CHILDHOOD TRAUMA, HEALTH OUTCOMES AND RESILIENCE FACTORS AMONG ADVENTIST SURVIVORS: IMPLICATIONS FOR CHURCH MINISTRY

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Summary of ACE study findings

• Adverse Childhood Experiences (ACEs) are common, threatening, & often denied.

• ACEs have a profound effect on later addiction, health risks, disease, and death.

• This combination makes ACEs the leading determinant of the health and social well-being of our nation, and the major factor underlying the addictions.

Felitti & Nanda
BACKGROUND: CHILD ABUSE

- **Major Public health problem**
  - 6 million cases/yr of child abuse\(^1\)
  - Lifetime cost/survivor $210,012\(^2\)

- **Adverse Childhood Experiences (ACE)**
  - Child abuse and other family dysfunction (10 categories)\(^3\)
  - Negative Mental/Physical Health Outcomes in adult survivors\(^3\)

- **Mental Health**
  - Depression/anxiety/ PTSD
  - Suicide risk
  - Substance abuse

- **Physical Health**
  - Premature mortality \(^3\)
  - Top 10 killers \(^3\)

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In what ways can the church have a positive impact in reducing the negative outcomes from child abuse and neglect? (choose 3)

- Raise awareness and work on prevention starting in childhood: 29%
- Develop resources and training for seminary students, pastors, lay leaders and health professionals: 14%
- Assist adult survivors in building resilience: 7%
- Make perpetrators accountable and assisting them to access help for behavioral change: 4%
- Refer survivor for mental/emotional care and spiritual counseling: 14%
- Provide opportunity for assessment of traumatic experience and immediate appropriate emotional support as needed: 7%
- Provide a healing, caring and supportive environment: 25%
PROTECTIVE FACTORS AND RESILIENCE

Not all victims of ETS suffer negative health consequences.¹,²

Resilience: A combination of abilities and characteristics that interact dynamically to allow an individual to successfully cope and function above the norm in spite of significant stress and adversity.³

Results in efficient termination of the stress response.³

Few studies on faith-based protective factors

Religious Involvement (RI)

RI: Institutional affiliation, beliefs, practices, or adopted behaviors which are guided by a religious denomination or community of faith.⁴

Intrinsic religiosity (IR)⁴

Religious Coping (RC)⁵

Linked to positive mental and physical health⁴

STUDY DESIGN

• Predictive | cross-sectional design
• Secondary analysis of data from the Biopsychosocial Religion and Health Study (BRHS) – an epidemiological study of Seventh-day Adventists (N=10283) BRHS-1R01AG02634
• The study draws from the society-to-cell model

SEVENTH-DAY ADVENTISTS

- Religious doctrine that promotes disease prevention\(^1\)
- Shared religious tradition (less differences of belief)
- Oversampling of Blacks (36%)
- Less confounding by SES (Education/Income)

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AHS-2
N=96,000
SDA churches
Across US
(R01CA094594)

BRHS –Wave 1
Randomly
Selected
N=20,000

N=11,000
returned
questionnaires

N=10,283
SDAs
(Blacks | Whites)

Results
Aim 1
Aim 2
Aim 3

n=496
Subset
(biomarkers
Collected)

BRHS-Wave 2
(not part of this
dissertation
study)

Integration
of Survey
and biomarkers
results

Results
Aim 4
Blue Lines: Direct effect of variables on health. Early trauma has negative effect on health. Religious involvement indicators have a positive effect on health (except negative religious coping depicted as (-) has a negative effect on health).

Red lines: Decrease the strength of early traumatic stress to health link by moderation through an interaction of early traumatic stress and each religious involvement indicator (except for negative religious coping depicted (+) which accentuates this effect).

Aim 1

Early Traumatic Stress

Sample N=10283

Aim 2 & 3

Religious Involvement Indicators

- Religious Coping
- Intrinsic Religiosity
- Gratitude
- Forgiveness

Health (Mental | Physical)

Early traumatic stress (ETS): Self-report child abuse (sexual, physical, verbal), neglect, witnessed abuse
Mental Health: SF-12 composite mental health scores
Physical Health: SF-12 composite physical health and diabetes risk factors

Religious involvement (RI): Religious coping (positive and negative), intrinsic religiosity, gratitude and forgiveness.
# Demographics

<table>
<thead>
<tr>
<th>VARIABLE, n (%)</th>
<th>MAIN SAMPLE (N=10283)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age, mean (Years)</strong></td>
<td>61.7&lt;sup&gt;a&lt;/sup&gt; &lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>3333(32)</td>
</tr>
<tr>
<td>Female</td>
<td>6946(68)</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
</tr>
<tr>
<td>Blacks</td>
<td>3750(36)</td>
</tr>
<tr>
<td>Whites</td>
<td>6533(64)</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
</tr>
<tr>
<td>≤High or trade sc.</td>
<td>2441 (24)</td>
</tr>
<tr>
<td>Some College</td>
<td>2237(22)</td>
</tr>
<tr>
<td>College degree</td>
<td>3403 (33)</td>
</tr>
<tr>
<td>≥Graduate School</td>
<td>2085 (21)</td>
</tr>
<tr>
<td><strong>Income (Self) mean</strong></td>
<td><strong>$40K (4.4)&lt;sup&gt;e&lt;/sup&gt;</strong></td>
</tr>
<tr>
<td>(past 12months)</td>
<td></td>
</tr>
<tr>
<td>&lt;$10K</td>
<td>5353 (17)</td>
</tr>
<tr>
<td>$11-20K</td>
<td>1987 (20)</td>
</tr>
<tr>
<td>$21-30K</td>
<td>1660 (17)</td>
</tr>
<tr>
<td>$31-50K</td>
<td>2159 (22)</td>
</tr>
<tr>
<td>$51-75K</td>
<td>1233 (13)</td>
</tr>
<tr>
<td>$76-100K</td>
<td>532 (5)</td>
</tr>
<tr>
<td>&gt;$101K</td>
<td>508 (5)</td>
</tr>
</tbody>
</table>

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[https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4969318/]
RESULTS

Early Traumatic Stress Effects on Health

N=10,283  ***p<.0001 Note. ETS (3 and 5 types = secondary findings). Controlled for age, gender, race, income, education.

RESULTS

ETS Effect on Health by Gender

<table>
<thead>
<tr>
<th></th>
<th>Mental Health</th>
<th>Physical Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>-1.93 ***</td>
<td>-2.80 ***</td>
</tr>
<tr>
<td><strong>Males</strong></td>
<td>-1.54 ***</td>
<td>-0.16</td>
</tr>
<tr>
<td><strong>Females</strong></td>
<td>-2.08 ***</td>
<td>-3.20 ***</td>
</tr>
<tr>
<td><strong>Combined ETS (≥1)</strong></td>
<td>-1.53 ***</td>
<td>-2.01 ***</td>
</tr>
<tr>
<td><strong>Combined ETS (5)</strong></td>
<td>-3.20 ***</td>
<td>-3.30 ***</td>
</tr>
</tbody>
</table>

N=10,283

**p<.001
**p<.01
*p<.05

RESULTS

ETS Effect on Health by Race

<table>
<thead>
<tr>
<th></th>
<th>Combined ETS (≥1)</th>
<th>Combined ETS (5)</th>
<th>Combined ETS (≥1)</th>
<th>Combined ETS (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>-1.93</td>
<td>-2.80</td>
<td>-1.53</td>
<td>-3.20</td>
</tr>
<tr>
<td><strong>Blacks</strong></td>
<td>-1.90</td>
<td>-1.74</td>
<td>-0.95</td>
<td>-1.50</td>
</tr>
<tr>
<td><strong>Whites</strong></td>
<td>-1.93</td>
<td>-3.41</td>
<td>-1.85</td>
<td>-4.24</td>
</tr>
</tbody>
</table>

N=10,283

**Mental Health**

**Physical Health**

Religious Involvement effects on Health

**N=10,283**  
**p<.01**  
**p<.0001**

Note. Controlling for age, gender, race, income, Education.

<table>
<thead>
<tr>
<th></th>
<th>Mental Health Score (B)</th>
<th>Physical Health Score (B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrinsic Religiosity</td>
<td>1.78 ***</td>
<td>0.39 ***</td>
</tr>
<tr>
<td>Positive Religious Coping</td>
<td>2.08 ***</td>
<td>0.4 **</td>
</tr>
<tr>
<td>Negative Religious Coping</td>
<td>-4.89 ***</td>
<td>-1.7 ***</td>
</tr>
<tr>
<td>Forgiveness</td>
<td>2.36 **</td>
<td>0.34 **</td>
</tr>
<tr>
<td>Gratitude</td>
<td>3.36 ***</td>
<td>1.5 ***</td>
</tr>
</tbody>
</table>

Adjusted Predictions of EarlyTrauma on Mental Health with 95% CIs

Moderation by Positive Religious Coping

Mental Health Scores

Positive Religious Coping

EarlyTrauma=No  EarlyTrauma=Yes
Adjusted Predictions of Early Trauma on Mental Health with 95% CIs
Moderation by Negative Religious Coping

B = -.05, ns
Adjusted Predictions of EarlyTrauma on Mental Health with 95% CIs

Moderation by Intrinsic Religiosity

B=.71, p<.05
Adjusted Predictions of EarlyTrauma on Mental Health with 95% CIs

Moderation by Forgiveness

Mental Health Scores

Forgiveness

B = .87, p < .01

EarlyTrauma=No

EarlyTrauma=Yes
Adjusted Predictions of EarlyTrauma on Mental Health with 95% CIs

Moderation by Gratitude

Gratitude

Mental Health Scores

B = .32, p < .05

EarlyTrauma=No

EarlyTrauma=Yes
SUMMARY OF FINDINGS
(OVERALL SAMPLE)

• Prevalence of ETS in this population is higher than other ACE studies – women > men, Blacks > Whites.
• The negative ETS-Health is significant (and dose dependent).
• IR, PRC, Gratitude and forgiveness significantly reduced negative effect of ETS on mental health.
• A gender difference was noted on the RC moderation of the effect ETS had on physical health (For women NRC accentuates the negative effect of ETS on physical health, while for men it does not).
SUMMARY OF FINDINGS: GENDER AND RACIAL DIFFERENCES

PREVALENCE

• **Women**: Higher prevalence than men for at least 1 or all subtypes except for physical abuse

• **Blacks**: higher prevalence than whites except for neglect.

ETS-HEALTH EFFECT

• **Women**: worse negative mental and physical health effect than men

• **Whites** had worse physical health with White women having 2x as much as White men.

Religious Coping

Intrinsic Religiosity

Gratitude

Forgiveness

Early Traumatic Stress

Mental Health

Religious Involvement Indicators

Sample N=10283

DATA SUPPORTED: ETS-RI-Mental Health Model

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4969318/

* p<.05
** p<.01
The Role of the Church

1. Engage in awareness, prevention and resilience building strategies.
2. Enforce accountability and clarify distorted notions of love, forgiveness and healthy relationships.
3. Provide acceptance, support, community and a healing environment for survivors and perpetrators.
4. Develop training/resources, referrals, ongoing research.
5. Ensure Comprehensive Health Ministry includes trauma informed care and education.
Based on findings of this report, what can the church do to help survivors experience healing and better health (choose 5 things)

- Raise awareness and work on prevention: 15%
- Develop resources and training for seminary students, pastors, lay leaders and health professionals: 11%
- Build resilience by discouraging negative religious coping: 15%
- Build resilience by encouraging gratitude and positive religious coping: 12%
- Build resilience by encouraging a deeper connection and relationship with God daily: 8%
- Build resilience by encouraging the survivors to cultivate forgiveness appropriately: 9%
- Make perpetrators accountable and assisting them to access help for behavioral change: 3%
- Refer survivor for mental/emotional care and spiritual counseling: 5%
- Provide opportunity for assessment of traumatic experience and immediate appropriate emotional support as needed: 6%
- Provide a healing, caring supportive trauma informed ministry: 19%
REFERENCES

- **Reinert, K.** Campbell, J., Bandeen-Roche, K., Szanton, S., & Lee, J (December, 2015). The role of religious involvement in the relationships between early trauma and health outcomes among adult survivors. *Journal of Child and Adolescent Trauma, 8*(4).
