Joseph Jay Breish

Omega Graduate School

Dr. Reichard

Submission Date: 7/19/23

100 Day - Essay

Write an 8-10 page essay, not including the cover and works cited pages. The essay should demonstrate scholarly work, cover the subject with sufficient detail to communicate a solid understanding of applying foundational Christian worldviews and show proper APA 7 style documentation for the resources (works cited).

1. Your essay should address the following:
   1. Create a hypothetical project for applied sociology (descriptive problem identification/diagnosis) based on a problem within an organization you either work for/with or with which you are familiar.
   2. Extending this project might include a “clinical” intervention to lead to social change. What might the intervention look like, and how would it be implemented?
   3. Evaluate ethical considerations for the above two scenarios.
   4. Propose means by which the project outcomes could be evaluated or measured for effectiveness.
2. Structure (Paper Evaluation includes the following structure below).
   1. Download the “OGS APA Course Assignments Template 7th Ed 2021” template from the General Helps folder in the AA-101 The Gathering Place Course on DIAL. Using the template, create the following pages.
   2. Title Page (not included in page count).
   3. Copy and paste the assignment instructions from the syllabus starting on a new page after the title page, adhering to APA 7th edition style (APA 7 Workshop, Formatting, and Style Guide, APA 7 Quick Guide).
   4. Start the introduction on a new page after the copied assignment instructions.
3. Be sure to meet the following expectations.
   1. Begin with an introductory paragraph that has a succinct thesis statement.
   2. Address the topic of the paper with critical thought.
   3. End with a conclusion that reaffirms your thesis.
   4. Document all sources in APA style, 7th edition (APA 7 Reference Example, APA 7 Quick Guide)
   5. Include a separate Works Cited page, formatted according to APA style, 7th edition (not included in page count).
   6. Use a minimum of seventeen scholarly research sources (three to four books and the remaining scholarly peer-reviewed journal articles).
4. Submit the completed paper to DIAL.

# Introduction

Within the last decade, especially in the previous three years, America has experienced many sociological crises. One of particular significance is the rise of childhood abuse and maltreatment (Tikka et al., 2020). Many children have experienced trauma. According to some, it’s as high as two out of every three children (Clements et al., 2020) or one-third of all children worldwide (Westerfield et al., 2022). The global COVID-19 pandemic exacerbated the problem by adding another layer of suffering to previous unresolved trauma (Knoetze & Black, 2023). Even worse, trauma is disproportionately represented in children with existing burdens and fewer resources (Chaudhri et al., 2019; Stephens, 2020, p.5).

Christians have the responsibility to be the salt and light to this world (NASB, 2020, Matthew 5:13-16), and the Church has a responsibility to be a sociological influence for moral good (De Villiers, 2020, p. 2; Miller & Miller, 2021, p. 194). Regrettably, churches and religious groups often add to the problem rather than mitigate it (Reisinger, 2022; Sheveland, 2021; Miller & Miller, 2021; Stephens, 2020). Further complicating the issue, Churches and faith-based organizations are often ill-equipped to respond to childhood trauma (Westerfield & Doolittle, 2022, p. 210).

Childhood trauma is known to be complex, having long-term personal, societal, and spiritual effects (Orionzi, 2023, p. 80; Westerfield & Doolittle, 2022; Bloom, 2014, p. 109). Westerfield and Doolittle (2022) note that when there is a lack of support in a child’s “critical moment,” a child’s spirituality will be negatively impacted (p. 205). The Church, with its evangelical worldview, must learn how to identify trauma and provide Biblical solutions. Therefore, this researcher desires to develop a church program to help identify childhood trauma, build resiliency, and create a grace-based community to surround that child and their family. Specifically, this researcher aims to develop this program for their local church.

# Sociology and the Church

Sociology, the concept of studying human behavior and society (Rebach and Bruhn, 2012, p. 5, Osowski, 2005), emerged as a discipline in the 1800s (Turner, 2014, p. xi). Sociology is related to social work (Trimikliniotis, 2020, p. 10) and contains research-based evaluation and clinical problem-solving techniques (Wan & Wan, 2020). Rocha (2022) claims sociology is practical on all levels, individuals, families, and social groups (p. 2). Fritz (2008) agrees, clinical sociologists work to “assess situations and avoid, reduce, or eliminate problems through analysis and intervention (p. 9). As such, a sociological perspective is critical for identifying and mitigating the problem of childhood abuse.

Notably, the Church has not always been agreeable to sociological perspectives due to its roots in humanism and positivism (Ballano, 2019, p. 2). That said, sociology can be used as a tool to integrate the Christian message into society (Ballano, 2019, p. 1). DeSanto et al. (1992) note that Christian sociologists measure societal norms against Biblical principles (p. 5). The Christian sociological perspective is ideal for providing “collaborative interprofessional” care (Parry et al., 2021, p. 995) needed to heal childhood trauma.

# Definitions and a Common Language

Before attempting to reduce childhood abuse and maltreatment, a common language must be established within an organization. First and foremost, trauma must be defined. Trauma is often thought to be the result of an experience that is too much to handle (Stephens, 2020, p.3). Papa and Robinson (2023) quote the APA when they state, “Trauma is the response to a terrible event like an accident, rape, or natural disaster” (p. 172). However, trauma is often complex and multifaceted, not confined to one horrific experience but a series of terrifying events, personal, social, or communal (Stephens, 2020, p. 1). Chaudhri et al. (2019) add that trauma can develop from physical or emotional stressors and that all trauma will have lasting effects. Stephens (2020) continues:

“A central feature of trauma is that it disrupts one’s personal narrative, interfering with one’s sense of self and experience of the world. Traumatic memories interrupt the present in ways unbounded by chronology. A traumatic memory can be neither coherently articulated nor forgotten. It is an unspeakable response to horror, a response that refuses to be integrated into the past even as it haunts the present” (p. 3)

Esaki et al. (2022) name two additional types of trauma, historical and racial, and note that the adverse side effects can include negative physical health, distrust, and even mental illness in future generations (p. 2). Papa and Robinson (2023) also quote The Substance Abuse and Mental Health Services Administration (SAMHSA) framework to help identify the “3 E’s” of Trauma: Events, Experience, and Effects (p. 173). Events are what lead up to the trauma. Experiences deal with how the event is perceived. Effects help us understand the outcome of a significant event. Ultimately a key to recognizing childhood abuse is identifying the signs and symptoms of trauma (Stephens, 2020, p. 6).

When discussing childhood abuse, another term needs clarification: Adverse Childhood Experiences (ACEs). Felitti et al. (1998, as cited by Westerfield & Doolittle, 2022) define ACEs as “childhood emotional, physical, or sexual abuse, [including] household dysfunction during childhood” (p. 204). Clements et al. (2020) add neglect, violence, loss, bullying, disaster, war, and “other similarly threatening experiences” to the list of ACEs (p. 499). While ACEs are more prevalent in children receiving foster, adoptive, and residential care (Parry et al., 2022), untreated ACEs have been identified as an overarching social epidemic (Chaudhri et al., 2019).

Lastly, the phrase “secondary trauma” needs to be defined. “Secondary trauma refers to the physiological, emotional, and mental effects of being exposed to the primary trauma of another person, either as a witness to the traumatic event itself or bearing witness to the traumatic effects on that person” (Stephens, 2020, p. 9). Stephens (2020) continues, frequently trauma involves “experiences that cannot be adequately shared through words yet manifest themselves in our bodies” (Stephens, 2020, p. 10). McPhillips (2021) notes that secondary trauma is sometimes referred to as vicarious trauma. Orionzi (2023) adds the phrase “secondary traumatic stress” as an alternative descriptor (p. 79). Secondary trauma is problematic because it results from people hearing about another person’s trauma (Orionzi, 2023, p. 79). As such, the Church must be aware that adults and caregivers could be triggered themselves when trying to identify and reduce childhood maltreatment. Programs seeking to help children must consider their staff and leadership in the caregiving process.

# Identifying Trauma in Our Youth

It is generally understood that maltreatment can cause trauma; therefore, identifying trauma in children can help identify abuse. Some forms of identification are accessible only to doctors; for example, Berna et al.(2022) describe a method of evaluating skull fractures that are only caused by abuse (p. 403) or Yavuz et al.’s (2022) assessment for neurodevelopmental impairment which requires a trained eye. Other methods are more readily teachable, as in Stephen’s (2020) classroom signs or Nazer & Greenbaum’s (2020) possible indicators for human trafficking. Common signs include emotional regulation challenges, difficulty focusing, attending, retaining, and recalling, excessive fear and anxiety, withdrawal and isolation, signs of malnutrition, and physical injuries (Stephens, 2020; Nazer & Greenbaum, 2020). Bisagno et al. (2023) mention the ECLIPS screening tool and note that a multi-pronged approach can provide the most conclusive evidence.

Churches must raise awareness of how prolific and challenging a topic trauma is, both in the “here and now” and in the long term (Demers et al., 2022; Orionzi, 2023). Since trauma can be complex, churches need to utilize a broad spectrum of support (Westerfield and Doolittle, 2022, p. 208). Understanding that this problem is mainstream, each church ought to review current assessment tools, select those most relative and accessible for their context, and begin training among their staff and volunteers on spotting potential childhood trauma. At the time of this writing, the webpage: *Trauma Informed Assessments: Resource Guide* provided a list of tools that could assist in the evaluation process. (Webpage listed in works cited.)

# Clinical Intervention Leading to Social Change

When considering intervention, we must reflect on Fritz‘s (2008) book on Clinical Sociology. Fritz defined Clinical Sociology as a “creative, humanistic, and multidisciplinary specialization that seeks to improve life situations for individuals and collectivities” (p. 9). Clinical sociology identifies and evaluates problems based on research so that interventions can be applied to improve situations (Fritz, 2008, p. 9). Rebach and Bruhn (2012) note that clinical sociology, in contrast to applied sociology, involves “direct intervention” to social problems (p. 1). Unlike some other “harder” sciences, sociology incorporates “the idea of joining perspectives, knowledge, [and] theory” (Rebach & Bruhn, 2012, p. 1). While the multidisciplinary approach sometimes leads to a “chaos of disciplines” (Andrew Abbott, 2001, as cited by Kalekin-Fishman & Denis, 2012), it also uniquely positions sociology at the forefront of solving social issues by taking a broader approach in recognizing and resolving them. Most Christian organizations, including churches, are not equipped to handle mental health issues by themselves (Westerfield & Doolittle, 2022, p. 210). Therefore, it is recommended that churches begin implementing Trauma Informed Care (TIC) based on social research.

Trauma Informed Care (TIC) was first developed in the 1970s but became prevalent in the 1990s when advocated for by child health systems (Demers et al., 2022, p. 2). As awareness grew about how wide-spread trauma was, the need for integrated, multidisciplinary solutions grew. As an evidence-based practice, TIC grew out of the desperate need for a solution. Demers et al. (2022) state that TIC “acknowledges the prevalence of traumatic experiences among patients, their family members, providers, and staff [and] accommodates the needs and vulnerabilities of trauma survivors [while] minimize[ing] the likelihood [of] re-traumatization” (p. 2). In other words, TIC shifts the focus from “What’s wrong with you?” to “What happened to you?” (Papa and Robinson, 2023, p. 172) It is a paradigm shift in how we treat people with trauma, and it requires systemic cultural changes within our organizations (Mahon, 2022, p. 2).

Trauma-informed care is a developing topic. There are various implementations to becoming a “trauma-informed” organization or church to date. Key foci are:

* Programmatic training including understanding signs, symptoms, and causes of trauma and paths to recovery (Clements et al., 2020, p. 499)
* Reframing one’s perspective and new acquiring skills to respond more effectively to others who have experienced trauma (Champine et al., 2022, p. 466)
* Accommodating for the needs and vulnerabilities of trauma survivors while preventing re-traumatization (Demers et al., 2022, p. 2)
* Gaining cultural awareness, responsiveness, and understanding (Esaki et al., 2022, p. 2)
* Organizational response through systemic culture change (Mahon, 2022, pp. 1-2)
* Emotional healing, growth, and well-being (Mahon, 2021, p. 306)
* Creating safe spaces that empower people’s voices (Parry et al., 2021, p. 993)
* One-to-one mentorship and building childhood resilience (Parry et al., 2021, p. 993; Orionzi, 2023, p. 80; Bunting et al., 2019, pp. 1-2)
* Policies and procedures that protect (Stephens, 2020, p. 5)

Specifically speaking, this researcher recommends that a church review and embrace one of the following models of Trauma Informed Care for their congregation. They are listed below in order of likely compatability.

* Godly Response to Abuse in the Christian Environment (GRACE) is an excellent Christian solution for Trauma-informed training.
  + Helps Christian communities recognize, prevent, and respond to abuse by providing training and consulting with your organization or church.
  + GRACE also helps your church establish policies to safeguard children.
  + Legal consulting is available.
* The Sanctuary Model is a gold standard in TIC. They identify organizations as systems (organizational theory) and have three categories of organizational change: training, skill building, and tools.
  + Their seven commitments include: Nonviolence, emotional intelligence, democracy, open communication, social responsibility, commitment to social learning, growth, and change (Esaki et al., 2013)
* The Substance Abuse and Mental Health Services Administration’s (SAMHSA) program which identifies six key principles of a trauma-informed approach:
  + 1. Safety, 2. Trustworthiness and transparency, 3. Peer support, 4. Collaboration and mutuality, 5. Empowerment, voice, and choice, 6. Cultural, historical, and gender issues (Papa and Robinson, 2023, p. 173).
  + Furthermore, they have created the “Four R’s” or assumptions: Realization, Recognize, Respond, and Resist (Papa and Robinson, 2023, p. 173)
* American Academy of Pediatrics Practice Guidelines includes five categories of training: Awareness, Readiness, Detection and Assessment, Management, and Integration. (Demers et al., 2022, p. 3)
  + This model was not designed for churches; however its principles could be contextualized for the church with some effort.

Implementing Trauma-informed care within the local church would be a multi-stepped process. After raising awareness through a public event, the church would begin training its leadership, staff, and volunteers about trauma and how to respond to it. This could take months to roll-out, but expediency is not the goal as much as perspective change and paradigm shifts. Next, the church would begin to implement policy and procedural changes that would affect every area of its ministry, starting with those areas that are directly related to children. Then, after training is well underway, and procedures are in place to support intentional decisions, partnerships with other local community, medical, and mental health providers will need to be developed. Training and cultural change could take years to implement, as in the Sanctuary Model (Esaki et al., 2022, p. 6).

# Ethical Considerations

Ethical concerns must be considered when implementing a church-wide system to address the sensitive issue of child maltreatment and abuse. Goodman et al. (2020) specifically note the potential of “power-over” dynamics when discussing advocates and those they serve (p. 226). There is a natural power disequilibrium between the advocate and the trauma survivor. In their article on mandated reporting, Goodman and Fauci (2020) note that a victim’s fear, when seeking help, is of great concern (p. 217). How should the Church respond? With humility and compassion (NASB, 2020, Colossians 3:12). If an atmosphere of grace is established where each member of the body sees themselves as equals, all capable of being victims or victimizers given the right circumstances, a natural sensitivity towards those who have experienced abuse will arise (NASB, 2020, 1 Corinthians 12:12-27; Galatians 3:28). Where possible, an “opt-in” choice should be provided for survivors, allowing them to decide when and how they receive help (Bryson et al., 2017, p. 14). Jesus was not in a hurry, nor should we be (NASB, 2020, Proverbs 19:2; Proverbs 21:5). Lastly, a servant leadership mindset, with love, will cover a multitude of potential problems (Mahon, 2021, p. 306; NASB, 2020, 1 Peter 4:8).

# Potential Barriers to Implementation

Raising awareness about childhood abuse, implementing trauma-informed care, and establishing a culture of grace requires great collaboration and effort. It cannot be assumed to be easy. As such, this researcher has identified some possible barriers to successful implementation. Below are six common obstacles to implementing TIC.

* Lack of buy-in or an Organizational Champion (Parry et al., 2021; Clements et al., 2022)
* Lack of an implementation plan, supporting data, or organizational alignment (Parry et al., 2021; Chaudhri et al., 2019)
* Fear of sociology and sociological methods, including non-Biblical content like radical feminism (Ballano, 2019; Yip, 2018)
* Insufficient staffing or time coupled with existing workload (Parry et al., 2021; Bryson et al., 2017; Demers et al., 2022)
* Competing roles between the old and new or a rigid and unchanging culture (Chaudhri et al., 2019; Bryson et al., 2017)
* Limited collaboration with outside services or community involvement (Clements et al., 2022; Chaudhri et al., 2019)

While there is no one-size-fits-all solution to these obstacles, creating relationships with all parties is an excellent start. Relationships provide context and language, which can be used to establish priorities, shift cultures, and gain buy-in. Champine et al. (2022), elaborate a similar idea in their “collaborative capacity [within] community” (p. 470). Bryson et al. (2017) add that when it comes to implementing TIC, a “train the trainer” approach generates long-term organizational change (p. 14). Ultimately, each TIC team will need to assess methods to address the potential pitfalls of Trauma-informed training.

# Program Evaluation of Effectiveness

Any evidence-based sociological intervention should have some level of follow-up evaluating its effectiveness. Implementing TIC in the local church is no exception. That said, evaluating successful implementation can be difficult as there is no unified definition of trauma-informed care (Thirkle et al., 2021, p. 31). Whether TIC can effectively be measured is up for debate (Thirkle et al., 2021, p. 31). Thrikle et al. (2021) continue:

“There is a debate on the nature and scope of trauma-informed care, as trauma-informed care has been viewed as both an organisational structure and treatment framework (Fallot & Harris, 2001), and also as a culture (Bateman, Henderson, & Kezelman, 2013). Trauma-informed care is a system development model (Paterson, 2014) that moves away from the traditional diagnosis model of “what is wrong with you”, towards a story-based approach of “what happened to you” (Sweeney,Filson, Kennedy,Collinson,&Gillard,2018). Trauma-informed Care requires all agents to be operating within the environment to be engaging in trauma-informed practice.”

According to Thirkle et al. (2021), evaluating TIC’s effectiveness requires evaluating structural, cultural, and system development models. In other words, the procedural changes within leadership, the cultural changes within the church, and the personal paradigm changes within the individuals. Speaking to the last point, Parry et al. (2021) claim that successful one-to-one mentorship has helped establish “hopeful thinking” for children in residential care (p. 993). This researcher suggests evaluating mentoring programs for.

Finally, when evaluating TIC, it is helpful to note that all instruments studied by Thirkle et al. (2021) included the following criterion: Safety, Trustworthiness, Choice, Collaboration, Empowerment, and a Trauma Screening Process (p. 36). Perhaps a Likert scale test prior to, during, and after the implementation of TIC could be used to evaluate program effectiveness. From a Biblical perspective, it appears we are trying to measure how well we are loving others. To that end, Yoo (2017, cited by Westerfield and Doolittle, 2022) writes, “The phrases I hear most often at trainings for trauma-informed care and community building are “unconditional love” and “relationship with constant care.” ” (p. 210)

# Conclusion

The practical impacts of sociology and sociological theory are far-reaching (Rocha, 2022, p. 3). TIC is an example of how research-based science can help serve individuals and local communities. And Trauma-informed care is rising in popularity as traditional models are not as effective as once thought (Thirkle et al., 2021, p. 30). “[Becoming] trauma-informed is a reminder of our basic humanity, our vulnerability, our creative capacity for adaptation, and our potential for growth within relationships that can heal and connect us.” (Thirkle et al., 2021, pp 30-31). While grace-based communities and servant leadership are not new to Christian circles, these concepts, mixed with evidence-based programs like TIC, churches can better serve those in their care. As Yoo (2017, cited by Westerfield et al., 2022) claims, “I believe that the church has a calling to step up and serve the mission field of trauma survivors and their effective recovery.” This researcher agrees and believes the world will better experience the Gospel as we do.

# Works Cited

Ballano, V. (2019). Catholic social teaching, theology, and sociology: exploring the common ground. *Religions*, *10*(10). <https://doi.org/10.3390/rel10100557>

Berna, U., Oğuzhan, T., & Sonay, A. (2022). Pediatric skull fractures: Could suture contact be a sign of abuse? *Emergency Radiology*, *29*(2), 403–408. <https://doi.org/10.1007/s10140-022-02024-6>

Bisagno, E., Cadamuro, A., Serafine, D., Dima, B. M., Groenen, A., Zane, L.-O., Annija, K., Dóra, V.-S., Dorottya, M., Noémi, L., Monika, R., Gruber, A., Laura, D. F. G., & Catharina, B. J. M. (2023). The development of a screening tool for childcare professionals to detect and refer infant and toddler maltreatment and trauma: A tale of four countries. *Children*, *10*(5), 858. <https://doi.org/10.3390/children10050858>

Bloom, S. L. (2014). Rebooting the organizational operating system in group care settings. *John Hopkins University*.

Bryson, S. A., Gauvin, E., Jamieson, A., Rathgeber, M., Faulkner-Gibson, L., Bell, S., Davidson, J., Russel, J., & Burke, S. (2017). What are effective strategies for implementing trauma-informed care in youth inpatient psychiatric and residential treatment settings? A realist systematic review. *International Journal of Mental Health Systems*, *11*. <https://doi.org/10.1186/s13033-017-0137-3>

Bunting, L., Montgomery, L., Mooney, S., MacDonald, M., Coulter, S., Hayes, D., & Davidson, G. (2019). Trauma informed child welfare systems—a rapid evidence review. *International Journal of Environmental Research and Public Health*, *16*(13). <https://doi.org/10.3390/ijerph16132365>

Champine, R. B., Hoffman, E. E., Matlin, S. L., Strambler, M. J., & Kraemer, T. J. (2022). “What does it mean to be trauma-informed?”: a mixed-methods study of a trauma-informed community initiative. *Journal of Child and Family Studies*, *31*(2), 459–472. <https://doi.org/10.1007/s10826-021-02195-9>

Chaudhri, S., Zweig, K. C., Hebbar, P., Angell, S., & Vasan, A. (2019). Trauma-informed care: A strategy to improve primary healthcare engagement for persons with criminal justice system involvement. *Journal of General Internal Medicine*, *34*(6), 1048–1052. <https://doi.org/10.1007/s11606-018-4783-1>

Clements, A. D., Haas, B., Cyphers, N. A., Hoots, V., & Barnet, J. (2020). Creating a communitywide system of trauma-informed care. *Progress in Community Health Partnerships*, *14*(4), 499–507.

Demers, L. A., Wright, N. M., Kopstick, A. J., Niehaus, C. E., Hall, T. A., Williams, C. N., & Riley, A. R. (2022). Is pediatric intensive care trauma-informed? A review of principles and evidence. *Children*, *9*(10), 1575. <https://doi.org/10.3390/children9101575>

DeSanto, C., Lindblade, Z. G., & Poloma, M. M. (Eds.). (1992). *Christian perspectives on social problems*. Wesley Press. <http://archive.org/details/christianperspec0000unse_l1r4>

De Villiers, D. E. (2020). Does the Christian church have any guidance to offer in solving the global problems we are faced with today? *HTS Teologiese Studies / Theological Studies*, *76*(2). <https://doi.org/10.4102/hts.v76i2.5852>

Esaki, N., Reddy, M., & Bishop, C. T. (2022). Next steps: Applying a trauma-informed model to create an anti-racist organizational culture. *Behavioral Sciences*, *12*(2), 41. <https://doi.org/10.3390/bs12020041>

Esaki, N., Benamati, J., Yanosy, S., Middleton, J. S., Hopson, L. M., Hummer, V. L., & Bloom, S. L. (2013). The sanctuary model: Theoretical framework. *Families in Society: The Journal of Contemporary Social Services*, *94*(2), 87–95. <https://doi.org/10.1606/1044-3894.4287>

Fritz, J. M. (Ed.). (2008). *International clinical sociology*. Springer.

Goodman, L. A., & Fauci, J. E. (2020). The long shadow of family separation: A structural and historical introduction to mandated reporting in the domestic violence context. *Journal of Family Violence*, *35*(3), 217–223. <https://doi.org/10.1007/s10896-020-00132-w>

Goodman, L. A., Fauci, J. E., Hailes, H. P., & Gonzalez, L. (2020). Power with and power over: How domestic violence advocates manage their roles as mandated reporters. *Journal of Family Violence*, *35*(3), 225–239. <https://doi.org/10.1007/s10896-019-00040-8>

*GRACE: Godly Response to Abuse in the Christian Environment*. (2019). GRACE. <https://www.netgrace.org>

Kalekin-Fishman, D., & Denis, A. (Eds.). (2012). *The Shape of Sociology for the 21st Century: Tradition and Renewal* (1st edition). SAGE Publications Ltd.

Knoetze, J. J., & Black, T. J. (2023). ‘Sinawe’ [we are with you]: Local churches as change agents in the lives of traumatised youth. *Verbum et Ecclesia*, *44*(1). <https://doi.org/10.4102/ve.v44i1.2694>

Mahon, D. (2022). Implementing trauma informed care in human services: An ecological scoping review. *Behavioral Sciences*, *12*(11), 431. <https://doi.org/10.3390/bs12110431>

Mahon, D. (2021). Trauma-informed servant leadership in health and social care settings. *Mental Health and Social Inclusion*, *25*(3), 306–320. <https://doi.org/10.1108/MHSI-05-2021-0023>

McPhillips, K. (2021). The trauma-informed classroom. *Journal of Feminist Studies in Religion*, *37*(1), 129–132. <https://doi.org/10.2979/jfemistudreli.37.1.09>

Miller, V., & Miller, S. (2021). Child sexual abuse, integrity systems and the anglican church: truth, justice and love. *Journal of Anglican Studies*, *19*(2), 193–212. <https://doi.org/10.1017/S1740355321000103>

Nazer, D., & Greenbaum, J. (2020). Human trafficking of children. *Pediatric Annals*, *49*(5), e209–e214. <https://doi.org/10.3928/19382359-20200417-01>

New American Standard Bible [NASB]. (2020). Lockman Foundation. (Original work published 1960)

Osowski, T. (2005). Sociological Perspectives. *South Dakota State University*.

Orionzi, B. (2023). Trauma-informed care and how social media contributes to trauma. *Pediatric Annals*, *52*(3). <https://doi.org/10.3928/19382359-20230118-02>

Papa, A., & Robinson, K. (2023). Leadership and trauma-informed care: Working to support staff and teams. *Journal of Emergency Nursing: JEN*, *49*(2), 172–174. <https://doi.org/10.1016/j.jen.2022.11.001>

Parry, S. L., Williams, T., & Burbidge, C. (2021). Restorative parenting: Delivering trauma-informed residential care for children in care. *Child & Youth Care Forum*, *50*(6), 991–1012. <https://doi.org/10.1007/s10566-021-09610-8>

Rebach, H. M., & Bruhn, J. G. (Eds.). (2012). *Handbook of Clinical Sociology* (2nd ed. 2001. Softcover reprint of the original 2nd ed. 2001 edition). Springer.

Rocha, Z. L. (2022). Clinical sociology and mixedness: Towards applying critical mixed race theory in everyday life. *Genealogy*, *6*(2), 32. <https://doi.org/10.3390/genealogy6020032>

Reisinger, D. (2022). Reproductive abuse in the context of clergy sexual abuse in the catholic church. *Religions*, *13*(3), 198. <https://doi.org/10.3390/rel13030198>

*SAMHSA’s National Helpline*. (2023, June 9). <https://www.samhsa.gov/find-help/national-helpline>

Sheveland, J. (2021). Clergy sexual abuse and the work of redemption: gestures toward a theology of accompaniment. *Buddhist - Christian Studies*, *41*, 71–86.

Stephens, D. W. (2020). Trauma-informed pedagogy for the religious and theological higher education classroom. *Religions*, *11*(9), 449. <https://doi.org/10.3390/rel11090449>

*Trauma Informed Assessments: Resource Guide*. (n.d.). Retrieved July 11, 2023, from <https://www.urmc.rochester.edu/MediaLibraries/URMCMedia/community-health/health-policy/TIA-chart-002.pdf>

Thirkle, S. A., Kennedy, A., & Sice, P. (2021). Instruments for exploring trauma-informed care. *Journal of Health and Human Services Administration*, *44*(1), 30–44. <https://doi.org/10.37808/jhhsa.44.1.2>

Tikka, S., Garg, S., & Dubey, M. (2020). Ascending child sexual abuse statistics in India during covid-19 lockdown: A darker reality and alarming mental health concerns. *Indian Journal of Psychological Medicine*, *42*(5). <https://doi.org/10.1177/0253717620948208>

Trimikliniotis, N. (2020). Public sociology, social justice and struggles in the era of austerity-and-crises. *International Social Work*, *63*(1), 5–17. <https://doi.org/10.1177/0020872818782324>

Turner, J. H. (2014). *Theoretical sociology: A concise introduction to twelve sociological theories*. SAGE Publications, Inc.

Wan, P. M., & Wan, A. H. (2020). *Clinical sociology: Moving from theory to practice* (1st ed. 2020 edition). Springer.

Westerfield, C. M., & Doolittle, B. R. (2022). Spirituality of the traumatized child: A call for increased faith community participation in the trauma-healing process for children. *Journal of Religion and Health*, *61*(1), 203–213. <https://doi.org/10.1007/s10943-021-01416-1>

Yavuz, H., Tumkaya, S., Uzer, A., & Yucens, B. (2022). Childhood trauma, neurological soft signs, and their relationship in obsessive–compulsive disorder. *Dusunen Adam: Journal of Psychiatry and Neurological Sciences*, *35*(4), 236–246. <https://doi.org/10.14744/DAJPNS.2022.00198>