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BRIEF REPORT

A Brief Report on the Prevalence of Adverse Childhood Experiences Among United Methodist Clergy

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Objective: This brief report examines the prevalence of adverse childhood experiences (ACEs) among United Methodist Church clergy in North Carolina. Clergy serve the mental, spiritual, emotional, and material needs of their congregants and communities, making it important to understand whether childhood adversity is associated with occupational selection as in other caregiving occupations. ***Method:*** Using data from the 2023 wave of the Clergy Health Initiative Longitudinal Survey and the 2023 Behavioral Risk Factor Surveillance System survey, we compared the prevalence of ACEs among clergy to a general population sample. Propensity score matching was used to balance covariates between samples. ***Results:*** Clergy were more likely to report growing up in a household with an individual experiencing mental illness and experiencing childhood sexual abuse. Clergy were less likely to have experienced physical abuse, to have experienced parental separation or divorce, and to have lived with an incarcerated person. ***Conclusions:*** These results contribute to the study of ACEs and career choice, highlighting the need for targeted support and training for clergy with these experiences.

Clinical Impact Statement
United Methodist clergy in North Carolina report higher rates of certain adverse childhood experiences, such as living with someone with a mental illness and experiencing childhood sexual abuse, compared to the general population. These findings highlight the need for targeted support and training for clergy to help them identify and manage their own past traumas and effectively support their congregants. Providing such resources can improve the well-being of both clergy and the communities they serve.

Keywords: adverse childhood experiences in caregivers, mental health and clergy, childhood adversity and career choice, propensity score matching

Research has shown that childhood experiences, including experiences of adversity, are associated with career choice. In general, people with elevated exposure to adverse childhood events (ACEs; Felitti et al., 1998) tend to select careers in the helping professions with a strong prosocial orientation, including, but not limited to, counseling, psychology, nursing, education, social work, and human services (Bryce et al., 2023). We examine whether clergy exhibit similar patterns of selection.

There is a strong association between ACEs and a higher mental health burden, including elevated depressive and anxiety symptoms,

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increased suicidal ideation, and higher rates of substance use disorder (Boullier & Blair, 2018; Daníelsdóttir et al., 2024; Felitti et al., 1998). ACEs can also have a detrimental impact on work performance, as they can impair the ability to effectively manage stressful circumstances, diminish a sense of self-efficacy, and create difficulties with collaboration and trust (Williams et al., 2021). In addition to these detrimental effects, among those in helping professions, higher exposure to ACEs also correlates with positive attributes such as increased empathy, purpose, compassion satisfaction, and positive coping (Pack, 2010).

Clergy, who serve in religious congregations, chaplaincy, and other settings, frequently perform activities that serve the mental, spiritual, emotional, and material needs of congregants and communities (Carroll, 2006). Research has shown that people seeking initial support for mental disorders more frequently contacted clergy than either psychiatrists or general medical doctors (Wang et al., 2003), underscoring the key role clergy often play as caregivers. Like other helping professionals, clergy members' history of life difficulties may play a role in their decision to enter the occupation. Additionally, clergy are often exposed to secondary trauma in their work (Roggenbaum et al., 2023), and this can exacerbate the negative impacts of ACEs on clergy.

Little is known about the prevalence of ACEs among clergy. The extant research consists of a small number of studies. One small sample of Black Protestant clergy and unpaid religious leaders (n = 102, 25 of which were clergy) in Texas found higher levels of ACEs across four domains: emotional neglect, parental separation or divorce, mental illness in the household, and having an incarcerated family member (Brown et al., 2024). Another study of seminarians at one institution (n = 535) reported higher prevalence of emotional abuse, living with someone with mental illness, and sexual abuse (Holleman et al., 2023). Neither of these studies measured ACEs prevalence in a systematically gathered or robust sample of clergy active in ministry. In this brief report, we present the prevalence of ACEs from a study of United Methodist Church (UMC) clergy in North Carolina. Although limited to one religious denomination in one state, this study is the first to report on the prevalence of ACEs in a large, systematically sampled study of active clergy members.

Method

Data

The present study is a secondary data analysis of the 2023 wave of the larger Duke University Clergy Health Initiative's Longitudinal Survey of United Methodist clergy (CHILS), which has been conducted every 2 years in the state since 2008. In 2023, all UMC clergy in North Carolina were asked to complete an online survey. The survey yielded a 70% response rate. We restricted our analytical sample to 1,083 active and retired UMC clergy who completed the survey. After case-wise deletion of cases with missing covariate values (age, race, gender, education, and retired status), the total sample size was 995.[1]

Comparative U.S. population data were derived from the 2023 Behavioral Risk Factor Surveillance System (BRFSS; Centers for Disease Control and Prevention, 2023). The BRFSS is a monthly, state-based surveillance system that collects data from noninstitutionalized adults using an independent probability sample of households with telephones. In 2023, nine states collected data on ACEs.[2] We limited our BRFSS analytical sample to individuals who reported they were currently working, had worked within the last year, or were retired, yielding an initial sample size of 55,903. After dropping cases with missing values for race, age, gender, education, or retirement status, the sample size was reduced to 55,739. Informed consent was obtained from all respondents, and all procedures were approved by the Duke University Institutional Review Board.

See Table A1 for demographics in the clergy and BRFSS samples prior to matching. Clergy were more likely to identify as White, a man, to possess a college degree, and to be older, and less likely to be retired, compared to the general population sample.

Measures

The surveys asked participants to report ACEs across eight domains (Giano et al., 2020). The CHILS used the same questions employed by the BRFSS and asked respondents if, before the age of 18: (1) Did you live with anyone who was depressed, mentally ill, or suicidal? (2) Did you live with anyone who used illegal street drugs? (3) Did you live with anyone who abused prescription medications? (4) Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility? (5) Were your parents separated or divorced? (6) How often did your parents or adults in your home ever slap, hit, kick, punch, or beat each other up? (7) Not including spanking, how often did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way? (8) How often did a parent or adult in your home ever swear at you, insult you, or put you down? (9) How often did anyone at least 5 years older than you or an adult ever touch you sexually? (10) How often did anyone at least 5 years older than you or an adult ever try to make you touch them sexually? and (11) How often did anyone at least 5 years older than you or an adult ever force you to have sex?

For the questions that included more than two response options (Questions 6 through 11), we dichotomized these variables into "never" and "once or more than once." Questions 2 and 3 were combined into a single dichotomous variable indicating household substance use. For Questions 9 through 11, we combined these into a single variable, coded "never," if the respondent answered "never" to all three questions about unwanted sexual experiences and otherwise to "once or more than once." Once the items were dichotomized, we calculated a composite ACE score by summing the number of individual ACEs experienced, with values from 0 to 8. ACEs domains and total scores were calculated in the same way across both surveys.

Statistical Analysis

We calculated total ACEs scores and prevalence estimates for each ACEs domain in the CHI data and the BRFSS data, using the supplied survey weights to perform calculations in the BRFSS. To adjust for differences in covariates between the two samples, we employed propensity score matching to match each clergyperson in the CHILS to the cases in the BRFSS that most closely matched them on the covariates of interest: age (in years), gender (man, woman), college degree (no college degree), and race (White, Black, other racial identity). We used coarsened exact matching to generate a matched BRFSS sample. We examined standardized mean differences between

[1] To preserve respondent confidentiality, we dropped four respondent cases who reported their gender as nonbinary.

[2] Delaware, Florida, Georgia, Missouri, Nevada, Oregon, Rhode Island, Tennessee, and Virginia.

values of the covariates in the matched sample—values less than 0.1 were considered good matches and 0.25 acceptable matches (Stuart et al., 2013). Survey weights were not used to estimate propensity scores or match cases (Lenis et al., 2019). However, we multiplied the survey weight by the propensity score weight to calculate the final modified survey weights. This weight was used to calculate summary statistics by comparing the matched BRFSS and clergy samples and to perform two-sample *t* tests to test for significant differences in the prevalence of ACEs and total ACE scores between the clergy and BRFSS data. The two-sample *t* tests incorporated the survey weights into the estimation, and we calculated robust standard errors. We plotted 95% confidence intervals for the estimates of the difference, and when those intervals did not cross zero, we considered them statistically significant. Propensity score matching was performed in R using the *MatchIt* package (Ho et al., 2011); weighted statistics were calculated using the *survey* package (Lumley, 2024).

After performing coarsened exact matching, we were left with 36,144 cases from BRFSS and 992 from the clergy data. There was good balance on most covariates, with standardized mean differences below 0.10 for all covariates except age. The standardized mean difference on age was 0.24, below the acceptable threshold of 0.25; the standardized variance difference on age was 0.93, also below the acceptable cutoff score of 2. See Table A2 for sociodemographic characteristics in the two samples after propensity score matching.

Results

In Table 1, we report total ACE scores and ACE prevalence in the two samples after propensity score matching. Among clergy, experiencing emotional abuse and living with someone with a mental illness were the most commonly reported ACEs in this sample, followed by living with someone with a substance use disorder, experiencing physical abuse, experiencing parental support or separation, experiencing sexual abuse, witnessing intimate partner violence, and living with someone who was incarcerated. The total ACE score was 1.5 with a standard deviation of 1.7. Table 1 shows that average total ACE scores were similar in both samples at 1.5. See Figure A1 for visualizations of these results. When analyzed as a categorical variable, the prevalence count of ACEs also did not differ significantly. However, differences were present between samples in specific domains. Sixty-six percent more clergy than the demographically matched sample from the general public reported living during childhood with an adult with a mental illness, the largest difference observed in this study. About 39% more clergy experienced childhood sexual abuse than the general population. About 60% more people in the general population experienced parental divorce or separation during childhood, and 33% more experienced childhood physical abuse. While 50% more people in the general population than clergy reported living during childhood with an incarcerated person, the overall prevalence in the population was low (4.5%). There were no significant differences in terms of childhood emotional abuse, household substance use, or witnessing interpersonal violence.

Discussion

Our findings provide the first robust evidence that clergy report a higher prevalence of ACEs in some domains than demographically similar adults from the general U.S. population. This is in line with evidence from other helping professions (Bryce et al., 2023). In our sample, the prevalence of living with someone with a mental illness and the experience of sexual abuse among clergy was significantly higher than in the general population. We found a lower prevalence of parental separation or divorce among clergy than the general population, as well as a lower prevalence of childhood physical abuse and living with an incarcerated individual. There were no significant differences in terms of household substance abuse, emotional abuse, or witnessing interpersonal violence. Recent research has demonstrated that ACEs domains differentially impact development and well-being, with child maltreatment (emotional, physical, and/or sexual abuse) being more highly correlated with significant mental and physical health struggles than household dysfunction (Negriff, 2020). More

Table 1
Comparison of ACEs in Clergy and General U.S. Population Samples After Propensity Score Matching

	Prevalence estimate		Difference analysis			
				95% CI		
Variable	CHILS (%)	BRFSS (%)	Difference (percentage point)	*UL*	*LL*	p^a
Household mental illness (%)	31.3	18.8	12.6	15.7	9.4	.000
Sexual abuse (%)	15.7	9.6	6.1	8.5	3.7	.000
Emotional abuse (%)	37.7	34.8	2.9	6.3	−0.5	.099
Intimate partner violence (%)	13.1	12.4	0.7	2.9	−1.6	.556
Household substance abuse (%)	22.4	23.2	−0.7	2.1	−3.6	.609
Incarcerated family member (%)	3.0	4.5	−1.4	−0.3	−2.6	.017
Physical abuse (%)	17.2	22.9	−5.7	−3.1	−8.4	.000
Parental divorce/separation (%)	15.7	25.2	−9.5	−6.3	−12.7	.000
No ACEs (%)	36.0	36.8	−0.8	2.8	−4.4	.663
One ACE (%)	25.3	25.5	−0.1	3.7	−3.9	.949
Two ACEs (%)	14.9	15.4	−0.5	2.1	−3.1	.702
Three ACEs (%)	10.1	9.4	0.7	2.9	−1.5	.522
Four+ ACEs (%)	13.7	12.9	0.7	3.2	−1.7	.599
ACE score (*n*)	1.5	1.5	0.0	0.2	−0.1	.590

Note. ACEs = adverse childhood experiences; CHILS = Clergy Health Initiative Longitudinal Survey; BRFSS = Behavioral Risk Factor Surveillance System; CI = confidence interval; *LL* = lower limit; *UL* = upper limit.
[a] *p* values indicate significance of prevalence difference.

research will need to be done to understand the relationship between specific ACE domains and well-being among clergy.

Institutions that train and support clergy should strive to provide targeted resources that enhance the well-being of both clergy and those they serve. As individuals struggling with their mental health frequently reach out to clergy first for assistance (Wang et al., 2003) and as clergy are often exposed to secondary trauma in their work (Roggenbaum et al., 2023), it is important for institutions to equip clergy to effectively navigate and recover from these encounters with an informed understanding of their own backgrounds. Given that this sample came from UMC clergy, a subset of the largest Mainline Protestant clergy population in the United States, the higher prevalence of certain ACEs may help explain why Mainline Protestant clergy have a higher prevalence of elevated depressive symptoms than the U.S. population (Holleman & Eagle, 2023). Alternatively, it is also possible that clergy (and helping professionals generally), as an occupational group that often works with individuals experiencing hardship and trauma, may be more able to recognize and name experiences of trauma in their own history. This ability may also be contributing to higher levels of reported ACEs among clergy and helping professionals.

Regarding limitations, our clergy sample was restricted to UMC clergy serving in one state. Our findings may not generalize to clergy in other religious traditions or geographic areas. Specifically, 40% of UMC clergy in our sample are women, which is larger than the proportion of women clergy in more theologically conservative religious traditions (Chaves et al., 2025). As women in the general population demonstrate higher ACEs scores on average (Giano et al., 2020), it may be that the prevalence of ACEs among clergy from other religious traditions differs from our sample. The lack of geographic diversity is mitigated by the fact that ACEs prevalence was similar across the nine states within the BRFSS data. Further research is needed to determine the prevalence of ACEs among clergy of other denominations and religious traditions.

Clergy provide substantial care, including care related to trauma, to a large number of people. Given that past trauma, especially when unresolved, can present barriers to effective caregiving, it is essential to know how common ACEs are among this occupational group. This study is, to our knowledge, the first to report the prevalence of ACEs in a large sample of active clergy members. We found higher-than-average rates of growing up with someone with a mental illness and experiences of childhood sexual abuse among clergy. There is an urgent need for more representative studies of clergy assessing the prevalence of ACEs among this occupational population.

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(*Appendix follows*)

Appendix

Sociodemographic Characteristics of Samples and Visualization of Propensity Score Matching Results

Table A1

Sociodemographic Characteristics of Clergy and the U.S. General Population Samples Prior to Propensity Score Matching

Variable	CHILS, n = 1,083[a]	BRFSS, n = 36,144[a]
Gender identity		
Man	644 (60%)	26,611 (51%)
Woman	434 (40%)	29,292 (49%)
Missing	0.5%	0%
Age	55 (13)	52 (18)
Missing	0.9%	0%
Race		
White	872 (87%)	43,489 (65%)
Black	73 (7.3%)	5,725 (15%)
Other	61 (6.1%)	6,689 (21%)
Missing	7.1%	0%
College degree		
No college	65 (6.0%)	29,700 (65%)
College	1,012 (94%)	26,039 (35%)
Missing	0.6%	0.3%
Retired	266 (25%)	23,887 (30%)
Missing	0%	0%

Note. CHI = Clergy Health Initiative Longitudinal Survey; BRFSS = Behavioral Risk Factor Surveillance System.
[a] n (unweighted; %); mean (standard deviation).

Table A2

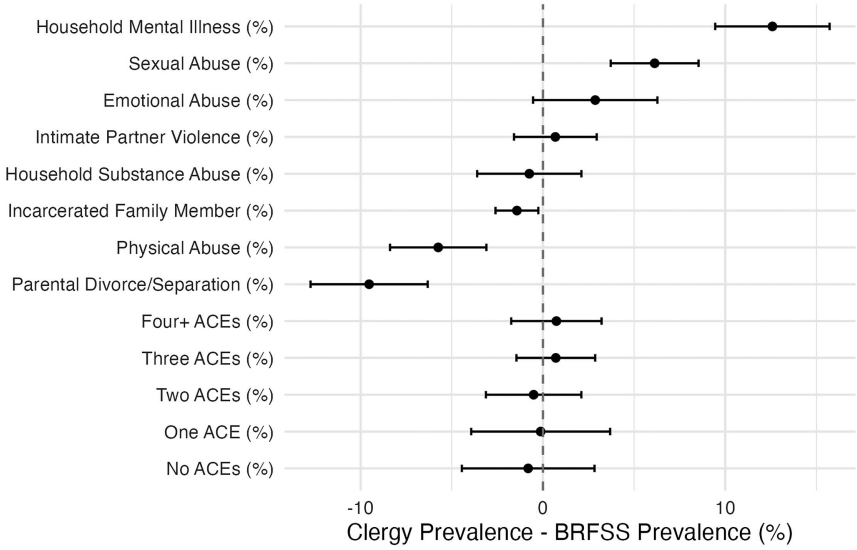
Sociodemographic Characteristics in Clergy and U.S. Population Sample After Propensity Score Matching

Variable	CHILS, n = 992[a]	BRFSS, n = 36,144[a]
Gender identity		
Man	599 (60%)	19,944 (62%)
Woman	393 (40%)	16,200 (38%)
Age	56 (13)	53 (13)
Race		
White	861 (87%)	31,781 (78%)
Black	70 (7.1%)	2,345 (10%)
Other	61 (6.1%)	2018 (12%)
College degree		
No college	58 (5.8%)	14,177 (8.3%)
College	934 (94%)	21,967 (92%)
Retired	256 (26%)	15,806 (20%)

Note. CHILS = Clergy Health Initiative Longitudinal Survey; BRFSS = Behavioral Risk Factor Surveillance System.
[a] n (unweighted; %); mean (standard deviation).

Figure A1

Difference in ACEs Prevalence Between Clergy and the U.S. General Population Sample After Propensity Score Matching



Note. ACEs = adverse childhood experiences; BRFSS = Behavioral Risk Factor Surveillance System.

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