOPE subscales (Pargament et al. 2011). Participants rated the extent (ranging from 0 = Not at all to 3 = A great deal) to which they engaged in various coping strategies when dealing with a critical life event. Items were summed to create an index of each type of religious coping. Example items from the positive religious coping subscale included “Looked for a stronger connection with God” and “Focused on religion to stop worrying about my problems”. Example items from the negative religious coping subscale included, “Wondered what I did for God to punish me” and “Wondered whether God had abandoned me”. Pargament et al. (2011) reported that a two-factor structure underlies the two subscales (each comprised of seven items). These scales demonstrate good concurrent, predictive, and incremental validity (Pargament et al. 2011).

In previous studies, both subscales generally demonstrate good internal consistency across a variety of populations (Pargament et al. 2011), with generally higher alphas for the positive religious coping scale (median $\alpha = 0.92$) compared to the negative religious coping scale (median $\alpha = 0.81$). The lowest reported α was 0.60 for the negative religious coping scale among Pakistani undergraduates (Khan and Watson 2006). For our African American clergy sample, however, we found the opposite trend—internal consistency for the positive religious coping subscale was $\alpha = 0.566$, which appeared to be below the unacceptable (>0.60) threshold for internal consistency (DeVellis 2017). On the other hand, internal consistency for the negative religious coping subscale was $\alpha = 0.853$, which appeared to be in the very good (between 0.80 and 0.90) range for internal consistency (DeVellis 2017).

3.2.4. Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)

Post-traumatic Stress Disorder (PTSD) symptoms experienced in the past month were measured with the Primary Care PTSD Screen for DSM-5 (PC-PTSD-5; Prins et al. 2016).

Respondents rated yes or no to the following items: (1) intrusive thoughts about traumatic event(s), (2) nightmares about traumatic event(s), (3) hypervigilance or exaggerated startle response, (4) anhedonia or feeling distant from others, and (5) guilt or self-blame related to traumatic event(s). Items were summed to create a total PTSD score. This measure is widely used as a screening measure among a variety of samples, including college students (López-Castro et al. 2021), police officers (Jetelina et al. 2020), healthcare workers (Murata et al. 2021), and veterans (Prins et al. 2016). Prins et al. (2016) reported good diagnostic accuracy in relation to the MINI International Neuropsychiatric Interview (MINI). For our African American clergy sample, this measure demonstrated very good internal consistency (KR-20 = 0.862; DeVellis 2017).

3.3. Data Analysis

Two analyses were conducted in our study. The first involved an item-by-item analysis of ACE endorsements between our African American clergy sample and the national sample from the BRFSS dataset. The second involved two moderated moderation analyses with our African American clergy sample. Details of each analysis are provided in the sections below.

3.3.1. ACEs Analyses: Clergy and Matched National Sample

As mentioned previously, the matched national sample consisted of African American respondents to the BRFSS survey ($N = 5333$), and our clergy sample consisted of all respondents from a network of African American churches in Texas ($N = 102$). The population distributions for age (18–54 years old versus 55 years of age), gender (male versus female), and marital status (married versus not married) were obtained from the matched national sample and used as target values to generate survey weights in a process called raking, or sample balancing (Lumley 2004) for our clergy sample.

We used R Statistical Software (v4.3.1 R Core Team 2023) and the anesrake package (v0.80; Pasek 2018) to conduct the raking process. Although three variables (age, gender, and marital status) were initially chosen as possible raking variables, the final choice for raking variables was determined by the sum of the differences between actual and target values for each prospective weighting variable (>5 percent; Pasek 2018). In order to minimize design effects and achieve complete convergence of results, the maximum weight that could be generated for each respondent was set to 3.0 and below.

3.3.2. Moderated Moderation Models: Clergy Sample

We tested two moderated moderation models with our African American clergy sample. No gross violations in linearity, normality, or homoscedasticity were observed in the regression models that composed each moderated moderation model. Additionally, variance inflation factor, tolerance, condition indices, and variance proportion statistics did not indicate multicollinearity concerns among the predictors in the aforementioned regression models. IBM SPSS Statistics (version 29) was used for all analyses related to moderated moderation models. Specifically, Hayes (2018) PROCESS Macro (Model 3) was used to test these models.

The first moderated moderation model tested the hypothesis that the relationship between adverse childhood experiences and PTSD symptoms would depend on two factors: emotional support from congregation and negative religious coping. Specifically, we expected higher adverse childhood experiences in the first 18 years of life to predict greater endorsement of PTSD symptoms in the past month. Moreover, we expected greater negative religious coping to strengthen the aforementioned relationship. However, we expected this moderation itself to be moderated by greater perceived emotional support from members of their congregation (i.e., greater emotional support would mitigate the aforementioned moderation effect).

Similarly, we tested another moderated moderation model with this sample, albeit with positive religious coping. As mentioned before, we expected higher adverse childhood

experiences in the first 18 years of life to predict greater endorsement of PTSD symptoms in the past month. However, we expected greater positive religious coping to mitigate the aforementioned relationship. Moreover, we expected this moderation itself to be moderated by greater perceived emotional support from members of their congregation (i.e., greater emotional support would strengthen the aforementioned moderation effect).

4. Results

4.1. ACEs Analyses: Clergy and Matched National Sample

For the ACE comparison analysis, we compared whether the mean total ACE score was statistically significantly different between the clergy and the matched national sample. Across both samples, we also checked whether the proportion of ACE endorsement differed for the following domains: (1) verbal abuse, (2) physical abuse, (3) sexual abuse, (4) emotional neglect, (5) physical neglect, (6) parental separation or divorce, (7) battered caregiver, (8) household substance abuse, (9) mental illness in the household, (10) and incarcerated household member. Figure 1 summarizes the percent endorsement of various ACE domains across the two samples.

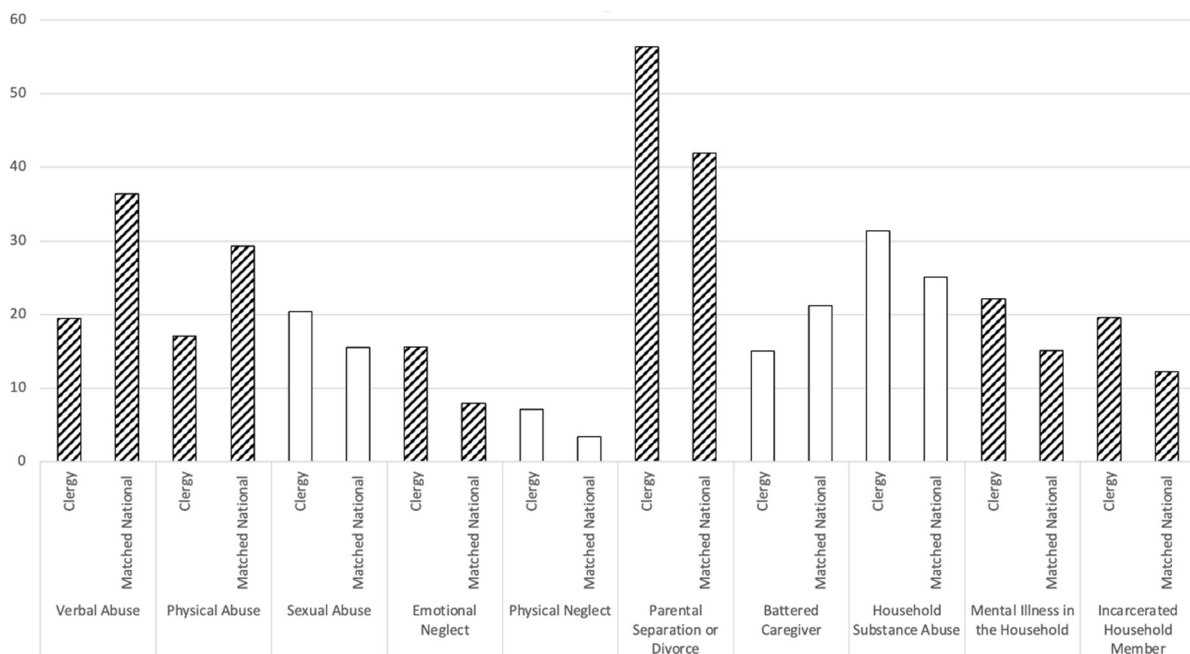


Figure 1. Percent endorsement of adverse childhood experience (ACE) domains across clergy and matched national sample. Note: Bars with diagonal patterned lines indicate statistically significant different percent endorsements between the clergy sample and matched national sample.

A one-way ANOVA was conducted to examine whether the mean total ACE score was statistically significantly different between the clergy and the matched national sample. There was no statistically significant difference in mean total ACE score across the samples $F(1,4,104,250) = 1.17, p = 0.279$. The average total ACE score for the clergy sample was 2.28 ($SD = 2.35$), and for the matched national sample, it was 1.93 ($SD = 1.95$).

A series of chi-square tests of independence was performed to examine the relation between the endorsement of ACE domains and the type of sample (clergy versus matched national sample). The clergy sample appeared to have a higher percent endorsement of four domains when compared to the matched national sample: (1) emotional neglect $\chi^2(1, N = 4,537,773) = 8.994, p = 0.003$, (2) parental separation or divorce, $\chi^2(1, N = 4,511,986) = 9.442, p = 0.002$, (3) mental illness in the household, $\chi^2(1, N = 4,578,808) = 6.512, p = 0.011$, and (4) incarcerated household member, $\chi^2(1, N = 4,609,044) = 4.407, p = 0.0036$. Compared to the clergy sample, the matched national sample appeared to have

a higher percent endorsement of two domains: (1) verbal abuse $c^2(1, N = 4,523,183) = 12.38$, $p < 0.001$ and (2) physical abuse $c^2(1, N = 4,503,531) = 7.90$, $p = 0.005$. All chi-square significance tests remained significant when limiting the overall false discovery rate to 0.05 using the Benjamini–Hochberg procedure (Benjamini and Hochberg 1995).

4.2. First Moderated Moderation Model: Clergy Sample

In the first moderated moderation model, we tested the hypothesis that the relationship between adverse childhood experiences and PTSD symptoms would depend on two factors: emotional support from congregation and negative religious coping. The overall regression model evaluating whether the total number of ACEs (X) and the two moderators, emotional support from congregation (W) and negative religious coping (Z_1), predicted PTSD symptoms in the past month was statistically significant ($R^2 = 0.26$, $F(7,92) = 4.58$, $p < 0.001$; see Table 3). Moreover, the three-way interaction ($X*W*Z_1$) between the predictors was statistically significant, as the interaction explained 4.21% of the variance in PTSD symptoms in the past month ($\Delta R^2 = 0.04$, $F(1,92) = 5.22$, $p < 0.05$). This confirmed the hypothesis that the relationship between ACEs and PTSD symptoms in the past month depended on the values of emotional support from congregation and negative religious coping.

Table 3. Regression coefficients for moderated moderation model involving negative religious coping.

Predictors	<i>b</i>	<i>SE</i>	<i>t</i>	<i>p</i>	95% CI
ACEs (X)	−0.72	0.39	−1.84	0.07	[−1.50, 0.06]
Emotional Support from Congregation (W)	−0.08	0.19	−0.42	0.68	[−0.46, 0.30]
Negative Religious Coping (Z_1)	−0.33	0.18	−1.81	0.07	[0.69, 0.03]
ACEs (X) * Emotional Support from Congregation (W)	0.12	0.07	1.89	0.06	[−0.006, 0.25]
ACEs (X) * Negative Religious Coping (Z_1)	0.16	0.06	2.62	0.01	[0.04, 0.28]
Emotional Support from Congregation (W) * Negative Religious Coping (Z_1)	0.05	0.03	1.69	0.09	[−0.008, 0.11]
ACEs (X) * Emotional Support from Congregation (W) * Negative Religious Coping (Z_1)	−0.02	0.01	−2.29	0.02	[−0.41, −0.003]

Note: The overall regression model was statistically significant ($R^2 = 0.26$, $F(7,92) = 4.58$, $p < 0.001$). Additionally, the three-way interaction ($X*W*Z_1$) was statistically significant, explaining 4.21% of the variance in PTSD symptoms ($\Delta R^2 = 0.04$, $F(1,92) = 5.22$, $p < 0.05$).

Because the interaction was statistically significant, we probed the interaction to determine the level at which negative religious coping (Z_1) had an influence on the three-way interaction. Based on the Johnson–Neyman technique (Hayes 2018), the three-way interaction was statistically significantly different from zero when negative religious coping (Z_1) was more than 10 points. Figure 2 displays the moderated moderation effect. At high levels of negative religious coping (top panel of Figure 2), higher emotional support from the congregation appeared to reduce the strength of the deleterious effects of ACEs on PTSD symptoms. The moderation effect of emotional support from the congregation on the deleterious effects of ACEs on PTSD symptoms, however, reduces in strength as negative religious coping scores decrease (middle and bottom panels of Figure 2). In other words, perceived emotional support from the congregation may be helpful in reducing the effects of ACEs on PTSD—especially among clergy who engage in more negative religious coping strategies.

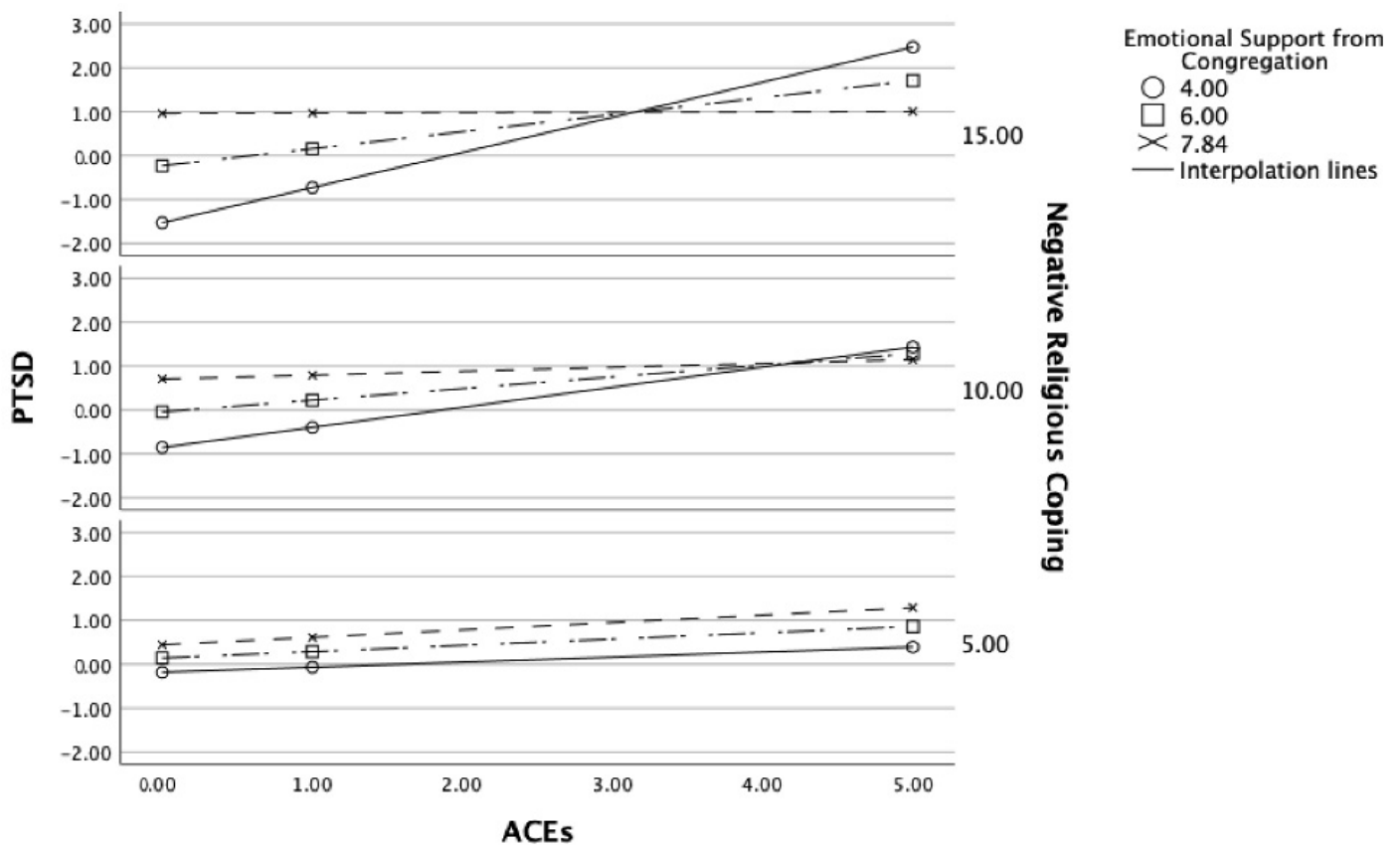


Figure 2. Conditional effect of adverse childhood experiences on post-traumatic stress disorder symptoms as moderated by emotional support from congregation and negative religious coping. *Note:* When Negative Religious Coping is more than 10 points, the three-way interaction among ACEs, emotional support from congregation, and negative religious coping was statistically significantly different from zero. PTSD = Post-traumatic stress disorder; ACEs = adverse childhood experiences.

4.3. Second Moderated Moderation Model: Clergy Sample

In the second moderated moderation model, we tested the hypothesis that the relationship between adverse childhood experiences and PTSD symptoms would depend on two factors: emotional support from congregation and positive religious coping. The overall regression model evaluating whether the total number of ACEs (X) and the two moderators, emotional support from congregation (W) and positive religious coping (Z), predicted PTSD symptoms in the past month was statistically significant ($R^2 = 0.56$, $F(7,92) = 5.92$, $p < 0.001$; see Table 4). Moreover, the three-way interaction ($X*W*Z_2$) was statistically significant, explaining 11.25% of the variance in PTSD symptoms ($\Delta R^2 = 0.11$, $F(1,92) = 15.02$, $p < 0.001$). This confirmed the hypothesis that the relationship between ACEs and PTSD symptoms in the past month depended on the values of emotional support from congregation and positive religious coping.

Because the interaction was statistically significant, we probed the interaction to determine the level at which positive religious coping (Z_2) had an influence on the three-way interaction. Based on the Johnson–Neyman technique (Hayes 2018), the three-way interaction was statistically significantly different from zero when positive religious coping (Z) was less than 18 points. Figure 3 displays the moderated moderation effect. At low levels of positive religious coping (top panel of Figure 3), a lack of emotional support from the congregation appeared to potentiate the deleterious effects of ACEs on PTSD symptoms. This moderation effect, however, reduces in strength as positive religious coping scores increase (middle and bottom panels of Figure 3). In other words, positive religious coping has the potential to compensate for the lack of emotional support from the congregation in

terms of the conditional effect of ACEs on PTSD, as moderated by emotional support from the congregation.

Table 4. Regression coefficients for moderated moderation model involving positive religious coping.

Predictors	<i>b</i>	<i>SE</i>	<i>t</i>	<i>p</i>	95% CI
ACEs (<i>X</i>)	7.41	1.85	4.00	0.001	[3.73, 11.09]
Emotional Support from Congregation (<i>W</i>)	3.13	1.20	2.60	0.01	[0.74, 5.51]
Positive Religious Coping (<i>Z</i> ₂)	0.90	0.40	2.28	0.02	[0.12, 1.69]
ACEs (<i>X</i>) * Emotional Support from Congregation (<i>W</i>)	−1.29	0.34	−3.82	<0.001	[−1.96, −0.62]
ACEs (<i>X</i>) * Negative Religious Coping (<i>Z</i> ₂)	−0.39	0.10	−3.92	<0.001	[−0.59, −0.19]
Emotional Support from Congregation (<i>W</i>) * Negative Religious Coping (<i>Z</i> ₂)	−0.16	0.06	−2.47	0.02	[−0.28, 0.03]
ACEs (<i>X</i>) * Emotional Support from Congregation (<i>W</i>) * Negative Religious Coping (<i>Z</i> ₂)	0.07	0.02	3.88	<0.001	[0.03, 0.10]

Note: The overall regression model was statistically significant ($R^2 = 0.56, F(7,92) = 5.92, p < 001$). Additionally, the three-way interaction ($X*W*Z_2$) was statistically significant, explaining 11.25% of the variance in PTSD symptoms ($\Delta R^2 = 0.11, F(1,92) = 15.02, p < 0.001$).

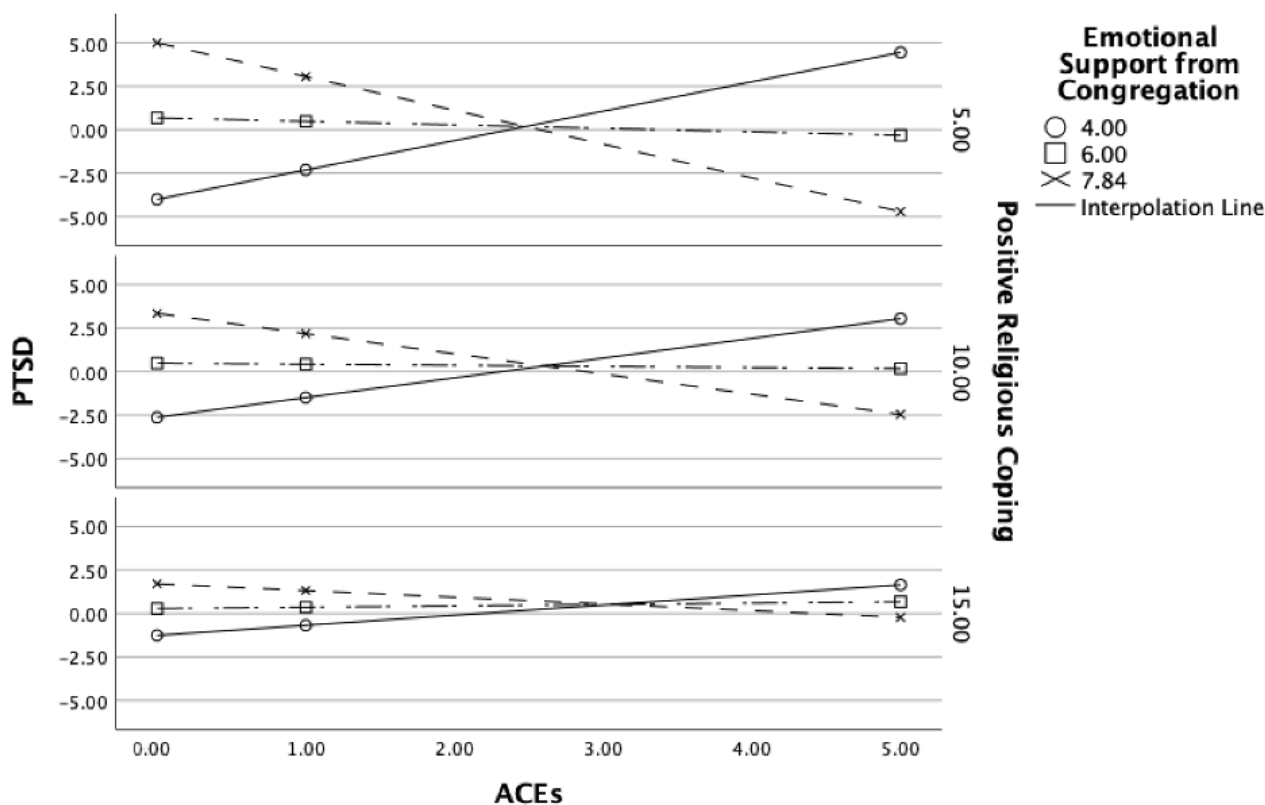


Figure 3. Conditional effect of adverse childhood experiences on PTSD symptoms as moderated by emotional support from congregation and positive religious coping. Note: When Positive Religious Coping is less than 18 points, the three-way interaction between ACEs, emotional support from congregation, and positive religious coping was statistically significantly different from zero. PTSD = post-traumatic stress disorder; ACEs = adverse childhood experiences.

5. Discussion

The purpose of this study was to compare the rates of ACEs among Black religious leaders to their peers in a national sample and to examine the nuanced relationships between ACEs, PTSD, religious coping, and perceived emotional support from one’s congregation. Results confirm that the PTSD symptoms of African American leaders are associated with a combination of personal historical factors (i.e., ACEs), their own religious coping, and the degree to which they experienced emotional support from their

congregation. While there was no significant difference in the mean scores of ACEs between our sample and the national sample, significant differences were observed in the endorsement of individual ACEs. Clergy were found to be more likely to have suffered from feeling unsafe and unprotected, their parents being separated or divorced, living with a family member with mental illness, or having a household member incarcerated. These results highlighting potential relational trauma during childhood are in line with those of [Holleman et al. \(2023\)](#), who reported higher prevalence rates of emotional abuse, living with someone with mental illness, and sexual abuse among a sample of Mainline Protestant clergy compared to a similar national sample. [Roggenbaum et al. \(2023\)](#) found that ACEs increased the likelihood of Black leaders suffering from depression, anxiety, and PTSD and that these three disorders were, in fact, correlated with STS.

Though there was no statistically significant difference in rates of being sexually abused as a child, the 20.4% rate of our participants is very high, given the national average regardless of race being 11.60% ([Merrick et al. 2018](#)). Likewise, our participants rated this particular ACE higher than the national average of Black persons at 13.28%, potentially in part because most of our participants were women. Numerous studies have found that experiencing sexual abuse in one's youth is associated with higher rates of depression, anxiety, PTSD, and suicidality well into adulthood ([Hughes et al. 2016](#); [McTavish et al. 2019](#); [Papalia et al. 2021](#)). [Leath et al. \(2022\)](#) found that Black women who have been impacted by ACEs and endorse the Superwoman schema were more likely to suffer from higher stress, anxiety, and depressive symptoms. The Superwoman schema is characterized by a belief that one needs to be strong for everyone else and one cannot afford to show weakness, which can be conflated with one's religious coping, resulting in a belief that weakness is evidence of a lack of faith in God ([Harris 2021](#)). This may have profound implications for Black female religious leaders as they navigate resistance against their leadership and other forms of sexism within the church ([Rogers and Tinsley 2023](#)).

It is worth noting that the mean ACE scores for participants in this study (2.27) and the national comparison group were both higher than a national sample of Black Americans of varying education levels (1.69) ([Merrick et al. 2018](#)). This was the case despite Merrick and colleagues finding that persons with less education, as well as those with lower income, were more likely to have higher ACE scores. This discrepancy may be accounted for in part by our participants identifying the ACE "living with anyone with a mental illness" at almost twice the rate of Black persons in the general population, 22.1% and 11.14%, respectively ([Merrick et al. 2018](#)). This particular ACE item may be one of the more subjective to identify, and it may be that those with higher education are more likely to identify family members with mental illness. The comparison group in this study, of other highly educated Black persons, identified this particular ACE at 15.1%, which was considerably lower than our sample and higher than the general Black population. Further research needs to be conducted to understand the factors contributing to this discrepancy in prevalence rates. Regardless of why these leaders had higher rates of this ACE, research has shown that persons raised in homes with a person struggling with mental illness were more likely to suffer from depression, anxiety, and struggle with life satisfaction as they got older ([Giano et al. 2020](#); [Hughes et al. 2016](#); [Lanier et al. 2018](#)).

Another unique contribution to this study is the examination of the interaction between Black church leaders' rates of ACEs, their religious coping, and their perceived level of emotional support from their congregation. We found that leaders with higher ACE scores who also reported low levels of positive religious coping (e.g., seeking a stronger connection with God, believing in God's love and care for them) were more likely to experience PTSD symptoms if they perceived low levels of emotional support from their congregation. Similarly, if leaders had higher ACE scores and higher levels of negative religious coping (e.g., wondering whether God is punishing them, questioning God's love, feeling abandoned by the church) and perceived low levels of emotional support, they were more likely to experience PTSD symptoms. Conversely, if leaders had low levels of negative religious coping regardless of their ACEs, their likelihood of experiencing PTSD

symptoms was not affected by the level of their perceived emotional support from their congregation. This has a few implications for church leaders.

It should be noted that participants who had higher rates of ACEs and negative religious coping, coupled with membership in a congregation they perceive as being less emotionally supporting, reported increasingly worse mental health outcomes—particularly as they relate to PTSD and, likely, STS. It may be that personality and developmental factors, such as childhood adversity, contribute to the perception of churches being less emotionally supportive, or it may be that being at less supportive churches may itself be a source of STS. It is also possible that one's past adversity is activated by a lack of emotional support while also influencing one's behavior in a way that decreases emotional support from congregants. The religious support–emotional subscale internal consistency was low for our participants. This may be a result of religious leaders being judiciously cautious in what they share with congregants, which may contribute to the loneliness they experience.

Although leaders have little to no influence over their past experiences of childhood adversity and perhaps limited control over the extent to which they experience emotional support from their congregation, they do have some level of control with regard to their engagement with religious coping. Leaders with higher ACEs may need to put time and energy into ensuring that during difficult seasons within their own lives, they are engaging in positive forms of religious coping, such as spiritual practices that strengthen one's belief that God loves and cares for them (Roggenbaum et al. 2023). In fact, there are many practices within the broader context of Christian contemplative practices (e.g., Wang et al. 2014) and also specifically within the Black contemplative Christian tradition that can help foster a more robust secure attachment with God (Holmes 2017). Christian religious leaders need to be aware that if they have suffered childhood adversity and are serving a congregation that is not emotionally supportive, or even hostile, they may be more likely to suffer from PTSD symptoms. Roggenbaum et al. (2023) found that there is a relationship between negative religious coping and negative religious interactions with congregants. It is possible that negative religious coping might contribute to a leader's relational style, which in turn affects the extent to which the congregation makes itself available for emotional support. The interaction between internalized theological beliefs and experiences with congregants may be more profound than church leaders realize.

Religious leaders are often trained to serve congregants without the expectation of being served or supported in return, beyond an occasional pastor appreciation service. Churches need to cultivate systems where the religious leaders can also receive holistic support from their congregations that encompass not only instrumental or financial support but also support that is emotional and spiritual in nature as well (Smith et al. 2022). Denominations and church networks can connect Black church leaders across congregations with whom they can share openly about challenges to gain emotional support. Seminaries or other contexts in which religious leaders are trained can serve religious leaders by facilitating formation contexts that can increase positive religious coping as well as decrease negative religious coping. Furthermore, seminaries can help future religious leaders better protect themselves from work-related stress and trauma symptoms by being aware of how their own childhood adversity may make them more vulnerable within troubled congregations.

Given the prevalence of police and community violence among these populations, future studies might benefit from using the updated version of the ACEs questionnaire (Finkelhor et al. 2015), which includes additional items that capture adversity and trauma exposure outside the home. Future research is also needed to examine possible connections between the average ACE score of a congregation and the burnout and STS of Black religious leaders over time using longitudinal designs. This may have particular relevance for Black leaders who serve financially under-resourced congregations. Furthermore, longitudinal research would allow scholars to examine whether there is a directional relationship between the positive and negative religious coping of church leaders and the emotional support they experience within their congregations. The lower reliability of

the positive religious coping scale in this study also invites further questions about the validity of that measure in Black religious contexts, parallel to questions in research on positive religious coping among sexual minorities (Heiden-Rootes et al. 2021). Park et al. (2018) found, in a sample of 2370 African Americans, that the reliability for the positive coping subscale was strong at 0.75, and the negative subscale was very low at 0.52. This is the opposite of the reliability found in the Brief RCOPE in our study and invites further inquiry to ascertain the potential differences between Black religious leaders and other Black Americans. It is worth noting that as a construct, negative religious coping can also include numerous forms of spiritual and religious struggle, so it could be helpful to tease out particular forms of struggle that increase trauma risks for Black religious leaders. Prior research with religious leaders from Abrahamic faiths also found PTSD symptoms were positively associated with vulnerable and grandiose forms of narcissism, so future studies might consider including measures of personality and developmental functioning that might help account for associations between religious coping, relational experiences with congregations, and mental health symptoms.

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