Pastors' Level of Adverse Childhood Experiences in Sub-Sahara Africa

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ABSTRACT

The study investigated the Pastors' level of Adverse Childhood Experiences (ACEs) using a descriptive design on a sample of 304 pastors in the East-Central Africa (ECD), West-Central Africa (WAD), and Southern Africa-Indian Ocean Divisions (SID) of the Adventist Church. Data from the self-constructed questionnaire was analyzed using SPSS 27 and SmartPLS 4.0 for statistical treatment. The pastors in the three Divisions (ECD, WAD, SID) exhibited a low level of ACEs. It is a sigh of relief that pastors in Sub-Sahara Africa have low levels of Adverse Childhood Experiences. Eight out of ten pastors are being disturbed by those who attempted or committed suicide of a close of kin. Two out of five are being disturbed by parental bereavement before 18 years. Four out of 10 pastors still nurse the effects of physical abuse from caretakers. Fifteen percent suffer from earlier lack of parental care while 24% nurse scars from battering. Forty percent still nurture the bereavement of nearest of kin. There is no significant difference in the levels of ACEs when age is considered. Future research would study the level of ACEs among ministerial spouses and children

Keywords: Pastors. Adverse Childhood Experiences. East-Central Africa. West-Central Africa. Southern Africa-Indian Ocean Divisions.

INTRODUCTION

Adverse Childhood Experiences (ACEs)

Adverse childhood experiences (ACEs) are types of stressful and traumatic events - including parental death, abuse physical, psychological, and sexual, neglect, and dysfunction - that occur before the age of eighteen (18) in the home. These cause long-term harm to one's physical, mental, emotional, spiritual, relational, and behavioral well-being (Felitti et al., 1998; Felitti et al., 2019). ACEs are associated with a higher risk of long-term behavioral problems and chronic illnesses in adulthood (Folger, 2018; Lê-Scherban et al., 2018; Madigan, 2017).

Studies have been conducted on the intergenerational effects of ACEs among infants (Folger, 2018; Madigan, 2017), and adolescents (Lê-Scherban, 2018), and the fetal effects of mother lifetime trauma exposure (Flom, 2018). However, there is a paucity of literature on pastors and seminary students who face stresses and trauma at work, juggle as students, as well as being spouses, and parents. ACEs are associated with a higher risk of long-term behavioral problems and chronic illnesses in adulthood.

According to Varga (2016), 26 percent of graduate students had lost significant people in the previous 24 months. Emotional disruptions were among the various grieving symptoms, but they were lessened by friends and family support. Prolonged grief disorder was encountered by a few of them (PGD). It causes a loss of sleep, excessive suicide ideation, impairment in health, and lower quality of life. This results in sleep disturbances, increased suicidal thoughts, health problems, and a lower standard of living. Although prolonged grief disorder is uncommon in undergraduate students, it is more common as people age. It was suggested by the Diagnostic and Statistical Manual of Mental Disorders (5th ed.) (American Psychiatric Association, 2013) that more research was necessary because complex bereavement disorder (CBD) exhibited symptoms that were similar to those of PGD.

Studies show that behavioral problems were common among children whose mothers had ACEs. The problems included emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and prosocial behavior (Doi et al., 2021). De Venter et al. (2013) observed that traumatic childhood experiences affected adulthood in the physical domain. The predisposing risk factors not only include childhood exposure to physical child abuse but also sexual child abuse, family violence, physical neglect, and substance abuse. There was a strong correlation between ACEs and later diagnoses of depressive and anxiety disorder and eventually future mental health of victims.

In another study, it was found that high ACE scores of parents predisposed children to poor overall health status, asthma diagnosis, obesity, low fruit and vegetable consumption, soda consumption, inadequate physical activity, and excessive television watching (Lê-Scherban, 2018). This is so because maternal lifetime trauma exposure is more likely to affect the hypothalamic–pituitary–adrenal (HPA) axis after a traumatic event (Bosquet et al., 2017). This dysfunction of HPA in mothers directly impacts the critical period of fetal brain development through higher exposure to cortisol resulting in mental health problems in offspring. There are psychological effects. Maternal psychological distress and poor parenting skills from the presence of ACEs were associated, associated with a higher risk of pregnancy in young adulthood, intimate partner violence (IPV) in adulthood (Li et al., 2019), and sour marital relationships.

Early research (Felitti et al., 1998) in the United States revealed that about half of the study samples had experienced at least one adverse event, while a quarter had suffered two adverse events. Besides, it was found that for each adverse experience, individuals had a corresponding increase in health challenges, such as higher levels of alcoholism, smoking, drug abuse, depression, and suicide attempts. In a mediation analysis (Doi et al., 2021) for the mediation effects of maternal psychological distress, economic status, maternal positive parenting behaviors, child maltreatment, and parental loss for children, there was a strong association between maternal ACEs and child behavioral problems. Liu et al. (2021) observed that ACEs were positively associated with suicidal ideation, suicidal attempts, major depressive disorders, and substance abuse.

ACEs among Pastors

The prevalence of ACEs is concerning and has far-reaching effects. According to the literature. They are pieces of evidence of the pastor's exposure to childhood psychological, physical, and sexual abuse as well as household dysfunction including domestic violence, substance use, and incarceration. Research (Liu et al., 2021) over several decades has demonstrated a strong causal relationship between ACEs and challenges related to overall well-being in adulthood (De Venter, 2013). Pastors experienced emotional abuse at roughly the same rates as the general population, but their rates of physical and sexual abuse were consistently higher. In addition, emotional neglect was more common among pastors' samples than physical neglect, but this relationship did not hold for physical neglect (Cincala & Drumm, 2021; Sedlacek & Drumm, 2023).

The degree of pastoral stress has revealed startling insights into the emotional needs of pastors in the United States, according to a related study published in Ministry Magazine (Sedlacek & Drumm, 2023). Although pastors do not often report such extreme effects from childhood difficulties, their distress can present itself in discouragement, spiritual dryness, and burnout (Frederick et al., 2021). The results from ACE studies (Aldawsari et al., 2018; Doi et al., 2021) suggested that, at least in part, such afflictions should be addressed by dealing with childhood trauma.

In addition, pastors were less likely than the general population to have a parent who struggled with alcohol or drugs, but they were more likely to have parents who experienced depression or mental illness, or who had attempted suicide. Finally, pastors were less likely to have a family member incarcerated. Studies (Cincala & Drumm, 2021; Sedlacek & Drumm, 2023) confirmed that pastors were more likely than the general population to have parents who were separated or divorced, but more likely to experience domestic violence.

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(Apple et al., 2016; Doi et al., 2022) suggested that, at least in part, such afflictions should be addressed by dealing with childhood trauma

It is important to note that current statistics (Cincala & Drumm, 2021) for the general population indicate that 67 percent have one or more ACEs, but among our pastor sample, this figure was 87 percent. Literature has demonstrated this situation to be worrisome because having at least one ACE predicts the probability of chronic physical illness, emotional challenges, and self-destructive behavior. More importantly, 12.5 percent of the general population have four or more ACEs compared to 24 percent of pastors. Having four or more ACEs leads to an exponential increase in physical, emotional, and behavioral challenges.

The researchers (Cincala & Drumm, 2021) hoped that both pastors in training and the field would begin to address their trauma, thus growing in resilience and commitment to self-care. Addressing it—a sometimes painful process—may involve trauma resources or education and counseling. As a result, pastors will then be able to take the lead in creating trauma-informed churches that will help church members face their ACEs. Such congregations will, in turn, become safe places for people in the surrounding communities to find healing. Church members who have been healed themselves will become vital channels to bring healing to others.

According to the literature (Cincala & Drumm, 2021), pastoral training typically does not prepare pastoral workers to handle the influence of their own emotions or the emotions of those they serve. They confessed to having the competence in knowing what the Bible stands for, but for emotions, they have no idea how to handle it. Besides, pastors are frequently viewed by their parishioners as sources of support in addition to their own emotional lives. Pastors who have personally healed from their emotional pain might appreciate mental health services and the importance of helping others who are hurting emotionally. The effects of ACEs have emotional, spiritual, and moral injury and countertransference in ministry (Cincala & Drumm, 2021).

Emotional problems

This earlier research suggested that parental loss and grief from parents may also mediate the relationship between maternal ACEs and mental health issues in children; however, little is known about the mediating effects of low SES in adulthood (Li et al., 2019). Varga (2016) noted that an improper transition had detrimental impacts on the individual. De Venter (2013), observed in a study on the effects of adverse childhood experiences and mental in adulthood that traumatic childhood experiences had a lasting impact on adulthood and had far-reaching problems that included depression, anxiety, substance abuse, marital problems, and divorce.

Parents who were more exposed to ACEs were more likely to have children with behavioral health issues, according to a study on the impact of parents' ACEs on their children's behavioral health via intergenerational hazards associated with ACEs (Thomas et al., 2018). Children whose parents had four or more ACEs were impacted. The kids scored 2.3 points higher on the behavioral issues test on average, and they were 2.1 times more likely to be hyperactive, 4.2 times more likely to be diagnosed with attention-deficit/hyperactivity disorder, and emotionally disturbed. Compared to paternal ACEs, maternal ACEs showed a larger correlation with behavioral issues in children. If parents' emotional anguish and annoyance acted as a mediator between ACEs, the situation became more convoluted. Consistent with this, Doi et al. (2021), confirmed that adolescent offspring of mothers with a larger number of ACEs exhibited significant levels of behavior disorders, including depressive symptoms.

According to a similar study, a mother's lifetime trauma exposure affects her infant's disposition. A child born to expectant mothers who experience trauma in the third trimester is more likely to exhibit negative affectivity dimensions such as fear, sorrow, distress reactivity, recovery, and later adult personality traits such as neuroticism (Bosquet et al., 2017). Post-Traumatic Stress Disorder and Major Depressive Disorders have been linked to young individuals in universities who were exposed to ACEs before the age of 18 (Rebbe et al., 2018).

Our mediation studies (Letourneau et al., 2019) revealed a connection between adult mental health issues and

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maternal ACEs. Although there is little evidence of a mediation effect between maternal positive parenting practices and child maltreatment, maternal psychological distress mediates 49.5% of the association between maternal ACEs and behavioral problems in children and 44.2% of the association between maternal ACEs and depressive symptoms in children. Besides, maternal ACEs also indicate psychological discomfort in mothers, which can impact SES and parenting practices today. This discovery could clarify the link between ACEs experienced by mothers and mental health issues in their offspring.De Venter (2013) posited that while family violence and sexual child abuse were the greatest risk factors for anxiety disorders, there were also strong correlations found between substance abuse and family violence or physical neglect. It appears that family violence and child abuse are the main factors that have a major impact on victims' future mental health. On average, the occurrence of emotional, sexual, and physical child abuse was the most important risk factor for the development of depression.

Spiritual problems

In addition to dealing with mental health issues, young persons selected from a southeastern institution were shown to struggle with their religious faith and/or spirituality (Bosquet et al., 2017). The literature suggests that specific Religious and Spiritual struggles, such as divine struggles, demonic struggles, interpersonal struggles, moral struggles, meaning struggles, and doubt struggles, may have an impact on the relationship between ACEs and mental health, even though research on the relationship between ACEs and major mental health symptoms like PTSD and MDDs is still lacking (McCormick et al., 2017).

Mefford et al. (2021) noted that when the impacts of adverse childhood experiences (ACEs) were controlled, there were higher levels of hope and forgiveness in a study on childhood loss experiences, religious/spirituality, and hope as predictors of adult life satisfaction. Meanwhile, adult life satisfaction was significantly predicted by ACE. Higher life satisfaction was solely predicted by forgiveness, values/beliefs, and hope after adjusting for the effects of chronic sorrow. The study found that treatments aimed at increasing forgiveness and hope could help adult survivors of early-life losses have a higher degree of life satisfaction. Adults who had ACEs require assistance in navigating their religious and spiritual beliefs in light of the loss they experienced as children.

Moral injury

There have been reports of preachers who are morally wounded. A moral injury is a wound that results from doing something—or not doing something—that goes against one's core principles and beliefs. Ramsay (2019) noted that moral harm results from a person doing, not stopping, or seeing acts that go against their moral convictions, which causes a great deal of internal struggle. It is characterized by a variety of psychological, social, and spiritual effects. Moral injury is a distressing experience that arises from a violation of personal ethics. This betrayal can upset a person's moral compass and sense of self, therefore healing requires a multimodal approach that includes both spiritual and psychological help.

Moral injury, according to Coady et al. (2021), is the term used to characterize the psycho-socio-spiritual distress that may ensue from potentially morally harmful occurrences. This includes doing or not doing anything that goes against strongly held beliefs about right and wrong, as well as seeing or personally being affected by the actions or inactions of others. It is further proposed that moral harm involves changes in spirituality and religiosity as well as concerns about meaning and purpose. Clinically speaking, because of the link between adverse childhood experiences, social problems, and adult mental and physical health, the presence of ACE can be utilized to help guide treatment. High ACE score holders will validate their experiences and learn more about their higher risk factors for health problems. Interventions that assist the mental health of the pastors who scored highly and encourage the development of adaptive behaviors are probably going to help them.

Higher ACE scores were associated with mental health issues in later life. According to Felitti et al. (1998), there are health risks associated with certain behaviors in adulthood, including substance abuse, major health issues, depression, suicidal thoughts and attempts, alcoholism, smoking, increased sexual partner count, inactivity, severe obesity, STDs, a higher risk of broken bones, heart disease, lung disease, liver disease, and

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multiple cancer types. Higher risks of mental illness, aggression, chronic disease, becoming a victim of violence, and several other outcomes are among the others. According to Nurius et al. (2012), having a high ACE score increases the likelihood of developing depression, PTSD, relationship issues, emotional distress, poor work performance, financial difficulties, ongoing family issues, high levels of stress, and an inability to regulate anger.

The client is more likely to develop social, mental, or other well-being issues if they have a higher score and a history of bad childhood events. Most adults (52%–75%) receive a score of one or higher on the ACE (Ford et al., 2011). A score of four or above was regarded as clinically significant. A small percentage of the general population (5%–10%) receive a score of 4 or higher, at which point the effects on long-term general health become most noticeable. Individuals with an ACE-Q score of 4 are twice as likely to smoke, five times more likely to experience depression, seven times more likely to be alcoholic, ten times more likely to use illegal substances, and twelve times more likely to attempt suicide as compared to those with an ACE-Q score of 0 (Hughes et al., 2017).

Pastor's countertransference

Činčala and Drumm (2021) found that the pastors' samples had greater levels of emotional neglect, but not physical neglect. Whereas 67% of people in the general population reported having had one or more ACEs, 87% of the pastor sample had the same experience. Furthermore, pastors were twice as likely to experience physical, emotional, and behavioral difficulties as the general population (12.5%), although only 24 percent of pastors reported having four or more ACEs.

Corey and Corey (2010) enumerated countertransference symptoms. These include: 1. a persistent need to please the client; 2. a loss of objectivity due to identification with the client's problems; 3. the development of sexual or romantic feelings toward the client; 4. the compulsive giving of advice; and 5. the desire to build a social relationship with the client. Moreover, these include: 6) never challenging the client for fear of losing their love; 7) avoiding confrontation out of anger; 8) satisfying her needs for intimacy; 9) providing longer sessions than the client needs; 10) last-line syndrome from selective listening; 11) dispensing needless advice out of a need to be an authority figure; and 12) placing too much value on the client's progress for her success.

One of the most important journals published by Watkins (1985) described countertransference as the pastor becoming too protective because they are overwhelmed by the member's situation. Concordant identification is another term for this situation, in which the pastor identifies as their client. Second, there is benign, in which the pastor becomes too attached to the member and over-identifies with them. There are three types of rejection: third, hostile, and, in the last case, disidentification. The client and the pastor are emotionally distant from one another.

Watkins (1985) and Gladding (2013) provided strategies for handling countertransference. The pastors' awareness of the warning signs is included in this list. In addition, it necessitates introspection on one's personal development as a pastor. The unresolved issues of abuse, neglect, divorce, inferiority complex, job satisfaction, and post-election wounds should be addressed by the pastors. The pastors should focus on your blind spots, hidden areas, and undiscovered portions of your life according to the Johari Awareness Model.

Gladding (2013) provided the following list of useful strategies for handling countertransference in pastoral service. Prioritize the needs and expectations of the client first. Second, the pastor needs to pay close attention to all of his senses. Thirdly, it entails building the member's and pastor's trust. Fourthly, the pastor should take the client's lead when assisting. Fifth, perspective-taking, or cognitive empathy (Spaulding, 2017) is a crucial skill to have. The ability of the assistant to enter the client's amazing world and experience it as if it were your own without losing the "as if" characteristic is known as cognitive empathy. "You can let yourself go into the world of another person and still know that you can return to your world" is what personal security is all about. All of your emotions are "as if."

Regarding demographics, Shannon (2023) confirmed that while cognitive empathy skills remained mostly consistent throughout adulthood, they progressively decreased in those over 65, with a particularly noticeable

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reduction in those over 75. At all ages, female performance outperformed that of males. Early adulthood is when cognitive empathy reaches maturity, and as people age, it gradually diminishes. Bracketing personal emotions before, during, and following sessions is one of the final three pieces of advice. Taking care of personal matters that surface is a good idea. To lessen the possibility of countertransference, the alternative method involves centering and attentive breathing. Terminating the assisting session and referring the client to another pastor or assistance is the final, professional technique to prevent countertransference.

There is a dearth of studies on ACEs among Adventist clergy. Besides, Joseph (2015) emphasized the importance of using positive psychology to assist people reach well-being. In response to the population, methodological, and knowledge gaps, the study purposed to assess the extent of the level of ACEs among Adventist pastors in Sub-Saharan Africa using a quantitative descriptive design.

Research Questions

The study aimed to determine the extent of Adverse Childhood Experiences in the three Adventist Divisions in Sub-Sahara Africa. Specifically, the study sought to address the following questions:

1. What is the extent of experience of ACEs of Pastors in Sub-Sahara Africa?
2. Is there a significant difference in the level of ACEs when personal profiles in terms of age, and territory are considered?

Hypotheses

The study will test the following null hypothesis. There is no significant difference in the level of ACEs when personal profiles in terms of age, and territory are considered.

METHODOLOGY

The section highlights the research design, population and sampling technique, personal profile, instrumentation, data gathering procedures, ethical considerations, and data analysis procedures.

Research Design

This study was a quantitative study specifically employing descriptive and inferential statistics to analyze the relationships by applying the Partial Least Square Structural Equation Modeling (PLS-SEM-4.0). This research design attempts to understand the kind of relationships occurring naturally between variables (Hayes, 2018). In this study, the Pastor's Woundedness was sought and how it related to personal profiles in terms of age and territory of work.

Population and Samples and Sampling Techniques

This research involved pastors within the 3 Adventist Church divisions in Africa – East-Central Africa (ECD), West-Central Africa (WAD), and Southern Africa-Indian Ocean (SID) Divisions. According to the statistical Report from the Office of Archives, Statistics, and Research (2024), ECD had 3,760, SID had 2,041 and WAD had 1,784 ordained and licensed ministers spread across the 38 Unions. The sample taken involved clergy working as pastors in the district, local church, Conference and Union department directors, and those working the chaplaincy facets (Schools, prisons, healthcare, and Disciplined forces).

Purposive sampling was used to select the Unions. The selection criteria for the Unions whose Conferences/Fields/ Missions to participate included the following: 1/ The entity must have more than 130 ordained pastors, 2/ must be using English as the major language to avoid translations, 3/ must have the number of ordained pastors greater than licensed ministers. These criteria will utilize West Congo Union having 3 entities with 137 ordained pastors, the West Kenya Union Conference with 6 entities having 344 ordained pastors, and the East Kenya Conference having 11 Conferences/Fields/ Missions with 308 ordained pastors – all in ECD territory. SID territory will have the Indian Ocean Union with 10 Conferences/Fields/ Missions having 134 ordained pastors, the Malawi Union with 3 entities with 169 ordained pastors, and the

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Southern Africa Union with 8 entities having 202 pastors. WAD territory will have the Northern Ghana Union with 11 entities having 166 ordained ministers. Other Unions include the Eastern Nigeria Union with 16 entities having 155 ordained and the Southern Ghana Union with 12 Conferences/Fields/ Missions having 133 ordained pastors (Office of Archives, Statistics, and Research, 2024).

The formula for calculating a sample for proportions of populations according to Cochran (1963) who developed Equation 1 to yield a representative sample for proportions.

$$n_o = \frac{Z^2pq}{e^2}$$

This is valid where n_0 is the sample size, Z2 is the abscissa of the normal curve that cuts off an area α at the tails (1 - α equals the desired confidence level, e.g., 95%)1, e is the desired level of precision, p is the estimated proportion of an attribute that is present in the population, and q is 1-p. The value for Z is found in statistical tables which contain the area under the normal curve.

$$n_o = \frac{Z^2pq}{e^2} = \frac{(1.96)^2(.5)(.5)}{(.05)^2} = 385$$

Given that the total number of ordained pastors is 3736 as of 2015, the sample size will be calculated thus,

$$n = \frac{n_o}{1 + \frac{(n_o - 1)}{N}}$$

n = 385 divided by (1 + (385 – 1) over N
385 divided by ((1 +(384 over 7585))
385 divided by (1+0.0506) = 385 divided by 1.0506)
n = 385 over 1.0506
n = 366 was the targeted sample size

Convenience sampling was used to pick the pastors from the Conferences, Fields, or missions. With a consent form attached and necessary permits, whoever was willing to respond to an email or WhatsApp message participated. The participants responded to the online questionnaire on Google Forms. The study had a final sample size of 304 pastors.

Personal profile.

This contained variables such as age, sex, and their current workstation.

Table 1 Demographic profile of the respondents

Profile	**Variable**	**Frequency**	**Percent**
Sex	Male	292	96.1
	Female	12	3.9
Age	Below 39 years	106	34.9
	Above 40 years	198	65.1

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Division	East-Central Africa Division (ECD)	130	42.8
	West-Central Africa Division (WAD)	72	23.7
	Southern Africa-Indian Ocean Division (SID)	102	33.6
Taken CPE	Yes	129	42.4
	No	175	57.6
Current Workstation	District/ Church Pastor	179	58.9
	Director Union/ Conference/ Field	73	24
	In a Chaplaincy Facet (School, Hospital, Prisons, Disciplined Forces)	52	17.1

The results indicated the following. In terms of age, the participants (n=304) distribution indicated that 65.1% were aged above 40 while 34.9% were below 39 years. In terms of sex, 96.1% were males while 3.9% were females. In terms of the Division of work, 23.7% are from WAD, 33.6% are SID, and 42.8% hailed from ECD.

In terms of training, 57.6% have not taken CPE while 42.4% have at least one unit of CPE. On CPE, this finding is contrary to existing data based on the number of pastors from the 3 Divisions (ECD, WAD, and SID) who have done CPE. ECD has 107 out of 3760 pastors, WAD has 115 out of 1784 pastors, while SID has 80 out of 2041 pastors that have done CPE. In general, out of 7,585 pastors on the continent of Africa, only 302 representing 3.98% have at least one Unit of CPE as of February 2025. Besides, it becomes more interesting since out of the participants, 42.4% indicated to have done while 57.6% of pastors have not done at least one Unit of CPE. This phenomenon could be explained by the fact that there's an ongoing emphasis on Clinical Pastoral Orientation training on the continent as well as the presence of CPE training at AUA and Babcock.

As for the current workstation, 58.9% are District/ Church Pastors, 24% are Directors at Union/ Conference/Field/Mission, and 17% are working in Chaplaincy Facets (School, Hospital, Prisons, Disciplined Forces).

Instrumentation

Self-constructed questionnaire on psychological well-being was based on literature. The questionnaires were subjected to external and internal validation by experts and statistical processes and had good statistical properties. The instruments' external validation was carried out by three specialists from the Adventist University of Africa. To verify internal consistency, the Cronbach alpha for each variable in the instrument was calculated in SPSS, with the Cronbach Alpha being computed. For coefficients were expected to have a Cronbach Alpha at or greater than 0.7 to have good acceptable statistical properties.

Adverse Childhood Experiences Scale

This refers to stressful and traumatic events that occurred during childhood, such as abuse (physical, psychological, or sexual), neglect, parental death, or dysfunction in the home, before the age of eighteen, and

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which have a long-term negative impact on an adult's physical, mental, emotional, spiritual, relational, and behavioral health. This variable had 9 items with a Cronbach's alpha of 0.747. The ACEs scale had an acceptable internal consistency.

Ethical Considerations

Given that the respondents were from a homogenous population, approval from the University's Ethics Review Board was secured, and the National Commission for Science Technology and Innovation (NACOSTI), an agency in Kenya. A consent form to request permission to participate in the study was embedded in the online Google Forms. It made clear to participants that this study was a voluntary activity. They were guaranteed the freedom to exit after reading the consent form or whenever they so wanted. Confidentiality and anonymity of participants were ensured. A participant who experienced emotional disruptions during data collection was assured of online psychological first aid as well as free counseling sessions by the principal investigator who has counseling as well as CPE skills.

RESULTS AND DISCUSSION

This section presents the meaning and implications of the results of all the questions. The findings in the tables below foster a better understanding of the study.

The Pastors' Level of Psychological Wellbeing

The following are the findings of the question: What is the level of psychological well-being of the pastors in terms of self-acceptance, positive relationships, autonomy, environmental mastery, and personal growth?

The Pastors' Level of Experiences of Adverse Childhood Experiences

The following are the findings of the question: What is the extent of experience of the pastors' Adverse Childhood Experiences?

The descriptive statistics indicated that the following childhood experiences before 18 years still disturb them. Four out of 10 pastors experienced physical slaps, beating, or repeated threats by their mother/father/ or stepmother as well as experienced bereavement of a parent that still haunts them. Eight out of ten experienced an attempted or committed suicide of a family member. Fifteen percent experienced a lack of parental care while 24% agreed that someone hit them so hard that they had marks or got injured. Forty percent still nurture grief of a close relative.

Table 2 The Pastor's Level ACEs Comparing Ages

	Age	N	M	SD
Adverse Childhood Experiences	Below 39	106	1.9864	.57166
	40 and Above	198	2.0152	.53757

The results bespeak that the pastors aged above 40 years experienced higher levels of ACEs that affect them. The results are contrary to the literature. Grigsby et al. (2020) opined that there were no significant differences in the levels of ACEs based on gender and was more prevalent for late childhood than at age 6 (Leban & Delacruz, 2023). Pastors experienced emotional abuse at roughly the same rates as the general population, but their rates of physical and sexual abuse were consistently higher. In addition, emotional neglect was more common among pastors' samples than physical neglect, but this relationship did not hold for physical neglect (Cincala & Drumm, 2021; Sedlacek & Drumm, 2023).

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Table 2 The Pastor's Level Adverse Childhood Experiences

Sub-variable	M	SD	Scaled Respo	Verbal Inter
My experiences before I was 18 years old				
1. Physical slaps, beating, or repeated threats by mother/father/ or stepmother	2.36	1.008	Disagree	Low
2. Attempted or committed suicide of a family member	1.57	.785	Disagree	Low
3. Family member was imprisoned, was a difficulty person, a problem drinker or alcoholic	1.86	.919	Disagree	Low
4. Loss of a parent	2.40	1.187	Disagree	Low
5. Separation or divorce of my parent/s	1.78	.992	Disagree	Low
6. The parents did not take care of me	1.73	.823	Disagree	Low
7. I felt one closer to me	2.02	.871	Disagree	Low
8. Someone hit me so hard that I had marks or got injured.	1.94	.933	Disagree	Low
9. Traumatic death of a close relative	2.39	1.013	Disagree	Low
Pastor's Level of ACEs	**2.00**	**0.95**	**Disagree**	**Low**

Scoring system: 4:00 – 3.50= Strongly Agree=Very High; 3.49 – 2.50= Agree=High; 2.49 -1.50=Disagree= Low; 1.49 – 1.00= Strongly Disagree=Very low.

The results from participants (N=304), demonstrate that the pastors' level of ACEs is low (M = 2.00, SD = .95). The results are contrary to the literature. Statistics in the US (Cincala & Drumm, 2021) posited that 67% of the general population had one or more ACEs, but among the pastor sample, this figure was 87 percent. More importantly, while 12.5 percent of the general population had four or more, the pastors had 24 percent of the ACEs. ACEs are stressful and traumatic events that occur before the age of eighteen (18) and cause long-term harm to one's physical, mental, emotional, spiritual, relational, and behavioral well-being and are associated with a higher risk of long-term behavioral problems and chronic illnesses in adulthood (Felitti et al., 1998; Felitti et al., 2019).

According to Ford et al. (2011), most adults with a score of four or above were regarded as clinically significant. Having four or more ACEs leads to an exponential increase in physical, emotional, and behavioral challenges. Individuals with an ACE-Q score of 4 are twice as likely to smoke, five times more likely to experience depression, seven times more likely to be alcoholic, ten times more likely to use illegal substances, and twelve times more likely to attempt suicide as compared to those with an ACE-Q score of 0 (Hughes et al., 2017).

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Isn't it a sigh of relief that the pastors in Africa have low levels of ACEs? If found, it would be worrisome because having at least one ACE would predict the probability of chronic physical illness, emotional challenges, and self-destructive behavior in adulthood which can be displaced to church members through countertransference.

Literature (Cincala & Drumm, 2021; Sedlacek & Drumm, 2023) hoped that both pastors in training and the field would begin to address their trauma, thus growing in resilience and commitment to self-care. As a result, pastors will then be able to take the lead in creating trauma-informed churches that will help church members face their ACEs. Such congregations will, in turn, become safe places for people in the surrounding communities to find healing. Church members who have been healed themselves will become vital channels to bring healing to others.

The Differences in Levels of ACEs when Personal Profile

The results tables presented in this part answer the research question: Is there a significant difference in the level of ACE when personal profile is considered?

The Differences in ACEs Considering Age

The table presented in this part answers the research question: Is there a significant difference in the level of ACEs when age is considered?

Table 3 T-test results Comparing Ages Below 39 years and Above 40 years old on ACEs

				Levene's Test for Equality of Variances		t-test for Equality of Means						
											95% Confidence Interval of the Difference	
		Mean	SD	F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
ACEs	Below 39 years old	1.986	.571	.539	.463	-.435	302	.664	-.028	.066	-.158	.101
	Above 40 years old	2.015	.537									

F(df) = -.435 (302); NS =Not Significant

An independent sample t-test was conducted to compare the level of ACEs among aged Below 39 years and Above 40 years old. There were no significant differences t(302), = -.435, p = .664) in the scores with the mean score for ages Below 39 years (M = 1.986, SD =.571) lower than Above 40 years (M = 2.015, SD = .537). The magnitude of the difference in the means (mean difference = -.028, 95% CI: -.066 to .101) was not significant. Hence, the hypothesis that there is no significant difference in the level of ACEs among pastors when age is considered is supported.

This result means that regardless of age, pastors experienced ACEs – the stressful and traumatic events that occurred during childhood, such as abuse (physical, psychological, or sexual), neglect, parental death, or dysfunction in the home, before the age of eighteen, and are currently being affected in ministry in terms of

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physical, mental, emotional, spiritual, relational, and behavioral health.

The findings agree with the literature. According to Ford et al. (2011), most adults (52%–75%) receive a score of one or higher on the ACE A score of four or above was regarded as clinically significant. Regarding demographics, Dorris et al. (2022) confirmed that while cognitive empathy skills remained mostly consistent throughout adulthood, they progressively decreased in those over 65, with a particularly noticeable reduction in those over 75.

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This section presents the meaning and implications of the results of all the questions. The findings in the tables below foster a better understanding of the study.

SUMMARY OF FINDINGS.

In general, the pastors in Sub-Sahara Africa exhibited a low level of Adverse Childhood Experiences. If found, it would be worrisome because having at least one ACE would predict the probability of chronic physical illness, emotional challenges, and self-destructive behavior in adulthood which can be displaced to church members through countertransference. However, 8 out of 10 pastors had experienced a family member who attempted or committed suicide, and 2 out of 5 experienced parental bereavement before 18 years. These emotional experiences still affect them in adulthood.

Four out of 10 pastors experienced physical abuse from caretakers as well as bereavement of a parent. Eight out of ten experienced an attempted or committed suicide of a family member. Fifteen percent experienced a lack of parental care while 24% agreed that someone hit them so hard that they had marks or got injured. Forty percent still nurture the bereavement of nearest of kin. There is no significant difference in the levels of ACEs when age is considered.

CONCLUSIONS

It is a sigh of relief that pastors in Sub-Sahara Africa have low levels of Adverse Childhood Experiences. However, 8 out of 10 pastors still experience bereavement of a family member who attempted or committed suicide while 46.8% experienced parental bereavement. Besides, 45.7% experienced a traumatic death of a close relative before 18 years that still affects them in adulthood. The Pastor who ever experienced an ACE has a higher risk of experiencing woundedness in ministry.

RECOMMENDATIONS

1. Since the pastors indicated competence in knowing what the Bible stands for but have emotional neglect and are incompetent in handling emotional pain, the study recommends they access mental health services as part of the medical package offered by the church institution.
2. Let there be continued effort of assistance such as having coping mechanisms such as action-oriented coping, social/emotional coping, passive coping, and reflective growth/internal change.
3. Let there be a contingency team to counsel and support pastors during meetings that are prone to emotional woundedness.
4. Future research would study how the spouses and children of pastors are affected by ACEs in families.
5. Further research to be conducted with a large sample to increase the chances of revealing one or more pastors having ACE who would predict the probability of chronic physical illness, emotional challenges, and self-destructive behavior in adulthood which can be displaced to church members through countertransference. This is deemed important because these emotional experiences still affect them in adulthood and they seriously need rehabilitation.

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