EARLY SHAME, SELF ESTEEM, AND CHRISTIAN WOMEN

by

Teneka GuyRue Miles

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

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Abstract

The purpose of this phenomenological study was to gain a deeper understanding of the lived experiences surrounding the self-esteem of evangelical Christian women with early shame experiences. The theory guiding this study was attachment theory as it explains self-esteem being rooted in early childhood through trust building, unconditional love, and security. The theoretical framework further illustrates the impact of self-esteem as life progresses due to a combination of positive and negative self-evaluations. Early shame experiences affect one's self-esteem adversely. Low self-esteem could breed isolation once people fail to see their self-worthy in establishing meaningful connections, without which individuals lack the nurture needed to grow and sustain their well-being. Data were collected through an unstructured interview. The study findings revealed that (1) poor parental bonds, (2) environmental stressors, and (3) identification with God were significant shared experiences. This study provided implications for community stakeholders in the field of education, healthcare, and ministry. It implied having an early secure attachment and a positive relationship with God as mitigators to adverse mental health, as they facilitate healthy coping among individuals who have faced trauma such as early shame experiences.

Keywords: early childhood shame, self-esteem, Christian women

Copyright Page

Dedication

This dissertation is dedicated to my children, Kennedy, Shondell Jr. Kayla, and Karrington, who has always been and will always be the proof of God's love towards me.

And to Shondell Sr., thank you for growing through life with me, being a demonstration of God's strength and faithfulness. I love you.

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To a gracious, merciful, and loving God, thank you for always making your presence known. Thank you for the inherent wisdom of your Holy Spirit and for creating me with a passion to serve.

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To the participants who took part in my study. I am honored that you allowed me the opportunity to explore and share your experiences. Thank you for your willingness to support research that will bring about more awareness to trauma, self-esteem, and faith practices.

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Institutional Review Board (IRB)

Post-traumatic Stress Disorder (PTSD)

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Social Anxiety Disorder (SAD)

Chapter One: Introduction

Overview

More than three-quarters of Americans identify as Christian (Christerson & Flory, 2017), but according to (Zurlo et al., 2021), this number will decrease by fifty percent by the year 2070. Mental health disparities among Christians have historically been disapproved; however, studies support the theory that one's relationship with God might be a source of social support related to improved mental health in Christians (Jeppsen et al., 2022; Wang, 2021). Although there are various studies on self-esteem and managing adverse childhood experiences (ACEs) that result in negative self-esteem, there has been no evaluation of these phenomena with evangelical Christian women (Budiarto & Helmi, 2021; Hallman, 2018; Velotti, 2018). The origins of psychopathology have been long linked to early life experiences in childhood (Felitti et al., 1998; Tyrka et al., 2008; Wojcik et al., 2019). The negative consequences of failures and disruptions early in life express themselves in poor representations of the self (Wojcik et al., 2019). Problems related to seeing oneself as devalued, shamed, or inferior compared to others are linked to poor self-esteem (Leary, 2015). Self-esteem is not only a fundamental human need but also inherently a social product (Schieman et al., 2017). Bowlby (1973) recognized secure attachment as the foundation of self-esteem. Krause (2005) documented there is a positive relationship between religion and self-esteem, but Frankel and Hewitt (1994) found no relationship at all. The study conducted by Schieman et al. (2017) further asserts that the relationship between religious involvement and self-esteem is positive but complex. This phenomenological study explores evangelical Christian women's experiences with low self-esteem rooted in early childhood adverse shame experiences. It surveyed the specific faith experiences that help to form healthy relationships as a means of overall well-being. This chapter addresses the historical, social, and

theoretical background of the study. It further provides the problem and purpose statements and explains the significance of the study. Research questions and key terms are identified and the chapter concludes with a summary.

Background

Being well-informed in the historical, social, and theoretical context speaks to the value and significance of this study. Each context was examined and implications discussed. Through this examination, considerations were explored for how this current study increases the understanding of the self-esteem of Christian women with adverse childhood experiences and shame.

Historical

The current study was grounded in the correlation between adverse childhood experiences and their impact on adulthood. The ACE study provides the historical context for understanding the association between early experiences and future behavior. The history of the ACE study began with the standardized examination of adults at the Kaiser Permanente San Diego Health Appraisal Clinic by researchers Felitti et al., (1998). Although published work from sociologists and psychologists on the frequency and long-term consequences of child abuse existed, the findings were not relevant to adult medical problems (Gold et al., 2021). Most of the early research also lacked significance for primary care physicians because it focused only on adolescents' health and single types of abuse, particularly sexual abuse (Felitti et al., 1998). However, the ACE study categorized events as physical abuse and neglect, emotional abuse, emotional neglect, and sexual abuse (Schütze et al., 2020). The ACE study aimed to describe the long-term relationship between childhood experiences and various medical and public health problems (Norman et al., 2012). Felitti et al. (1998) assessed the outcomes levels of disease risk

factors incidences, quality of life, health care utilization, and mortality. Findings from the ACE study revealed a significant impact on psychological and physical health in adulthood (Felitti et al., 1998; Monnat & Chandler, 2015; Norman et al., 2012; Springer et al., 2007). The data from this study indicated that at least 25% of the examined individuals had experienced more than one ACE and at least 90% had experienced at least one ACE. The study also showed the higher an individual's ACE score, the more likely they would develop health issues (Souers & Hall, 2016).

Adverse childhood experiences have also been associated with higher levels of experiencing self-conscious emotions such as shame (Wojcik et al., 2019). Shame is associated with conflicts of power and status between superiors and inferiors (Sedighimornani et al., 2021). Factors such as parental abuse, put-downs, and criticism have been implicated as possible contributions to the development of shame (Gilbert et al., 1996; Mintz et al., 2017; Sedighimornani et al., 2021). When early experiences are positive and safe, likelihood of shame to happen is low. Brown (2006) asserted that people responded to shame by moving away from, moving towards, or moving against it. The lack of shame management adds to prolonged negative self-evaluation (Sedighimornani et al., 2021). Self-esteem responds to life's circumstances and influences one's evaluation of the self.

Increasing levels of self-esteem in adulthood contributes to individual's ability to approach life stressors and their overall well-being. This study enhances the understanding of the impact that God, faith, or religious practices have on the self-esteem of women who have experienced adverse early childhood events of shame. Historically there has been a link between aspects of religious involvement and self-esteem that was contingent upon the nature of beliefs about God (Schieman et al., 2017). For example, if a person viewed God as punitive, they might not feel support, love, or protection, which are all important to building self-esteem. In addition,

the belief in a loving God was reported as a predictor of increasing self-esteem (Schieman et al., 2017). The lens of attachment theory was used to view one's attachment and service to God as a means of positive self-evaluation. Traditionally, faith practices such as prayer and meditation were used to mitigate adverse mental health and spiritual concerns and facilitate healthy coping among individuals who have faced trauma (Walker & Aten, 2012). Thus, a Christian woman with self-esteem concerns might benefit from reconnecting to the biblical text that revealed God's love and support.

Social

Human relationships are crucial to people's survival and well-being (Bowlby, 1969; Matos et al., 2013). Throughout life, social relationships, and in particular attachment relationships, are powerful physiological and psychological regulators (Matos et al., 2013). Shame is recognized as vital to the development of both social and moral behavior. Thus, how individuals relate to and treat others is significant to advancing society at large. Shame results from a perceived loss of social attractiveness and serve the adaptive function of alerting individuals to threats against their power and status in society (Vaughn et al., 2019). The shame-experience usually occurs in adverse childhood encounters. Dickerson and Gruenewald (2004) conceptualized shame as an adaptive psychobiological response that results from threats to the individual's social self; it is elicited in response to social rejection and other events that threaten the individual's self-esteem, social status, and sense of belonging.

Theoretical

Having healthy and stable self-esteem contributes to positive relational experiences. Attachment theory asserts that children internalize their interactions with their primary caregivers, formulating mental representations of them (Shen et al., 2021). This aspect is also

known as a child's internal working model, which is generally conceptualized as beliefs about the self and others and are stable over time (Spinelli et al., 2017). A child's attachment style emerges from their early interactions, whether positive or negative (Groh et al., 2017). For example, Shen et al. (2021) reported that adults with memories of family harmony and openness were linked to less attachment anxiety; and adverse events such as parental divorce and interpersonal traumas were related to reducing secure attachment and increased insecure attachment. Negative experiences such as adversity in childhood form negative representations, which directly influence one's relationships with others over time, thus impacting their overall well-being (Felitti et al., 1998).

Living with shame leads to issues with self-esteem. Low self-esteem breeds isolation, limiting the individual's ability to connect to others to hopefully receive the nurture needed to grow and sustain well-being. Restoring an identification with the self brings hope for a stronger self-esteem. Connecting with the dimension of a loving God is positively related to the self through self-love (Yust, 2017). The perception of God as a confidant, secure, and caring attachment figure might be positively associated with different aspects of psychological well-being (Culver & Denton, 2017). The current study builds on the premise that self-esteem is negatively impacted by shame and addresses how one's view of the self could impact interpersonal relationships and overall well-being. Moreover, this study asserts that seeing God as a secure base increases the feeling that one is in good standing and thus boosting the levels of self-esteem.

Situation of Self

The motivation for conducting this study emerged from my therapeutic work with evangelical Christian women who have struggled with intrapersonal and interpersonal conflicts.

Even more significant, these women seem to secretly have a very low sense of the self. Their public persona was much different than their private persona. Lcking acknowledgment of how their childhood contributed to their inability to have healthy relational experiences, was the main contributor to their problems. Most had significant early shame experiences due to relational trauma with caregivers. Most women reported being constantly criticized or belittled with name-calling. Some reported being isolated in the home with others having to provide emotional support for an abusive parent. Women who succeeded in therapy attributed their success to consistent faith practices. This led to my believe in the assumption that faith could mitigate adverse mental health and facilitate healthy coping among individuals who have faced trauma (Walker & Aten, 2012).

Problem Statement

The problem is anchored in the evangelical Christian culture that being a Christian believer is synonymous with being mentally and emotionally resilient (Bloom, 2013). Christian believers or not, all adults have experienced childhood and some of these experiences might have been traumatic. Traumatic events, especially those involving a child feeling shamed, results in a diminished view of the self (Budiarto & Helmi, 2021). Being Christian does not exclude individuals from trauma or the need to overcome the impact of early shame experiences. Having faith in Christ comes with the expectation of not experiencing weakness. This religious anticipation leads to more pressure, particularly for women (Bloom, 2013). Current literature on self-esteem does not address the pressures on Christian women since it neglects to report on how early shame experiences affect the self-esteem of Christian women (Bogolyubova & Kiseleva, 2016; Budiarto & Helmi, 2021; Hallman et al., 2016; Schütze et al., 2020). There is no current literature on the specific faith practices that contribute to high levels of self-esteem in Christian

women with early shame experiences (Schieman et al., 2017; Szcześniak & Timoszyk-Tomczak, 2020; Waldron et al., 2018). This study addresses the current gaps found in literature and exposes the present trends and themes regarding self-esteem, early shame experience, Christian women, and faith practices.

Purpose Statement

The purpose of this qualitative phenomenological study was to gain a deeper understanding of the experiences surrounding the self-esteem of evangelical Christian women with early shame experiences. This study sought to provide understanding in regards to how specific faith practices serve as a supporter of well-being and areas of mental and emotional health, especially self-esteem. Self-esteem is generally defined as the overall sense of personal value and self-worth (Budiarto & Helmi, 2021). It is also explained as being rooted in early childhood and founded through trust, unconditional love, and security; furthermore, it impacts people as their lives progress through a combination of positive and negative self-evaluations (Budiarto & Helmi, 2021). This study provides enlightenment pertaining to the experiences of evangelical Christian women who experienced early adverse shame and faith practices that could have increased their levels of self-esteem.

Significance of the Study

The significance of this study stems from the biological need to properly develop attachment and have healthy relationships. Unfortunately, healthy relationships are not possible without being mentally and emotionally prepared. Having a strong sense of the self contributes to positive relational outcomes (Budiarto & Helmi, 2021). Conversely, low self-esteem is associated with negative relational outcomes (Budiarto & Helmi, 2021). Living with shame leads to issues with self-esteem. Low self-esteem breeds isolation, limiting the individual's ability to

connect to others to hopefully receive the nurture needed to grow and sustain well-being. Restoring an identification with the self brings hope for establishing a stronger self-esteem. Connecting with the dimension of a loving God is positively related to the self as loving (Yust, 2017). The perception of God as a confidant, secure, and caring attachment figure might be positively associated with different aspects of psychological well-being (Culver & Denton 2017).

Research Questions

The research question for this study was designed to explore and understand the lived experiences of Christian women with low self-esteem and have had early shame experiences. The central question is:

RQ. How do evangelical Christian women describe their experiences with adverse childhood shame experiences?

This research question was intentionally designed as open ended to avoid personally guiding any themes and trends that were to emerge due to my work involving evangelical Christian women with early shame experiences and identifying self-esteem issues as matters to address. With numerous studies on self-esteem and managing the effects of early shame, there has been no evaluation of these phenomena in Christian women (Bloom, 2013). The interpersonal consequences of experiencing shame are predominantly negative (Matos et al., 2013).

Definitions

Adverse Childhood Experiences (ACE) – Adverse childhood experiences are traumatic events such as domestic violence, divorce or separation, substance abuse, mental illness, death of a loved one, incarceration of a parent, and abuse/neglect (Felitti et al., 1998).

Early Shame – Early shame refers to experiences where an individual needs were not attuned to by a caregiver, leading to a perceived break in connectedness, and where one was made to feel small, worthless, and powerless (Budiarto & Helmi, 2021).

Evangelical Christian – Evangelical Christians are those who believe the death, burial, and resurrection of Christ to be the centrality of the gospel (Bloom, 2013). This gospel is also known as the "good news" of salvation brought to sinners by Jesus Christ.

Faith Practices – Faith practices are acts done that allow one to express, connect, feel strengthened, and be transformed by their faith in God (Bloom, 2013).

Self-esteem – Self-esteem refers to the overall sense of personal value and worth (Bogolyubova & Kiseleva, 2016).

Summary

The purpose of this phenomenological study was to gain a deeper understanding of the lived experiences surrounding the self-esteem of evangelical Christian women with early shame experiences. Experiencing early shame could have adverse effects on lead one's self-esteem. Low self-esteem could breed isolation due to failing to see oneself as worthy of meaningful connections, without which individuals might lack the nurture needed to grow and sustain their well-being. Restoring a meaningful and positive identification with the self brings hope for altering self-esteem in a positive direction. For some, the restoration of connection is done through faith traditions. Judeo-Christian scripture teaches that all humanity is God's beloved creation, and thus is created in God's image. Data was collected through ACEs questionnaire, an unstructured interview, observations, and evaluated for major themes and trends. This phenomenological study addressed the gaps found in Christian counseling literature and practice

in regards to the impact of scripture meditation as a means of altering one's negative perceptions of the self. Chapter two covers the theoretical framework that guided the study. It also entails literature review to explore past studies on shame, self-esteem, evangelical Christian women, and faith practices to identify the gap that warrants the current study.

Chapter Two: Literature Review

Overview

At birth, children have untapped potential and abilities (Krombholz, 2018; Lo & Poth, 2017). They have instinctual drives and needs, with the greatest of these being the desire to bond (Ainsworth, 1989; Ainsworth & Bowlby, 1991; Bowlby, 1946, 1950, 1954; Swartz, 2015). The earliest relational attachment is commonly between a child and their primary caregiver, mainly the mother (Ainsworth & Bowlby, 1991). Relationships are imperative to people's survival and well-being (Bowlby, 1969; Matos et al., 2013). Throughout life, social relationships, and in particular attachment relationships, are powerful physiological and psychological regulators (Matos et al., 2013). Children's attachment quality has in turn been repeatedly linked to the child's development (Groh et al., 2017; Vaughn et al., 2019). The modification of early attachment insecurity has become the focus of interventions aiming to promote social-emotional regulation (Groh et al., 2017). Given the evolved power of relationships, to feel safe, fit in, belong, and engage in advantageous social roles, humans are motivated to stimulate positive affect and create positive images of themselves in the mind of others. Groh et al. (2017) asserted that all emotions are embedded in humans' lifelong attachment system.

Shame occurs in response to perceived rejection or separation from attachment figures (Morrison, 2011). This typically begins with the interactions between the infant and primary caregiver, as part of socialization. Once shame has alerted the individual to the threat, action could be initiated to protect or repair the attachment bond (Groh et al., 2017). Shame is followed by intense discomfort and feelings of inadequacy, which reduce self-esteem (Lewis, 2003). With various studies on self-esteem and managing the effects of early shame (Budiarto & Helmi,

2021; Matos et al., 2013; Schieman, 2017), there has been no evaluation of these phenomena in Christian women.

A systematic review of the literature was conducted to explore evangelical Christian women's low self-esteem rooted in early childhood adverse shame experiences and faith practices that enhance one's overall well-being. The literature began with the theoretical underpinnings of the study. Theories of attachment serves as a strong foundation for understanding how trauma, shame, and self-esteem are related. Next, a review of the literature was conducted regarding shame, self-esteem, evangelical Christian women, and faith practices. This process provides the reader with the most current literature on these subjects, the limitations, and the need for their unexplored connection.

Theoretical Framework

Piaget (1954) explained in his studies of child development that the internal conceptualization of the self and esteem was a major concern. Stanley Coopersmith further expounded self-esteem as being rooted in early childhood and founded on trust, unconditional love, and security; accordingly, self-esteem impacts one's life progresses due to a combination of positive and negative self-evaluations (Matos et al., 2013). Theorists such as Harry Stack Sullivan, an influential figure in psychoanalysis, believed that relationships proceed according to what he called the principle of reciprocal emotions in which the reciprocity of behaviors and attitudes determines the trajectory of a child's relational development (Evans, 2020). He viewed pathology, such as poor self-esteem, resulting from unhealthy parental relationships (Evans, 2020). Thus, healthy self-esteem and other life-long factors of well-being are rooted in the quality of one's early life experiences with primary caregivers. Humans are biologically predisposed to form attachments with others (Bowlby, 1969). If the experience of attachment

bonding is positive, the development of a healthy emotional state occurs and could last throughout life (Ainsworth, 1989; Reisz et al., 2018). Positive attachment, later defined as secure attachment, increases self-esteem and helps individuals discover their potential as they evolve (Akin & Radford, 2018).

The theoretical framework supporting this study is attachment theory. First, a review of concepts developed through object relations theory supports the strength of attachment theory. The central concept of object relations theory is that adult personality characteristics depend on the nature of people's early relationships, particularly the relationship the child had with the mother or the primary caregiver (Evans, 2020). Healthy infant development happens when consistent and nurturing parenting has been provided throughout the child's life. According to this theory, the infant is driven to attach to an *object,* the object not being the other person, but the internal mental structure that the infant forms of that person through introjection (Evans, 2020). These internal mental depictions affect people's later sense of themselves as well as their perceptions of the self and capacity for building external relationships (Evans, 2020). Object relations theorists believe impaired relationships reflect the nature of people's problems with object relations and corresponding threats to their sense of the self (Shahar, 2021). Most influential in object relations theory were Melanie Klein and later John Bowlby, who developed attachment theory.

Attachment theory, pioneered by John Bowlby, focused on the lasting bonds and relationships between people and the effect of these relationships on long-term psychological growth and well-being (Bowlby, 1946, 1950, 1954). Bowlby (1954) hypothesized the existence of a universal human need to form close emotional bonds. Consequently, he viewed the child-caregiver system as a means to develop attachment bonds and provide security and emotional

regulation. Later, Bowlby (1969) asserted that strong causal relationships existed between children's attachment to their parents and their later capacity to form affectional bonds and experience positive emotional development. Attachment theory was explored as a significant component to understand the grounds of self-esteem and adverse childhood experiences of shame of evangelical Christian women.

Foundations of Attachment Theory

Main et al. (2016) described attachment as the relational and emotional bond between caregivers and infants who establish safety and protection through seeking and maintaining proximity. Pioneered by British psychologist John Bowlby, attachment theory centers around the lasting relational bonds between individuals and their long-term effects on psychological growth and well-being (Ainsworth & Bowlby, 1991; Bowlby, 1969, 1973; Schwartz, 2015). Bowlby (1969) conceptualized attachment through four stages: pre-attachment, attachment in the making, clear-cut attachment, and goal-correct partnership. The pre-attachment stage is characterized by infants 0–2 months. Children at this stage do not have difficulty separating from their parents because they are unable to differentiate their parents from other adults. Children ages 6 months up to 4 years of age fall within the clear-cut attachment stage. At this stage, they begin to experience separation anxiety. The goal-oriented partnership phase defines children ages 4 years and beyond. At this phase, separation anxiety declines. By analyzing the children's behavior after separation from the primary Caregiver, Bowlby (1969) conceptualized described features of the attachment bond as proximity, maintenance, separation distress, haven, or secure base.

Child attachment, before Bowlby's research findings, was believed by the early theorist to be learned rather than an internal mechanism (Bowlby, 1946, 1950, 1954). Bowlby's interest began with investigating mother-child separation, taking an evolutionary perspective, where he

proposed that humans favored attachment behaviors because it increased the likelihood of mother-child proximity, thus increasing protection and providing a survival advantage (Bowlby, 1946, 1950, 1954). Infant-caregiver relationship was also developed as a protective function for survival, which supports the evolutionary role of attachment (Bowlby, 1951). Bowlby anticipated that feeling secure would maintain some stability over time due to the resilience of relationships. This aspect overlaps with the evolutionary survival of the species perspective, which ensures that securely attached individuals would be able to safely explore and respond to external stimuli (Bowlby, 1951).

Attachment is also a biological function and infants are predisposed to seek security, especially in times of distress (Grady et al., 2017). In contrast, although infants seek closeness to avoid distress, they would still attach to abusive mothers to achieve the desire for attachment (Grady et al., 2017). Bowlby (1946, 1950, 1954) suggested that the attachment system is driven by not only positive association but also the inherent motivation for the child to connect for exploration. Bowlby (1954) later held the belief that attachment had multiple benefits (e.g., self-regulation, feeding, social interaction). This suggested that attachment is a healthy characteristic of humans throughout the lifespan, not a weakness from infancy to be overcome. Bowlby found infants' anxiety was characterized by distinct behavioral and motivational patterns where infants sought out proximity for nourishment or protection when frightened (Bowlby, 1946, 1950, 1954). According to Bowlby (1946, 1950, 1954), the goal of the child is not an object (e.g., the mother), but rather a state of being, which is one of homeostasis, like physiological homeostasis, the process whereby people’s physiological systems (e.g., blood pressure, body temperature) are regulated. The increase in these physiological systems is correlated with anxiety. Hence, attachment resolves the need for sustenance while providing regulation for elevated levels of

stress. If the child-caregiver bond is strong and secure, it brings comfort to the anxious child (Bowlby, 1946, 1950, 1954).

Attachment is a lifelong construct and forms out of one's experience throughout the lifecycle from infancy to death (Bowlby, 1973). Repeated interaction over time between the child and caregiver teaches the child how to adjust their behavior accordingly. Relational expectations are developed, and the child begins to form mental representations, coined by Bowlby (1951) as their internal working model. An infant's internal working model allows them to predict the caregiver's sensitivity and receptiveness (Bowlby, 1951). Infants learn to evaluate the fulfillment of their needs from others and whether they are worth the response and feeling of connection from their caregivers (Bowlby, 1964, 1973). The attachment theory serves as a foundation for understanding the working model of the self and others, providing a framework for relationships throughout the lifespan (Bowlby, 1973). As a child's internal working model develops, positive and supportive caregivers help to establish a sense of self-worth for the child; however, given an inconsistency with the caregiver, the child Could develop a negative sense of the self and feelings of worthlessness (Bowlby, 1973). Accordingly, the negative sense of the self, propagates subsequent insecurities that are projected in future relationships. In a positive view, internal working models are flexible and open to change (Bowlby, 1973). As a child grows, they form relationships with others and their attachment expands to other individuals who become important to the child such as grandparents, siblings, peers, and other adult caregivers (Shlafer & Poehlmann, 2010). The child could assimilate and accommodate these new attachment experiences into their already established internal working model (Shlafer & Poehlmann, 2010). This aspect develops the child's inner guidance system for future behavior,

influencing their emotions, interaction with others, and expectations of others when in relationships (Shlafer & Poehlmann, 2010).

Attachment Theory's Evolution

Psychologist Mary Ainsworth is known for expanding Bowlby's original theory of attachment. It was her study, *The Strange Situation* that provided the context for which attachment styles were born (Ainsworth, 1989; Schwartz et al., 2016). This study comprised evaluating the response to the situation of children ages 12-18 months of age who were left alone and then reunited with their attachment caregiver (Ainsworth, 1989; Schwartz et al., 2016). Ainsworth (1985) described the following four criteria as the foundation for attachment bonds: 1) maintaining proximity with the attachment figure, 2) using the attachment figure as a secure base, for explorative behavior 3) regarding the attachment figure as a haven, and 4) experiencing anxiety when separated from the attachment figure. Mary Ainsworth provided labels to the styles of attachment and how they explained the behavior of children separated and reunited with their primary caregiver (Schwartz et al., 2016). Ainsworth's (1989) research findings established three major styles of attachment (secure, ambivalent-insecure, and avoidant-insecure). These styles are discussed in further detail in the following section. Duschinsky and Solomon (2017) added a fourth attachment style (disorganized-insecure), expanding Ainsworth's work on attachment theory.

Main and Solomon (1986) were the first to classify attachment as disorganized. In Bowlby's early work, he mentioned disorganized attachment, but this work remained unpublished (Schwartz, 2015). In his view, disorganization results from threat conflict, safe haven ambiguity, and/or activation without relief, which interfere with coordination and integration across the behavioral system (Schwartz, 2015). Main and Solomon (1986) used

Bowlby's and Ainsworth's work to operationalize disorganized attachment. They defined disorganization as both conflicts at the level of the attachment system, rejecting the coherence of its behavioral expression; and the behaviors that imply disruption (Main & Solomon, 1986). Researchers Duschinsky and Solomon (2017) conducted further research using the findings of Solomon's early work with Main as a guidepost. Their research yielded a formal definition categorizing a "lack of any strategy" or the "lack of any way of coping with stress," as the foundation for insecure-disorganized attachment. Thus, disorganization demonstrates a collapse of attachment strategy under conditions of stress; with these conditions, disorganized individuals select behaviors that are extraneous to their need for downregulation of discomfort (Reisz et al., 2018).

Beginning with Bowlby's evolutionary theory of attachment, continuing with Ainsworth's 'strange situation,' and the current findings of Duschinsky and Solomon (2017), their work is a significant contribution to the four attachment styles (secure, ambivalent-insecure, avoidant-insecure, disorganized-insecure). Secure attachment is a preferable primary strategy wherein children are free to connect with their attachment figure, comfortably displaying all emotional states and exploring their surroundings (Ainsworth et al., 1978). Insecure attachments (i.e., avoidant, resistant, disorganized) are adaptive functional qualities that enable children to cope with the various caregiving environments. Infants classified with an avoidant attachment use a secondary attachment strategy aimed at minimizing effect, manifesting in masking or distracting from their distress. Another attachment concept is disorganization, which is identified in response to a proportion of conflict, confusion, or apprehensive behavior towards their caregiver in the situation (Reisz et al., 2018). This forms the basis of secure, avoidant, or resistant attachment patterns.

Attachment Styles

Secure. According to Ainsworth (1989) and Schwartz et al. (2015), this attachment style is characterized by positive models of the self and others The child perceives themselves as worthy of affection and security and able to self-regulate at the absence of comfort. The secure style is reinforced through positive and consistent caregiving (Ainsworth, 1989; Schwartz et al., 2015). Secure attachment is associated with seeking positive caregiver behavior, demonstrating comfortability with autonomy, and displaying trust during times of relational conflict (Ainsworth, 1989; Brennan & Shaver, 1995).

Ambivalent-Insecure. Children with this type of attachment are often wary of strangers and need constant reassurance that they are loved (Ainsworth, 1989; Schwartz et al., 2015). These children are frequently worried that they were going to be rejected or abandoned by the caregiver (Ainsworth, 1989; Schwartz et al., 2015).

Avoidant-Insecure. The avoidant-insecure attachment style often occurs because of early trauma and is said to be a type of defense mechanism (Ainsworth, 1989; Schwartz et al., 2015). Thus, individuals with avoidant-insecure attachment relationships might avoid relationships altogether and be extremely reluctant to form new relationships because of extreme fear of rejection.

Disorganized-Insecure. A child who displays a disorganized-insecure attachment bond exhibits behavioral disorganization through freezing, undirected movements, wandering, confused expressions, or contradictory patterns of social interaction with a caregiver (Briere et al., 2017; Duschinsky & Solomon, 2017; Reisz et al., 2018; Stover et al., 2018). Disorganized attachment is associated with marked impairments in the emotional, social, and cognitive domains, and predisposition toward a clinical condition known as an association in which the

capacity to function in an organized, coherent manner is at times impaired (Ainsworth, 1989; Schwartz et al., 2015). It arises from a child's spirit of the caregiver and might also be a result of unresolved trauma and the parents (Hesse & Main, 2000; Main & Solomon, 1990).

Table 1

Attachment Styles and Patterns

Attachment Styles	**Psycho-Emotional Behavioral Patterns**
Secure Attachment	A child demonstrates security through being able to secure bonds with others and develops a healthy self-esteem
Ambivalent-Insecure Attachment	A child demonstrates ambivalence through fears of the caregiver being neglectful, inconsistent, or unavailable
Avoidant-Insecure	A child is avoidantly demonstrated by guarding against forming new relationships for fear of being rejected this cycle is due to early trauma
Disorganized-Insecure Attachment	A child is disorganized demonstrated through freezing, undirected movements, wandering, confused expressions, and contradictory patterns of social isolation.

Attachment theory, serving as the foundation for this research, provides a framework to examine the impact of relational trauma from early neglect or caregiver rejection results in having negative internalized views of self. The central component of the origins of attachment theory suggests mothers or primary caregivers who are readily available and responsive to the needs of the child assist in the development of a sense of security and emotional well-being within the child (Ainsworth, 1989; Ainsworth & Bowlby, 1991; Bowlby, 1946, 1950, 1954, 1977, 1982; Schwartz et al., 2016). This aspect is vital for a child to feel the mother or caregiver is reliable and dependable so that a secure attachment bond could be established between the child and the mother or any other primary caregiver (Ainsworth, 1989; Ainsworth & Bowlby, 1991; Bowlby, 1946, 1950, 1954; Schwartz et al., 2016). This secure attachment bond helps

children develop a secure sense of self-esteem and self-reliance and is thus able to explore the world in which they live and develop secure relationships with others (Ainsworth, 1989; Ainsworth & Bowlby, 1991; Bowlby, 1946, 1950, 1954, 1977, 1982; Schwartz et al., 2015). Thus, parental bonding is crucial to the child's emotional well-being (Bowlby, 1969). The lack of secure bonding because of unsafe and inconsistent caregiving fuels a sense of shame for the child. Moreover, frequent experiences of shame could be conceptually related to chronically low levels of self-esteem (Velotti et al., 2017). The following related literature begins with adverse childhood experiences as a foundation for understanding how early trauma informs shame identification, self-esteem, and attachment styles. The literature validates the relationship between attachment, shame, and self-esteem, as well as builds a foundation for understanding the experience of self-esteem for evangelical Christian women who suffered early shame.

Related Literature

Adverse Childhood Experiences (ACEs)

Adverse childhood experiences are described as potentially traumatic events that could have negative lasting effects on health and well-being (Boullier & Blair, 2018). These events include maltreatment and abuse, as well as living in an environment that is harmful to the child's development (Boullier & Blair, 2018). Given this description, ACEs could be divided into three different groups: abuse, neglect, and household challenges. The abuse includes sexual, physical, or emotional. Neglect is either emotional and/ or physical. Household challenges occur as violence experienced by the mother, household substance abuse, mental illness in the household, parental separation or divorce, or criminal household member (Boullier & Blair, 2018).

Healthcare providers develop a questionnaire to assess 10 different abuse experiences as a child. The results of the original ACE study by Kaiser Permanente found that out of 17,337

participants “12.5% of respondents had experienced more than four ACEs and 64% had experienced at least one ACE” (Boullier & Blair, 2018, p. 132). A second study was conducted in 2015 and revealed that 47% of 2028 adults had experienced at least one ACE and 14% had experienced more than four (Boullier & Blair, 2018).

The severity of ACEs in childhood directly impacts their well-being as adults and has grave implications specifically for mental, physical, and relational health (Boullier & Blair, 2018). Boullier and Blair (2018) later found that individuals' exposure to abuse or maltreatment during childhood, the development of their self-regulatory skills, and shame management could be poorly impacted. Higher levels of shame and impaired self-regulatory skills might negatively impact an adult’s capacity and confidence to manage life’s challenges and possibly lead to an unhealthy coping mechanism such as substance abuse (Bogolyubova, & Kiseleva, 2016). As it relates to shame, exposure to trauma has been associated with increased shame in adulthood, leading to higher rates of depression (Irons & Gilbert, 2005)

Shame

Shame as defined by the online version of the Oxford Dictionary (n.d.) is a “painful feeling of humiliation or distress caused by the consciousness of wrong or foolish behavior.” It is also seen as failing to meet own internalized ideal, resulting in a focus on the entire self as being inferior, flawed, or weak (Bogolyubova & Kiseleva, 2016). Shame is a common emotion, but rarely understood or even discussed once experienced (Hahn, 2009; Kaufman, 1989). It emerges when an individual does not meet their own or societal expectations. Shame could often be categorized as feeling bad at one’s core. Valid definitions all use words such as “damaged,” “defective,” “unlovable,” or “disgusting” to describe shame. Feelings of inadequacy, worthlessness, and a sense of being isolated an instance of experiencing shame (Hahn, 2009).

Shame is central to identity and could be a source of low self-esteem and a diminished sense of self (Kaufman, 1989). One distinction between shame and guilt is that shame is evidenced by focusing on the inner self and guilt is evidenced by focusing on behavior (Tangney et al., 2007)

Shame, mostly lodged in the right brain, is imprinted implicitly in the early months or years of childhood (Grey et al., 2019). It has a strong connection to the emotional and survivor centers of the brain (Heard-Garris et al., 2018). In the first three years of life, the right brain that sufficiently processes and stores memories is active (Johnson, 2018). Distressing early childhood memories are processed by the right brain and stored nonverbally, beneath conscious awareness (Lee et al., 2017). These memories might emerge as images, bodily sensations, and autonomic survival tendencies when anxious (Loudermilk et al., 2018). It is not until the third year of life that the left brain, which stores and consciously recall memories with words and logic, becomes active (Heard-Garris et al., 2018). Until then the right brain stores shameful memories as a sense of dread or wrongness that manifest as visceral sensations, emotions, and images (Hunt et al., 2017). Later on, a child could have words and logic to what they are experiencing beneath their conscious. Although shame is initially lodged in the right brain, the left brain shuts down during overwhelming moments of stress (Lee et al., 2017). Hence, a child would be unable to communicate during times of distress. Current experiences of shame only layer on top of childhood shame, triggering painful reactions from the first three years of life (Heard-Garris et al., 2018).

Findings illustrated that shame is a predictor and contributor to psychopathology and has a significant impact on mental health (Cândea & Szentagotai, 2013). The relationship between shame and different psychological symptoms and disorders rests on how individuals cope with their shameful feelings (Vagos et al., 2019). The compass of shame model proposes that

individuals might adopt four different maladaptive shame coping strategies: attack-self, withdrawal, avoidance, and attack other (Vagos et al., 2019). When using the attack-self coping strategy, individuals recognize the shaming experience as negative and valid, tolerate shame to maintain relationships with others, and turn anger inward. When using the withdrawal approach, people also recognize the experience of shame as negative and valid, but because they are unable to tolerate it, they move away from others or from the shameful situation. Resorting to the avoidance move implies that the affected try to minimize the expense of shame, this time by distracting the self and others from the same experience. Finally, when using the attack other strategy, individuals try to minimize the shame-experience that externalizes it, turning anger outward (Vagos et al., 2019).

Shame has been linked to various mental health diagnoses, including depression, anxiety, post-traumatic stress disorder (PTSD), and substance abuse disorders (Brown, 2006). When the intensity, frequency, or duration of shame is amplified, shame could obstruct interpersonal communication via the paralyzing bind of self-consciousness thereby dividing the self and prohibiting healthy functioning (Bogolyubova, & Kiseleva, 2016). Although shame has an adaptive value, there is an increasing body of research that implicates otherwise. Maladaptation such as prevention (i.e., dependency, imagination), escape (i.e., isolation, misdirection) and aggression towards others or self, are common ways used to regulate shame (Schoenleber, 2012).

Various studies have been emphasizing the role of childhood maltreatment in the development of social anxiety disorder (SAD), which is linked to shame (Infurna et al, 2016; Moscovitch, 2009). Specifically, it is suggested that early experiences of maltreatment contribute to the development of SAD via the internalization of a shame-based cognitive–affective schema, characterized by an overall sense of inadequacy (Infurna et al., 2016). While feeling inferior and

different, individuals with SAD are primarily concerned that their perceived flaws would be exposed (Moscovitch, 2009), which also results in the activation of highly aversive shame-based feelings.

The interpersonal consequences of shame experienced from adverse parental encounters are predominantly negative (Claesson & Sohlberg, 2002). Shame emerges within the first three years of age (Mills et al., 2010). Thus, children have self-awareness, and they could take the view of others and think about others' perspectives toward them. They have acquired standards, rules, and goals and could evaluate themselves as succeeding or failing to meet them. Because shame essentially disturbs the natural functioning of the self, it could have a significant negative impact on an individual's overarching psychosocial development, but most saliently, on an individual's developing concept of the self and identity formation (Hallman, 2018).

Feelings of inadequacy result in people using maladaptive behaviors because of their inability to regulate their emotions, particularly shame, which leads to difficulty understanding, unwanted feelings, and negative behaviors (Schoenleber & Berembaum, 2012). Shame experienced early in life disrupts ongoing activities, stimulate an inability to talk, act, or think clearly, and promote a passive self (Farr et al., 2021). At an interpersonal level, shame has been associated with the tendency to socially withdraw, hide, disappear, inhibit social interactions, and isolate oneself from others (de Hooge et al., 2018). Thus, shame's impact on interpersonal and intrapersonal relationships is imperative to study.

Shame and Guilt

Shame, not to be confused with guilt, directs an individual to focus inwardly and view self in a negative light. Although guilt and shame are used interchangeably, research supports there are marked emotional experiences eliciting different results (Lewis, 1971; Lindsay-Hartz,

1984; Tangney & Dearing, 2002). According to Tangney and Dearing (2002) and Van Vliet (2008), shame and guilt embody different sentiments, as the former has constantly been identified as more painful thus leading to a consistent desire to hide, self-silence, deny or escape the shame-inducing circumstance. In contrast, guilt reflects feelings of remorse that make one to apologize or seek to rectify the guilt-causing issues (Tangney & Dearing, 2002; Van Vliet, 2008).

Research on the associations between guilt, shame, and psychopathology indicates that shame, but not guilt, is associated with poorer mental health (Benetti-McQuoid & Bursik, 2005). Guilt has an adaptive nature, whereas shame does not. Shame appears to have no adaptive function and has been empirically linked to psychological maladjustment (Velotti et al., 2017). Guilt feelings are reparative in nature, prompting apologies, confessions, and empathetic responses (Benetti-McQuoid & Bursik, 2005; Tangney & Dearing, 2002). Shame is also positively correlated with suspiciousness, resentment, irritability, self-oriented personal distress reactions, anger, and externalization (Tangney & Dearing, 2002).

Early Adverse Shame and Attachment

The quality of attachment relationships is strained when childhood adversity is experienced. Secure attachment is a preferable primary strategy wherein children are free to connect with their attachment figure, comfortably displaying all emotional states and exploring their surroundings (Ainsworth et al., 1978). Contrastingly, insecure attachments (i.e. avoidant, resistant, & disorganized) are functional adaptations that enable children to cope with variant or suboptimal caregiving environments. Gilbert (2003) proposed troubling family experiences in childhood strengthen the long-term influence of shame and significantly contribute to shame-proneness in adulthood. Early adverse experiences of shame not only influence the quality of the

attachment figure relationship, but also impact a person's expectations of all attachment relationships throughout the lifespan (Sroufe, 2005). Acts of personal betrayal such as abuse and neglect early in life result in shame (Moscovitch, 2009). This forms the belief that one must experience shame to hold on to attachment figures throughout their lifespan (Ein-Dor & Hirscheberger, 2016). Hence, shame becomes a strand in the attachment process itself. Consequently, a child with a poor attachment from early shame would be ashamed even in new relationships.

Family trauma has roots in Ainsworth and Bowlby's (1991) work on attachment. Attachment theory proposes that the security of initial bonds formed with primary caregivers impacts developmental pathways that influence personality development (Ainsworth, 1989). Derin et al. (2022) found that childhood adversity was associated with numerous maladaptive outcomes including attachment anxiety. Attachment anxiety is described as having a negative self-image and using hyperactivated attachment strategies, including vigorous efforts to maintain closeness, difficulty with autonomy, and exaggerated reactions to relational distress (Mikulincer et al., 2003; Wilke et al., 2020).

Shame is more than a feeling; it operates at primitive levels below rational thinking (Matos et al., 2013). Feeling shame could be described as having a sense of smallness, worthlessness, and powerlessness. It is triggered by a perceived break in connectedness to self or others (Bynum et al., 2021). Thus, "self in the eyes of another" is the center of shame. Shame also involves autonomic reactions. The activation of the autonomic nervous system is a part of the brain's overall crisis response (Mills et al., 2010). Triggering the brain's crisis response system gives shame the power to generate flight-fight-freeze tendencies like the activation of behavior from adverse childhood experiences.

Childhood shame bears a strong relationship with parental hostility, lack of recognition of positive behavior, lack of discipline, neglect, overprotectiveness, placing the child in the parental role, use of conditional approval, use of love withdrawal techniques, discipline that focuses on the child's self rather than behavior, and the use of public humiliation as a discipline tool (Hayes & Filipovic, 2018). For children with attachment difficulties, ordinary discipline and being given directions could be reliable triggers for a shame reaction (Ein-Dor & Hirscheberger, 2016).

Adult Attachment Relationships

Parental caregivers, more than anyone else in a child's life prime them for future attachment relationships (Schore, 2002). People re-create in their intimate relationships, patterns of interaction that were scripted in their relationships with primary caregivers, whether they were good or bad (Lampis et al., 2019). These interactional patterns, once wired into the brain, tend to re-create themselves in each subsequent relationship throughout life. As humans, they are psychologically wired to be attached. In its most positive form, attachment provides a safe harbor. Neuroscience research of the past two decades confirms that attachment, separation, and laws during our formative years profoundly affect lifelong patterns of relating and these relational blueprints correspond to the structural and functional development of the brain (Corcoran & McNulty, 2018; Wilke et al., 2020). Primary attachment relationships, whether characterized by sensitivity, insensitivity, or frightening unpredictability, powerfully alter the brain, mind, and body on the cellular level, even affecting DNA and gene expression (Shore, 2002).

The bond of intimacy brings up the very same yearnings, disappointments, and protective defenses that occur in the primary balance of infancy and childhood (Harris et al., 2017). Most insecure partners come with a history of unresolved trauma, loss, vulnerability to future

relational trauma. During childhood, children depend on their caregivers for help in regulating their internal states. The ability to regulate emotions in relationships is a sign of relational health. Early adverse experiences affect emotional regulation, as well as other areas that executive functioning, arousal management, and recognizing danger (Dvir et al., 2014). Regulating emotions involves having control not only over how and when, but the prevalence with which emotions could be felt, experienced, and expressed (Schore, 2002).

When the caregiver is too intrusive, too unresponsive, too reactive, or too preoccupied to maintain relational equilibrium missteps occur (Harris et al., 2017). If the caregiver could adjust or correct it, regulation is restored. However, if the primary caregiver is unable to correct or adjust, mis-attunement is extended and goes unrepaired resulting in dysregulation of the infant's internal state (Harris et al., 2017). Attachment insecurity and dysregulation go together. The more insecure a partner is, the more likely psychological dysregulation would appear as a regular feature in the coupled system (Matos et al., 2013).

In the case of severe adverse early childhood experiences such as rejection, neglect, or physical, emotional, or sexual violence, the adult is more likely to develop a disorganized, disoriented, and disassociated attachment style (Main & Solomon, 1986). These types of attachment styles have become synonymous with traumatic childhood (Duschinsky & Solomon, 2017). As Pan et al. (2016) reiterated, people with an insecure attachment style generally report unpredictability, emotionally unavailable, lack of support, or aversive attachment relationships in childhood and adulthood. This experience impairs the ability to fully trust others and elicits the expectancy that partners would be unavailable, unpredictable, or absent. Consequently, an insecure preoccupied attachment style, which is linked to excessive dependency or a dismissive

avoidant or fearful avoidant attachment develops, culminating into fears of independence and avoidance of relationships (Pan et al., 2016).

To securely connect with self and others is the deepest human longing (Butzer & Campbell, 2008). Securely attached individuals commonly report greater satisfaction and adjustment in their relationships as a balance of intimacy with independence (Brennan & Shaver, 1995). Individuals with secure attachment find it easy to be emotionally close to others and are generally comfortable depending on others and having others rely on them (Brennan & Shaver, 1995). They do not tend to worry about being alone or lacking acceptance from others. Securely attached couples build shared self-esteem by facing and working through problems (Butzer & Campbell, 2008). Even if the problems do not get fully resolved, confronting rather than hiding from them produces strength. Securely attached adults have optimistic beliefs and attitudes and see their partner's intentions in a positive light (Brennan & Shaver, 1995). Secure adults score higher on measures of trust, intimacy, open communication, prosocial behavior, self-disclosure, support seeking, marital satisfaction, and self-esteem (Schwartz, 2015).

Shame and Gender

Research has documented that individual differences in gender role development predict neuropsychological phenomena, including cognitive skills, relational capacities, and behavioral scripts (Benetti-McQuoid & Bursik, 2005). These gender role differences influence perceptions of and reactions to shame. Some individuals' responses to shame reflect stereotypical response patterns and gender scripts; those with more aschematic gender roles might be less bound by gender conventions and norms (Benetti-McQuoid & Bursik, 2005).

Men and women experience shame, although literature makes a distinction in their shame expression (Gilbert, 2017; Tangney & Tracy, 2012). Men are expected to exude courage and

strength, while women are projected to openly express their emotions. Gender and shame have been studied, providing discrete differences between male and female experiences of shame. A historical study by Lewis (1978) described women as more prone to shame reactions than men, because women were more centered on and sensitive to others than men. Some other studies found females were more prompt, and socially expected, to experience and express more feelings of shame than males (Adams, 2005; Ferguson et al., 2000). However, other studies have shown that females and males might express or handle their shame experiences differently, but there are no differences in the frequency or intensity of shame feelings (Lewis, 1978; Senecal et al., 2000; Szentagotai-Tatar & Miu, 2016; Vagos et al., 2016). There are variances in male and female behavior following shame experiences. Females tend to present more internalizing and self-destructive behaviors in an attempt to suppress shame or other negative emotions (Garnefski et al., 2005; Irons & Gilbert, 2005; Johnsonte et al., 2016). On the contrary, males tend to express more externalizing behaviors directed towards others (Johnsonte et al., 2016; Kivisto et al., 2011).

Jordan (1997) suggested that there were three significant reasons women feel more shame than men. That is, men being seen as the head of women, silencing their reality; women share their desire for connection and are extremely vulnerable to broken connection; and women tend to carry more of a burden for letting others down. This creates a sense of being the “weaker vessel,” and being unable to have appropriate relationships. Shame then leads to feeling disempowered and unable to experience needs or wants (Jordan, 1997). Later, Brown (2008) conducted grounded theory research evaluating why and how women experience shame, as well as strategies used to develop shame resilience. Shame resilience theory (SRT) emerged out of Brown's (2006) research and stands as the only comprehensive theory on shame. Brown (2006)

found twelve categories where women felt shame: appearance and body image, motherhood, family, parenting, money and work, mental and physical health, sex, aging, religion, being stereotyped and labeled, speaking out, and surviving trauma. This demonstrates the extent to which shame bleeds into all aspects of women's lives, from childhood to adulthood.

Self-Esteem

Trzesniewski et al (2013) defined self-esteem as the individual's subjective evaluation of his or her worth as a person. This subjective appraisal results in a negative or positive attitude toward themself (Rosenberg, 1979). Self-esteem is positively associated with important life outcomes in work, relationships, and health domains (Orth & Robins, 2014). When considering influential factors on self-esteem, research suggested stressful life events and social relationships rank high (Orth et al., 2016). Self-esteem becomes more stable and difficult to change as individuals mature and become adults (Orth & Robins, 2014; 2016; 2020). Thus, addressing self-esteem is more effective if done early in life, not later in the adult years. A longitudinal study conducted by Orth (2018) found that the early childhood family environment has a long-term, and possibly enduring, effect on self-esteem that could still be observed in adulthood. According to Orth's (2018) research, the quality of the home environment partially mediated defects of other characteristics of the family environment, such as the quality of parental relationships, maternal depression, presence of the father, and poverty.

Stets and Burke (2014) posited that self-esteem had three dimensions: self-worth, self-efficacy, and authenticity. It also functions as a coping resource and protective factor during life hardships (Budiarto, & Helmi, 2021). Budiarto and Helmi (2021) suggested that it would be plausible to think of high self-esteem as enabling people to recuperate quicker or entirely from misfortunes and setbacks. Waldron et al. (2018) highlighted that high self-esteem associated with

happiness, coping skills, and societal norms appear more successful in any kind of situation and challenges in an environment that leads to a positive relationship. If self-esteem refers to individuals' perceptions about themselves, their bodies, their aspirations, and their ability to cope with problems, practices designed to enhance self-esteem would be significant in their relational well-being.

Self-esteem has been described in the literature in various ways, but there has been limited evidence on self-esteem's impact on physical health. Branden (1994) noted that although self-esteem was the immune system of consciousness, the immune system is healthy does not prevent one from becoming ill. However, it does allow for one to be less vulnerable to diseases and more empowered to overcome them. Healthy self-esteem does not guarantee one would never suffer depression or anxiety when faced with life difficulties, but it would make one less vulnerable and more equipped to cope, rebound, and transcend (Branden, 1994).

One of the most widely used definitions of self-esteem entails one appreciating their own words and importance and having the character to be accountable for self and to act responsibly towards others (Stets & Burke, 2014). Branden (1994) found that self-esteem had two dimensions: 1) confidence in the ability to think and cope with the basic challenges of life, and 2) confidence in the right to be successful and happy, the feeling of being worthy, deserving, entitled to assert needs and wants, achieve values, and enjoy the fruits of individual efforts. Hence, self-esteem influences all aspects of a person's life and shows a positive correlation between such qualities as creativity, flexibility, ability to manage change, cooperativeness, and willingness to admit mistakes. In contrast, poor self-esteem correlates with blindness to reality, rigidity, fear of the unfamiliar, defensiveness, and hostility towards others (Branden, 1994). Healthy self-esteem would not prevent emotional challenges and questions of worth, but it could

make one less susceptible to the hollow pit of low self-esteem. The goal is to develop and nurture esteem in a positive direction that focuses on honoring self, not suppressing it.

The theory of symbolic interactionism, not used as a foundation for this research, adds to the understanding of how self-esteem could be developed. It proposes that the self develops and is continuously shaped throughout the life course through social interactions (Orth & Robbins, 2019). It is presumed that social interactions reflect how much others appreciate an individual. During childhood, a large proportion of a child's social interaction occurs in the relationship with his or her parents, so these exchanges could be primarily determinative. Building on the theory of symbolic interactionism, attachment theory posits that a secure attachment to the caregiver contributes to the development of a positive internal working model of the child (Bowlby, 1969, 1969, 1973, 1980). Further research findings suggested security gained through positive parental interaction relates to higher self-esteem in children (Parker & Benson, 2004).

Parental Relationship and Self-Esteem

There is often pressure put on a child to deny their own dependency needs and wants so as not to bother parents. Because of these attitudes, children might never sense their inherent worth and might feel worthless to others. This occurrence also leads them to esteem themselves based on perceived quality of doing or performance rather than their existence (Parker & Benson, 2004). When a child's value is exposed to either shaming or empowering dysfunctional parenting, the resulting survival trait is one of two extremes: the child feels less than or better than others (Harris et al., 2017). Either of these traits develops into the adult core symptom of difficulty experiencing appropriate levels of self-esteem. Both the low self-esteem response and the arrogant, grandiose response to dysfunctional parenting stem from the same problem: lack of awareness of one's value or inherent worth.

Positive parenting is vital to the nurturing and strengthening of self-esteem. This interaction includes factors such as parental warmth, involvement, and monitoring are associated with positive self-esteem (Orth, 2020). Parental warmth is characterized by love, support, nurture, affection, involvement, responsiveness, and acceptance (Parker & Benson, 2004). Some longitudinal studies found that parental warmth positively predicts children's self-esteem (Amato & Fowler, 2002; Harris et al., 2017). Parental monitoring, catalyzed by wearing this attention, watchfulness, and tracking and supervision of children's activities, has also been positively associated with self-esteem (Orth, 2016). Furthermore, parental monitoring should not be mistaken for parental control, which restricts autonomy and negatively impacts self-esteem (Orth & Robbins, 2019). Nonetheless, parental involvement in child education, similarly to parental monitoring, is associated with higher levels of self-esteem (Orth, 2020). It is characterized by interest, participation, encouragement, and supervision of the child's schoolwork (Orth, 2020). Not only does parental involvement in a child's education enhance self-esteem, but also increases the child's sense of competence (Orth, 2020). These factors contribute to the quality of parental relationships, which also has a positive effect on self-esteem (Orth, 2020).

Other parental characteristics impacting a child's self-esteem are family values, maternal and paternal depression, economic hardship, parental hostility, and the presence of the father. Positive family values include a strong orientation toward the family, commitment to the family, and prioritizing the interest of the family over personal interest (Krauss et al., 2020). Research conducted by Orth et al. (2014) suggested that maternal depression has negative effects on depression, and paternal depression yields similar negative effects. Parental hostility was characterized by rejection, neglect, maltreatment, punishment, and verbal and physical aggression (Schaefer, 1965). A child being ignored and humiliated by their parents negatively

correlates with poor self-esteem (Krauss et al., 2020). Economic hardship is another negative influential characteristic associated with various problems in child development of self-esteem (Conger et al., 2010). Finally, research indicates the absence of a father is associated with lower self-esteem (Luo et al., 2012).

Religion and Spirituality

One of the most powerful forces in an individual's life is their spiritual narrative; it reveals the authentic, good, right, true, wise, desires and feelings, thoughts, values, actions, and practices that exemplify worth (Szcześniak, 2022). Religion and spirituality provide people with a sense of purpose and meaning, which is highly correlated with belonging, a sense of control, and a positive impact on a person's psychosocial and mental well-being (Russo-Netzer, 2018). Both are important human resources and are often called upon in times of crisis, which could also have an adverse effect, causing individuals to question the existence and goodness of God.

To understand how these constructs influence one's life, it is important to first address the differences between religion and spirituality. Religion and spirituality represent significant dimensions of human well-being. One of the main focuses of religion is to offer answers that address human questions about meaning (Koenig, 2012). Exploration of spirituality and religion demonstrates the distinction between the two (Manning, 2012). There has been a conversation about their variations for over a century (Ivtzan et al., 2013). Religion and spirituality became separate constructs during the mid-1900s with distinct definitions for the two, yet faith is a thread that runs through them both (Keller et al., 2015).

As time passed, spirituality became more associated with an inner subjective experience, while religion was known for keeping rules and rituals (Ivtzan et al., 2013). Spirituality demonstrates connectedness towards a Higher Power, whereas religiosity focuses on service to

an institution (Villani et al., 2019). Spirituality also centers around having a relationship with God and finding meaning and purpose (Manning, 2012). However, religion has a different motivation. Acts of worship encompasses the measurement of man's ability to perform, rather than relationship, meaning, or purpose relating to God's love. For example, religion and spirituality could be understood by looking at the difference between doing and being. *Doing* becomes a way of appeasing God for approval while *being derived* from knowing they are accepted by God (Houck-Loomis, 2015).

The rules of religion initially produced confidence for a person who has spent their life performing to seek approval and acceptance. Religious serving offers a way of life, contributes to personal and social development, and is a symbiotic means of transformation (Egri, 1997). Spirituality is founded on God's goodness, not one's perceived worth or performance. Practicing spirituality within religion provides a deeper meaning to an individual's life, but practice and religion alone have an opposing effect (Koenig, 2012). Practicing religion is not always negative, it has a positive effect on spiritual individuals. Their act of worship is not founded upon fear or the need to be accepted, but on an understanding of God's care for them. Those who are spiritual and religious have a more positive view of religious traditions such as worship, prayer, giving, or attending Church (Hill et al., 2000). Both spirituality and religion give people a sense of self-worth, which is associated with positive well-being (Russo-Netzer, 2018).

Christian Religion

The Christian faith is a religion that allows people to full express their spirituality. It is founded and maintained in the person of Jesus Christ. The Christian movement began with the public teaching of the ministry where Jesus proclaimed the coming of God's Kingdom. Jesus selected 12 Jewish disciples and together ministered to the poor and outcast. The core principles

of the Christian faith are believing Jesus is the son of God, was crucified, and resurrected after three days. Believing in these core tenets proposes that one would be saved from their sins that caused spiritual separation and would be united back to God. After Jesus' death and resurrection, the Christian religion grew and continues to grow today. Currently, in the United States, Christian beliefs are often described as evangelical, fundamental, liberal-conservative, or a combination of these terms (Schmitker et al., 2017). For this research study, the focus was evangelical Christianity.

Evangelical Christians are known for a set of principles and beliefs. The term "evangelical" is commonly used to describe Churches that stress evangelization or converting non-Christians to faith in Jesus (Schmitker et al., 2017). Evangelicals are typically conservative and support devoted service to the mission of Christ. Polonyi (2010) proposed evangelicals should emphasize three core beliefs: 1) Christianity requires conversion or rebirth through a personal spiritual encounter with Jesus Christ; 2) Christians must witness their faith to or evangelize Christians and non-Christians alike, and 3) the Bible is directly inspired by God. These key standards are vital to claiming oneself as a Christian believer or follower of Christ.

Main evangelical denominations in the United States include Baptist, Presbyterian, Methodist, and Episcopal (Richards & Bergin, 2000). In the South and among Blacks and brown people, evangelical Protestant movements such as Charismatic, Pentecostal, Holiness, and Word of Faith are known for taking a work-based approach to expressing their faith. Work-based is viewed as performing for God's approval versus knowing that one is unconditionally loved by God. Research has shown individuals who ascribe to this sect of religion have experienced adverse childhood experiences (Entringer et al., 2020); the feeling of being wrong that often proceeds from childhood trauma is often soothed through attending work-based churches.

Because religious practices contribute to a sense of being saved from wrongness, individuals engage in religious duty to avoid feeling wrong (McKay & Whitehouse, 2015). In addition, church attendees are encouraged to imitate Christ and when they fail to do so, shame emerges. Statements like, “a lack of discipline is the cause of failure,” or, “you did not get healed because you are indulging in sin,” could provoke a higher level of performance to avoid such a feeling of inadequacy.

Churches, a place where many should feel welcomed and embraced, could be a breeding ground for shame. The feelings of not meeting God’s law or being perfect could lead to one hiding in the shadow of shame. Religion provides the backdrop for people’s understanding of good or bad, right, or wrong, clean, or unclean. These defining standards contribute to the possibility of experiencing shame and feeling oppressed by religion. It might enhance already existing shame or cause people to feel ashamed. Mental health or areas of personal weakness have been seen as taboo in evangelical movements as they focus on the message of Jesus as a form of deliverance. This being a true source of liberation, they are not taught to access it by faith, rather by being good enough for such a gift. This performance-based religion often seen in Christianity is a significant contributor to shame (Błażek & Besta, 2012).

Religion and Shame

A common criticism of religion is individuals experiencing feelings of judgment by those expressing themselves as religious. This sense of judgment contributes to feelings of shame and isolation from religious communities. For some, religion informs areas of their life while at the same time being an all-encompassing reality (Russo-Netzer, 2018). Religion contributes essential elements of self-esteem, values, and orientation to human life (Blazek & Besta, 2012). Under certain circumstances, religion could be an impactful vehicle for self-worth, but can also

result in feelings of inadequacy (Szcześniak, & Timoszyk-Tomczak, 2020). Some Christians live continually with internalized shame, unaware of its presence and negative effect on the relationship with God and with others (Bradshaw, 2005). If shame is not acknowledged or resolved, it could hinder the Christian's relationship with God and others.

Religion provides critical ideals of excellence that one could identify with to build a sense of self upon (Parks, 2016). When acted upon people now form crucial parts of their identity. Not only is identity formed around these ideals, but also meaning, well-being, and a sense of social belongingness accompany (Stets & Burke, 2000). In different ways, religion shapes the world and how people's experience themselves and others. Because shame implies a judgment of a person's conduct, it is not determined solely by the individual and their relationship with God; rather, shame is mediated by the social world (Parks, 2016). This social world is mainly the religious community.

Being religious is usually associated with belonging to a religious group, like a congregation. Conformity and compliance are almost necessary to be a part of a group. The smaller the group, the easier it is to monitor expectations. When members fail to meet group expectations, their propensity for shame through self-policing, regulates their behavior (Tomkins, 2013). Shame emerges because of incongruence between actual conduct and internalized ideals; thus, leading to a lack of autonomy (Ryan & Ryan, 2019). To avoid shame in these settings, compliance with rules shapes the individual's agency to circumvent judgment and ensure belongingness to the group is possible (Ryan & Ryan, 2019). However, within a religious community, belongingness could be in jeopardy at any time. If behavior fails to fall within the parameters set by the group, be it a doctrine or religious practice, placement and acceptance within in the group might not be secured.

Failure to fall within certain parameters is known in certain religious community as sin. The sin is viewed as acts that separate one from God and by its nature produces shame. In Genesis 3, after disobeying God's command, Adam and Eve hid from God. One solution for shame is God's grace offered through the act of reconciliation by Christ's substitutionary death on the cross for all the sins of all humans (Tomkins, 2013). Ward (2012) stated if a shame prone person is urged to believe that Jesus died for them to be reconciled to God, their understanding of the relationship with God might enhance shame. However, the work of reconciliation means God has found the person worthy, not unworthy.

Bringing resolution to shame within a religious setting allows the community to embody its biblical responsibility toward its body of believes; and this to be a place of hope. Stump (2016) identified honor as another antidote to shame. She argued a person who feels ashamed is convinced that something about herself permits that real or imagined others have no desire for being in a community with her. Here, shame is emerging out of weakness, powerlessness, or other defects. Honor means to regard with great respect, to esteem, to lift a person above their ideal or reality of abasement. When one believes that God honors them, the belief in this acknowledgment provides an exchange of self-evaluation that provides another lens through which to view themselves (Stump, 2016).

Religion, Women, Shame

Women have been the backbone of many patriarchal religious movements, with more women attending religious services than men (Rassoulian & Loeffler-Stastka, 2021). However, using the Christian Bible as a foundation, women have been described as weaker than men. Adding to this description, they were also expected to be submissive to their spouses, community, and God according to the book of Proverbs chapter 31. The book of Genesis

stipulates that God created women to be helpers for men. Women such as Deborah, Phoebe, and Pricilla were all mentioned as leaders in the Bible. Yet, as modern organized religion emerged, women are still seen as subservient to men and void of their call from God to religious duty other than serving in the home or assembly (Frustration with these traditional gender roles is not often captured within the Christian faith communities. However, Aune (2008) reported evangelical Christian women were dissatisfied and leave at higher rates than women in any other religion, yet they still departed at lower rates altogether. Even with the mild acceptance of current women leaders in the Christian ministry such as Joyce Myers and Paula White, women who ascribe to such marginalized roles, might be reluctant to share feelings.

Shame could be described as a sense of smallness, worthlessness, and powerlessness (Bynum et al., 2021). Furthermore, it results from the devaluation of self by others (Tangney & Dearing, 2002). Honoring traditional religious doctrine regarding a woman's role as a subordinate could be viewed as oppressive. Feelings of oppression are directly associated with experiences of shame (Rassoulian & Loeffler-Stastka, 2021). feelings of being controlled, unable to verbalize needs, or exercising a sense of agency are all forms of oppression associated with strict religious rules for women. With no recognition or provision of needs, people experience neglect. Most early childhood shame comes from emotional and physical neglect (Cohen et al., 2017). Childhood abuse allegations are considered secondary emotional neglect when being investigated (Cohen et al., 2017). There has been a lack of attention due to the challenge of defining neglect in literature (Dubowitz, 2013; Reyome, 2010). Dubowitz (2013) suggested defining neglect as occurring when a child's basic needs were not met in an immediate and broader sense over time. Emotional neglect consists of involved and uninvolved parents who might have met their children's physical needs, but lack necessary nurturing (Cowen, 1999).

Women who experience emotional neglect talked less about their problems and shied away from resources (Schutz et al., 2020).

God and Attachment

Until the early 1990s, most attachment theory research centered around the child-caregiver relationship. Kirkpatrick (1988) was one of the first researchers to explore the idea of integrating the psychology of religion and attachment theory. He later explored God as a substitute attachment figure and laid the foundation for future work on attachment to God and adult attachment styles. For some time, researchers devoted attention to understanding God as an attachment figure (Granquvist, 1998; Kirkpatrick & Shaver, 1992). God attachment is characterized by the relationship an individual has with God, just like their bond with their primary caregiver; it affords them similar psychological and emotional benefits (Granquvist & Kirkpatrick, 2013). Attachment theory asserts that attachment shapes one's perceptions of God and influences how religion might be used to manage emotions (Granqvist, 2005). Kirkpatrick and Shaver (1992) found that participants who described their relationship with God as secure or attributed characteristics of warmth, love, and consistency scored lower on measures of loneliness, depression, anxiety, and high on life satisfaction. Further research found a correlation between internal working models of parents and God, supporting the idea of God as an attachment figure (Birgegard & Granquvist, 2004). Granqvist et al. (2007) found a correlation between the experience of loving parents and positive images of God. This finding supports the connection between attachment styles and perceptions of God as positive or negative, safe or unsafe, loving or unloving.

Most research has been centered around the idea of compensation versus correspondence concerning one's relationship with God (Hall et al., 2015). In other words, there are concerns on

whether relationship with God follow compensation for deficient caregiver bonds or attachment styles remain stable across all attachment domains. Ainsworth (1985) described four criteria as the foundation for attachment bonds: 1) maintaining proximity with the attachment figure, 2) using the attachment figure as a secure base, for explorative behavior 3) regarding the attachment figure as a haven, and 4) experiencing anxiety when separated from the attachment figure. Individuals must perceive God as able and willing to meet their psychological needs to form a secure attachment (Miner et al., 2014). Attachment to God could be used to compensate for a lack of secure attachment with others (Kirkpatrick, 1997).

The role of trust is essential to establishing a secure relationship for individuals with a history of neglect. Even if an intermediate caregiver fails to provide a sense of security, state that only one important relationship is needed to disconfirm insecure expectations of unreliability or rejection to increase the possibility of forming a secure attachment in adulthood (Hong & Park, 2012). When trust suffers due to human error, developing trust for a divine being, God, is a challenging. Trust is developed when a child feels a sense of felt security from caregivers (Bosman et al., 2019). One develops a trusting relationship with God by experiencing his faithfulness, which requires being in position to need his assistance. Confidence and future relationships result from securely attached individuals who have cultivated trust and dependability (Campbell & Stanton, 2019).

Attachment to God has significant implications for relationships with others, religious coping, and psychological well-being. Seeing God as a secure base, one of the foundations for attachment bonds might vary given how God has been presented to the individual. Individuals who have built a secure attachment with primary caregivers have a positive relationship with spirituality and religion and move closer to God in times of distress (Rowatt & Kilpatrick, 2015).

If God is viewed as loving, supportive, and stable, bonding is possible and uninterrupted; but if God is seen as punitive and only loving if you are good, one might not establish a secure attachment (Beck & MacDonald, 2004). Research has also shown that an anxious style of attachment to God reflects faith challenges, whereas a secure attachment style to God reflects spiritual maturity (Hart et al., 2010).

The impact of attachment on psychological well-being is documented in the literature (Corcoran & McNulty, 2018; Pan et al., 2016; Wilkinson, 2004). One's belief and attachment to God also impact their psychological well-being (Granqvist, 2014). A perception that God would meet an individual's needs is essential to a healthy attachment to God and well-being (Miner et al., 2014). The differences in the attachment to God style most certainly impact psychological well-being (Granqvist & Kirkpatrick, 2013). For example, anxious God attachment was linked to perceived stress, psychiatric symptoms, and psychological distress (Knabb & Pelletier, 2014). Like parental attachment, anxious God attachment and avoidant God attachment styles are both correlated with high levels of depression and anxiety (Homan, 2014) and also have implications for personality traits (Rowatt & Kirkpatrick, 2002).

Secure attachment has protecting factors, whereas anxious God attachments heighten levels of distress (Ellison et al., 2012). Ways to mitigate anxiety or avoid it to secure attachment to God should be explored in future research. Treatment for impaired early bonds should be considered when seeking to transition from an anxious to a secure God attachment. Also, reflecting on the relationship with God as separate from the relationship with parents would open the possibility to attach solely to experiences with God. Progressing empirical evidence on the likelihood of stability of attachment in the absence of intervention is needed to aid the understanding of its necessity.

Summary

This chapter provided a review of the literature to support the relationship between early shame, self-esteem, and Christian women. Because all relationships are of crucial importance to people's survival and well-being (Bowlby, 1969; Matos et al., 2013), it was vital to study the impact of early shame, attachment styles, and the individual's perception of self and God. Moreover, this study investigates the association of these areas in participant's life. Limitations of previous studies and areas for potential future research were explored. Christian women could have a variety of religious experiences that could either strengthen or weaken their self-esteem or expose their shame. There is need to explore the types of religious coping associated with the experience of higher self-esteem or lowered shame. In addition, investigating further how shame is a moderator between attachment styles and self-esteem for Christian women increases the depth of current knowledge on this subject.

Chapter Three: Methods

Overview

Creswell and Poth (2018) described phenomenologists as those who focus on describing what participants have in common as they experience a phenomenon. Developed within the interpretivist epistemology, hermeneutic phenomenology seeks to provide a "nonreductionist" understanding of individuals' experiences with a phenomenon as they interact within their environments (Creswell & Poth, 2018). The current study explored the phenomenon of shame by looking at the faith and relationships of evangelical Christian women. The interpersonal consequences of experiencing shame are predominantly negative. Shame disrupts ongoing activities, motivate an inability to talk, act, or think clearly, and promote a passive self (Farr et al., 2021). At an interpersonal level, shame has been associated with the tendency to socially withdraw, hide, disappear, inhibit social interactions, and isolate oneself from others (de Hooge et al., 2018). Thus, shame's impact on interpersonal and intrapersonal relationships is imperative to study. Literature provides great support for understanding the negative impacts of shame. This research used unstructured interview questions to gain more depth data to understand of how Christian women have managed or overcome the negative imprints of early shame experiences.

Design

A qualitative approach using a descriptive phenomenology design was implemented for this research. According to Creswell and Poth (2018), qualitative research focuses on description, discovery, exploration, interpretation, and verification. The researcher should be comfortable with fieldwork because a qualitative design involves working and spending in-depth time with participants. The researcher should focus on understanding the meanings found in the lived experiences of several participants rather than one (Creswell & Poth, 2018). This meaning

is conveyed through a rich phenomenological description of the relationships among the parts and the whole that could "reawaken our basic experience of the phenomenon it describes" (Tinker & Armstrong, 2015). Although the number of participants required for a qualitative study is less, the amount of face-to-face time is greater. The design encompassed gathering oral histories, observation, ACEs questionnaire, and in-depth participant interviews. The design reflects organized methods of interpreting data such as transcribing, coding, and examination of any emerging themes from data. This type of design allows for the validation of human experience (Creswell & Poth, 2018).

Research Questions

Evangelical Christian women were chosen for this study because of the negative religious coping found in their culture regarding mental health. Floyd (2021) stated that negative interactions surrounding mental distress included being rejected by the church, broader teachings that mental distress was exclusively associated with the work of demons, and that mental distress was the consequence of personal sin. Early shame experiences serve as a foundation for self-identity development (Davis et al., 2018). These experiences shape negative perceptions of the way people exist in their minds (external shame) as well as their negative personal judgments of one's characteristics, feelings, or fantasies of internal shame (Matos et al., 2013). It is vital to understand how the shame-based identity impacts interpersonal and intrapersonal relationships as well as women's overall mental and emotional well-being and if scriptural meditation prevents further detriment of shame experiences (Knabb et al., 2021). Research question for this study was designed to explore and understand the lived experiences of Christian women who have had early shame experiences:

RQ. How do evangelical Christian women describe their experiences with adverse childhood shame experiences?

Participants and Setting

For this study, 5 evangelical Christian women living in Savannah, Georgia who had experienced early shame were recruited. There was a desire to seek a range of age, ethnicity, and socioeconomic status. Before participant recruitment, full ethical clearance from Liberty University Institutional Review Board (IRB) was granted. This consisted of submission for approval and any revisions requested. Once approved, participant recruitment started. The participants were recruited from Kingdom Life Ministries, a large multicultural church in Savannah, Georgia. The ACEs questionnaire was provided to ensure proper matching for the study. It was aimed at recruiting women with early adverse shame experiences.

Approval by the church leadership and informed consent was obtained from each participant that met the recruitment criteria. Once five participants were selected, no additional participants were accepted for the study. Qualitative research aims to refine the process of theory emergence through continual "double-fitting" (Tinker & Armstrong, 2015). This involves researchers generating conceptual images of their settings, and then shaping and reshaping them according to their ongoing observations, thus enhancing the validity of their developing conceptualization. The participants were interviewed in the Kingdom Life Ministries private conference room or via Zoom. The room included a large table with 10 chairs, a couch, two chairs, good lighting, soft music playing, and a balanced temperate to ensure participant’s comfort.

Research Procedures

Qualitative procedures follow the process of ensuring an in-depth understanding would be gained from the research area being examined. Before conducting research, full approval from the IRB was obtained. Participants were recruited from Kingdom Life Ministries, a large multicultural church in Savannah, Georgia. Permission was acquired from church leadership before contacting potential participants. Once approval was granted, participants were to complete the ACEs questionnaire to determine eligibility. If eligible and willing, participants were asked to participate in an unstructured interview lasting approximately 90 minutes. All interviews lasted 90 minutes with the exception of Participant One. Participant One interview lasted 120 minutes. The study respondents were asked to be prepared to conduct a short follow up interview lasting approximately 30 minutes to clarify unclear statements. Follow up interviews were conducted to ensure there were no mental or emotional side effects from the interview. No one reported negative side effects. Participants had the option of their session being conducted at the Church or via Zoom, the HIPAA compliant version. If a participant chose to meet at their Church, the interview was audio recorded and saved to a password protected Voice Memo computer program. Meeting times were scheduled based on participant's availability Monday-Friday 8 A.M. to 12 P.M. and 5 P.M. to 7 P.M.

Participants were presented with informed consent information prior to participating in the interviews. Taking part in this study was completely voluntary, and participants were welcome to discontinue participation at any time. Naturalistic qualitative methods are commonly known to include but are not limited to open-ended questionnaires, in-depth interviews, participant observation, and focus groups (Tinker & Armstrong, 2015). For this study, participants were given the ACEs questionnaire, followed by an unstructured interview. Open-

ended questions are not presumptions and allow the respondent to express himself or herself freely on a given subject (Tinker & Armstrong, 2015). Oral words whether in conversations, sentences, or monologues were captured to understand how shame, early in life, had impacted the participants. Once consent was given and interviews were conducted, respondents were asked to journal and document their experience and any thoughts about the early shame, self-esteem, and supportive faith practices they did not share during the interview. The journals were gathered one week after each interview had been conducted. This information was used later to analyze any similarities amongst the participants. All journals were collected from each individual participant. Only one participant provided additional information through journaling. The other four participants reported not having any additional information to provide. In addition to the interviews and journals, visual modes of self-expression such as facial expressions, body language, physical presentation of self, modes of dressing, and other forms of self-expression were captured.

Interviews took place in a span of two weeks. Participants were able to sign up for the stipulated day and time within the two weeks. One participant met in person at Kingdom Life Ministries private office and the other four participant's interview was conducted via Zoom. Upon the participant's arrival, she was given 10 minutes to grab refreshments and get comfortable. The same followed for Zoom participants. They were given up to 10 minutes to get relaxed. During the 10 minutes, the researcher had soft music playing. All participants were asked the same question in the same manner. Interviews were conducted, as well as follow-up questions as needed. After all the presented content was collected, field notes were reviewed along with all transcripts for emerging themes and trends. After coding and documenting the data, an analysis was conducted for research discussion.

The records of this study were kept private on a password protected hard drive. Research records were stored securely in researcher's locked office and only the researcher had access to the office. Published reports did not include any identifying information of the participants. Recordings were transcribed and would be kept in the researcher's computer for three years after completion of study. Similarly, video recordings and transcription were kept in same computer until the lapse of three years after completion of study. Data was stored on a password protected computer with access only granted to the researcher.

Researcher's Role

The researcher worked in family trauma for 15 years. As a licensed clinical social worker, the researcher currently provides therapeutic services to evangelical Christian women. Most women interviewed had an extensive history of adverse childhood experiences. Feelings of shame, low self-esteem, and poor relational health were usually at the center of concerns to be addressed. Current trauma protocols were used to provide effective treatment. Clients were treated with dignity and honor and stories were and still are valued and affirmed. There was an expectation that this study would provide a greater awareness of avenues for a richer healing experience for evangelical Christian women with issues of shame and/or self-esteem.

The researcher's professional role as a therapist could have contributed to bias therefore major considerations to reduce any potential bias were taken. In this study, the researcher was fully invested in the recruitment phase to the data analysis and reporting phase. Before recruitment, the researcher's role was to obtain ethical clearance from the IRB. Following clearance and recruitment, the researcher was responsible for the interviewing process, including ensuring informed consent was obtained. Most researchers use transcribers to prepare data for analysis, but in this study the researcher was responsible for the transcription. The analysis

required the researcher to code and the transcribe data. The data coding was done manually by the researcher, and the researcher was responsible for naming and defining categories. After coding the data, the researcher reported findings and discussed research implications for the future. This involved Braun and Clarke (2006) thematic analysis process, which will be discussed later in this chapter.

Data Collection

When conducting data analysis, the researcher looks for themes and trends that emerge from the interviews, ACEs questionnaire, and observations of the participants. This is done through transcription. According to Steffen (2014), transcription requires listening repeatedly to participants' voices, which could assist in early analysis. Fact-checking, meaning listening to records while reading over transcripts, could help researchers correct any mistakes made during transcribing. The importance of transcription is to allow the researcher to verify the collected data. Organizing transcripts is vital to the success of the data interpretation. This process starts with coding the dataset either manually or through software. Coding is a way used to systematically organize and understand the data. Just as with grading written work, instead of looking for mistakes, the researcher looks for similarities that stand out. Manual coding requires almost scrutinizing the transcripts, making comments, and emphasis for the identification of emerging themes. In doing so, researchers could also make connections between themes to develop first-level and second-level codes (Steffen, 2014).

Interviews

In phenomenology methods, van Manen (2016) explained that interviewing has two purposes: (1) to explore and develop a rich understanding of the phenomenon; (2) to develop a conversation around the meaning of experience. Accordingly, van Manen (2016) encouraged

more conversational interviewing, which is often seen a more flexible interview format than structured interviews. Interviews help the researcher explore and understand the participant's behavior and the phenomenon being researched (Bynum, 2021). Interviews took place in a span of two weeks. Participants were able to sign up for the stipulated day and time within the two weeks. One participant met in person at Kingdom Life Ministries private office and the other four participant's interview was conducted via Zoom. Upon the participant's arrival, she was given 10 minutes to grab refreshments and get comfortable. The same followed for Zoom participants. They were given up to 10 minutes to get relaxed. All participants were asked the same question in the same manner. Interviews were conducted, as well as follow-up questions as needed. After all the presented content was collected, field notes were reviewed along with all transcripts for emerging themes and trends.

It is assumed that all humans take in and make sense of their world by drawing on what they know and have experienced in the past. The act of recalling and reconstructing what occurred and then sharing the experience during the interview is integral in research. It provides the research participants with the opportunity to reflect on what that occurrence meant and choose important aspects within the experience; it further allows the researcher an opportunity to understand the participants' perspective as well as the context within which they occurred (Bynum, 2021). Instead of the traditional list of interview questions, only one pertinent question was asked to participants. The following interview question was specifically chosen to support the research purpose:

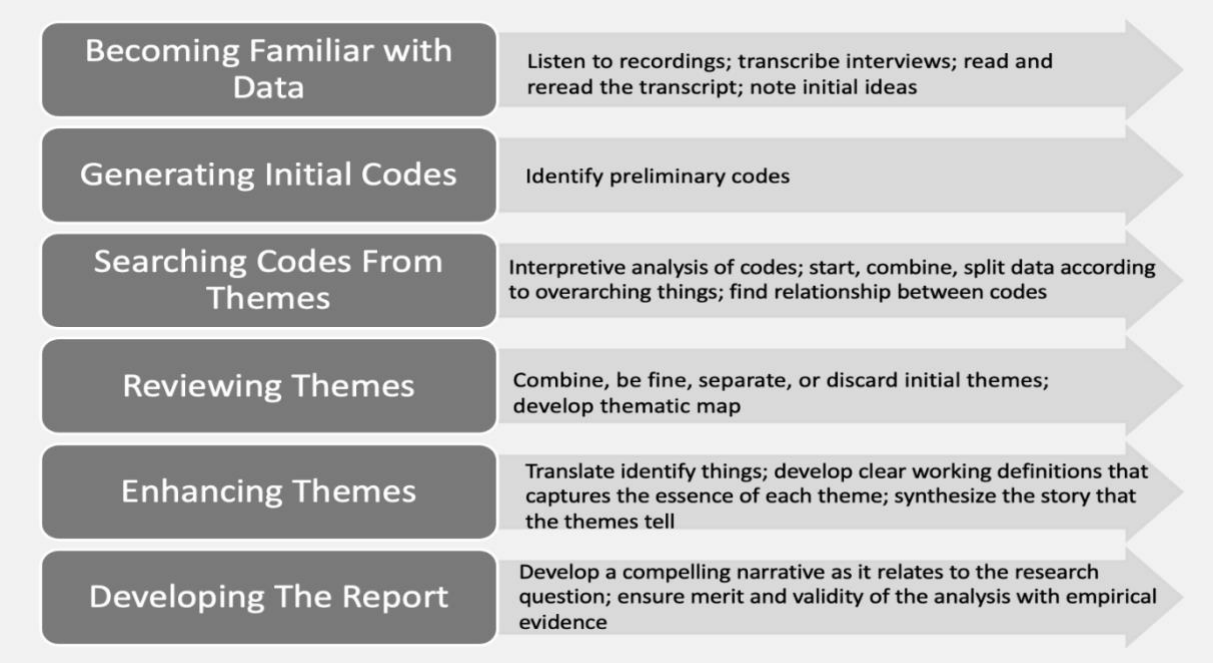
1. Describe your lived experiences as a Christian woman with an adverse childhood.

Data Analysis

Qualitative studies might include structure and semi-structured interviewing procedures. According to Creswell and Poth (2018), phenomenology focuses on discovery through participants lived experience and this is best gathered through an unstructured interview process. For this study, the unstructured interviews were recorded and transcribed verbatim. The reflexive process of reading and reviewing data, closely observing to themes for meaning was utilized throughout the analysis process (Creswell & Poth, 2018). I adapted Braun and Clarke's (2006) 6-step approach to thematic analysis for this study (see Figure 1). The process of thematic analysis required 8-10 hours for each participant.

Figure 1

Steps of Braun and Clarke's Thematic Analysis



The first step of Braun and Clarke's (2006) analysis was to listen intently and transcribe recording. After transcription, data was read twice for familiarity. The second step involved coding each transcription based on the relevancy of the research question being asked. Using

Braun and Clarke's (2006) third step, the codes were placed in possible thematic categories based on the research question. The fourth step involved reviewing and analyzing participant narratives for connected shared experiences. Next, clear working definitions were developed to capture the essence of each theme. Finally, a narrative reflective of the research question was developed.

Trustworthiness

Trustworthiness provides researchers with confidence of having conducted precise and consistent research (Shenton, 2004). It refers to the credibility of the research being conducted and the integrity of the researcher. Moreover, trustworthiness, also known as rigor of a study, refers to the degree of confidence in data, interpretation, and methods, ensuring a study's quality (Pilot & Beck, 2014). Building trust in research is not a definite procedure (Shenton, 2004). A responsible study establishes protocols and procedures necessary for a study to be considered by readers (Amankwaa, 2016). Research activity to the trustworthiness of this study rested upon credibility, dependability, and transferability.

Credibility

To ensure the credibility of this study the researcher had peer debriefings regarding the research process. Nowell (2017) claimed that the credibility of a study is determined when the researcher has a bias but could recognize it. Several techniques to address credibility include activities such as prolonged engagement, persistent observation, data collection triangulation, and researcher triangulation. Another technique used to explore credibility is respondent validation, which involves testing initial responses through member-checking to see if they matched what the participant said (Nowell, 2017). Brit et al. (2016), recommended a form of respondent validation as a means of enhancing the thoroughness of the study, proposing that

credibility is inherent in the interpretations of phenomena. The researcher allowed participants to validate their responses after data is collected.

Dependability and Confirmability

The dependability and confirmability of this study was achieved by ensuring future researchers could replicate the study. This aspect required stringent research procedures. Nowell (2017) claimed that to achieve dependability, researchers could ensure the research process is logical, traceable, and documented. In this study, the research provided thick and detailed description of the research process and procedures to ensure dependability and transferability. When readers could examine the research process, they would be able to judge the dependability of the research (Nowell, 2017). The research also allowed audit trail to further enhance dependability and confirmability (Nowell, 2017).

Ethical Considerations

When humans are the instrument of choice for naturalistic studies, researchers should respond ethically to any challenges that might arise (Creswell & Poth, 2018). Ethical considerations were established with IRB approval prior to conduct the study. Considering the nature of qualitative studies, the interaction between researchers and participants could be ethically challenging; therefore, the formulation of specific ethical guidelines in this respect was essential (Shirmohammadi, 2018). Varying ethnic, cultural, and religious differences were valued and respected. This study utilized principles of respect for persons, beneficence, and justice founded in the Belmont Report to conduct research.

Respect of Persons

Respect for persons is paramount, thus participants were carefully chosen for this study. This aspect requires individuals to be autonomous and those with reduced autonomy to be

protected (Nardi, 2016). Given the nature of early childhood trauma, extensive protection was considered and participants unable to endure questioning were excluded from study. Consideration of competence and cognitive capacity was evaluated before participant selection. The participants were chosen based on their capability of self-determination. All vital information was provided before the study allowing for self-determination through informed consent. Participants were treated as autonomous agents and allowed to withdraw from the study without objection or consequence.

Beneficence

This study involves recalling what could be considered extremely traumatic experiences; therefore, beneficence was revered. Beneficence, as described in the Belmont Report, obligates the researcher to do no harm and maximize benefit and minimize potential detriment (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). The researcher managed risk by using trauma-informed insight to select participants. Target respondents who indicated through the screening process they were mentally and emotionally stable to discuss past trauma were considered. Furthermore, participants who disclosed they had already shared extensively about their trauma history and suffered no significant breaches to their well-being moved further in the screening process.

Justice

The researcher's professional role as a therapist might contribute to bias, thus the area of justice must be evaluated. The researcher also took careful consideration in not selecting participants for the researcher's benefit. All participants were treated with fairness; they were all informed of the reason they were selected and their rights (Creswell & Poth, 2018). The interviewing and data collection process was the same for all participants. They were provided

with their interview transcripts for participant validation. Amazon gift cards valuing $25 were provided to show participation was appreciated (Creswell & Poth, 2018). All reported information and data were kept confidential and not altered even if contrary to other findings (Creswell & Poth, 2018).

Summary

This study explored the phenomenon of shame among evangelical Christian women and looked at their faith and relationships. According to Creswell and Poth (2018), qualitative research focuses on description, discovery, exploration, interpretation, and verification. This research had unstructured interview question to gain more depth data to foster the understanding of how Christian women managed or overcame the negative imprints of early shame experiences. The interpersonal consequences of experiencing shame are predominantly negative. Shame disrupts ongoing activities, motivate an inability to talk, act, or think clearly, and promote a passive self (Farr et al., 2021). At an interpersonal level, shame has been associated with the tendency to socially withdraw, hide, disappear, inhibit social interactions, and isolate oneself from others (de Hooge et al., 2018). The questionnaire was designed to collect a richer source of information about how shame has impacted the participants on an interpersonal and intrapersonal level.

Chapter Four: Findings

Overview

The purpose of this phenomenological study was to understand the experiences of Christian women with adverse childhood experiences of shame. Within the research, shame was evaluated as a major phenomenon that impacts a Christian woman's relationships, to include their relationship with God Participants were aged between 31 and 59 years, attended the same local Church in Savannah, Georgia, and completed the ACEs questionnaire as a criterion for eligibility. The respondents were not directly identified but used pseudonyms to protect their identity. Data was derived from content gathered from the participant's transcribed narratives. Themes and subthemes were created using Braun and Clarke's thematic analysis. This chapter provides background information on each participant and outlines their adverse childhood shame experiences. The chapter concludes with a summary of findings from data collection. An unstructured interview was conducted to ensure the interview was not controlled (Jamshed, 2014). The following research question guided the interview:

RQ. How do evangelical Christian women describe their experiences with adverse childhood shame experiences?

Participants

This study involved five Christian women between the ages 31 and 59 with adverse childhood shame experiences. Each participant was provided with a pseudonym randomly to protect their identity. These individuals assessed against the criteria concerning adverse childhood shame experiences by completing the ACEs questionnaire (Appendix A). All attended Kingdom Life Ministries and active participants within their religious community including attending weekly church services, home bible study, and prayer groups. All participants

completed the ACEs questionnaire and qualified for the study. The women's status ranged from stay-at-home mothers, working single parents, and a business owner. Of the five participants, three were African American and two were Caucasian American. Participants came from a myriad of family and socioeconomic backgrounds, but experiences with shame were similar. Each participant shared their experience through an unstructured interview. In the end, common themes emerged from their multitude of experiences.

Table 2

Participants' Demographics

Pseudonym	Age	Ethnicity	Years Being a Christian
Participant One	30's	Caucasian	7 years
Participant Two	50s	Caucasian	20 years
Participant Three	40s	African American	19 years
Participant Four	50s	African American	42 years
Participant Five	30s	African American	10 years

Participant One

Participant One was a 36-year-old White woman who was a single mother and full-time caregiver to an 11-year-old son. She had never been married and was not in a relationship during the time of the interview. She was a veteran of the United States Army, never attended college and worked from home as a coordinator for elderly care services. She was also an ordained minister at Kingdom Life Ministries and had been attending the ministry for seven years during the time of our interview.

The participant completed the ACEs questionnaire, scoring six out of ten. Her earliest recollection of shame surrounded her being sexually abused by her uncle at age four, who she later found out was her father. Once her maternal grandfather heard of this, she was taken from her mother's care and reared by her grandparents. After a few years, around age nine, her mother

moved into the grandparents' home as well. She remembered desiring her "mother's approval" and "feeling rejected" by her mother. The mother-child bond is crucial to one's survival and well-being (Bowlby, 1969; Matos et al., 2013). She was physically, emotionally, and verbally abused by her mother. The mother also told her how "sexy" she was as a child. She said she learned that her "body was a commodity" to be used to get what she wanted. She described her relationship with her mother as more of a friendship. Her mother worked at a bar and at age 14 she frequented the bar with her and became familiar with the regular bar attendees. She recalled liking an older gentleman who later "raped" her in his truck. She never shared this information with her grandparents. When shared with her mother, she stated "my mother called me a slut." She joined the military at 18 years old and vowed to never contact her mother again.

Participant One did not know the message of Jesus Christ until she had her son. At the age of 26 years, she developed a relationship with her child's grandparents who were Christians. She noted when she met them, she was "broken". I asked her to expound on that word. She stated, "I had no clue who I was, where I was going, or how I would get there. I was lost, depressed, and full of anxiety about life." She continued to say, "having a relationship with God through Jesus Christ was the best decision I have ever made, and it has allowed me to give my son the life I never had." She ended by saying, "serving God is my greatest joy, it has given me purpose."

Participant Two

Participant Two was a 54-year-old White woman with a 33-year-old daughter who lives in Chicago, Illinois. She had never been married and was not in a relationship during the time of the interview. She worked at a local nursing home as a physical therapist and was active in the

ministry, serving as support to ministerial staff. She had attended Kingdom Life Ministries for four years during the time of our interview.

After evaluating the ACE questionnaire, Participant Two scored a six out of ten. She began the interview by sharing about being sexually abused by her grandfather at age five. She was later raped by a college friend at 20 years of age, resulting in the pregnancy of her child. (Although there could be age disparity, the information is provided as shared by the study participant to avoid incorrect representation of the content she provided). She reported she had never felt as much shame as she felt from being verbally abused by her family, including her parents and siblings. Adverse childhood experiences have also been associated with higher levels of experiencing self-conscious emotions such as shame (Wojcik et al., 2019). She also shared an incident of trauma at age 10 with the dentist where she felt her mother abandoned her. The respondent was afraid to be left alone and when the dentist gave her mother the choice to stay for comfort, her mother opted not to. She recalled the dentist being very angry and aggressive towards her. That experience kept her from seeing a dentist for years as an adult.

Participant Two reported feelings of not being loved by her family and always wanting to have a different family. Her family was not perfect, she stated. Her mother had an affair, which resulted in family violence and the police being called to the home. She remembered being removed from the home and taken to her grandparent's home. She reported having "significant depression" as a teenager and not feeling wanted. She stated that she avoided large social groups and was described as an introvert by others. She also reported struggling with perfectionism throughout college and her professional career to avoid feelings of insignificance (Sedighimornani et al., 2021).

Participant Two stated she was reintroduced to the Christian faith at age 25. She recalled attending church with her grandparents, but her memories were somehow vague. She described struggling with believing God loved her. She described God as a punisher of sin and having conditional love. According to her if she did well, God was pleased, but if she sinned, she was doomed to punishment. The feeling of being wrong that often proceeds from childhood trauma is often soothed through attending work-based churches (Entringer et al., 2020). Because religious practices contribute to a sense of being saved from wrongness, individuals engage in religious duty to avoid feeling wrong (McKay & Whitehouse, 2015). When asked about the journey of that perspective shifting, she stated, "it took a while to simply believe the scriptures." She mentioned becoming extremely disciplined with her thoughts about herself and her past. Reading and meditating on scriptures was also a faith practice that helped her to be disciplined with her thought life. She added, surrounding herself with other Christian believers strengthened her efforts to overcome the impact of shame and build her self-esteem. In describing how she felt about herself at the moment, she reported being able to achieve goals that were impossible because she did not believe in God or herself.

Participant Three

Participant Three was a 44-year-old Black woman with five children. The two older children were from her first marriage and the latter three from her current marriage. She owned a daycare in her home and had no college or other work experience. She reported being very active in the ministry and served as the children's ministry director. She had attended Kingdom Life Ministries for five years during the time of the interview.

Participant Three completed ACE's questionnaire and scored a four out of ten. She began the interview by sharing about being taken away from her mother at the age of five, after the

parent had been diagnosed with Schizophrenia. Although her father became her primary caregiver, he was not present, leaving her to be molested under his care at age eight by a live-in aunt. For years she did not speak and reported her lack of communication was due to being molested by her aunt. She contributes being extremely promiscuous to the sexual abuse. She also reported feeling extremely responsible for her mother as a teenager. “I never had a childhood,” she stated. Although there was not a close relationship with her mother, she felt responsible for her.

When asked about how her childhood impacted her life as an adult, she reported, “I have struggled in my marriages.” She further stated, “I have focused most of my adult life trying to save my mother.” Her mother never received proper help for her mental health. She reported her experience with her mother led to seeking mental health services in her adult life. Therapy revealed that she had been “overcompensating” for the lack of a relationship with her mother. This type of “dysfunction” contributed to the termination of her first marriage. Her mother resided in a personal care home during the time of this interview and the participant visited her once a week.

Participant Three used the word “rededication” when asked about her faith. She shared about attending a Baptist church as a child and being baptized at 12 years old. She later departed from her faith and did not return until age 30. She reported her faith was extremely important to her, as she described her daily routine as being “ridged,” but felt necessary to maintain mental and emotional stability. She described her relationship with God as being the most secure relationship she has ever had, unlike her childhood filled with a sense of unworthiness. The lack of secure bonding because of unsafe and inconsistent caregiving fuels a sense of shame for the

child (Velotti et al., 2017). Mastering her faith brought her great confidence and stability, she shared.

Participant Four

Participant Four was a 59-year-old Black woman, married to her second husband for 28 years with no biological children. She was a real estate agent and had served as an Associate Pastor for 15 years during the time of our interview. With extensive education, she served in the political and education systems for 20 years before settling in real estate. She cared for her 82-year-old mother who lived alone, but still required supervision.

Participant Four completed the ACEs questionnaire and scored four out of ten. Her first memory of shame involved being sexually abused by a stepbrother at age 14. After she shared the information with her mother, she remembered her parents divorcing. She reported being bitter towards her mother and father for years. She also shared her father had a second family he spent most of his time with. She recalled her mother and father fighting most of her middle school years. The respondent participated in the violence between her mother and father, cursing and hitting her father. She reported taking up for her mother because she did not want her to feel alone and rejected by her father. After speaking about this, she said, “maybe I was angry about being rejected.” Most individuals who suffered the rejection of a parent experience anger (Boullier & Blair, 2018). She reported being filled with anger towards her dad and that anger drove her professional success but contributed to her relational failure.

Like many who have experienced early childhood trauma, defense mechanisms develop to protect them from future harm (Schwartz et al., 2015). Participant Four shared during her interview that she accepted God in her heart but remained angry with God for a long time. She stated this was displayed through never asking God for anything, and never trusting him to keep

His word. “I kept God at a distance because I simply did not trust Him,” she was quoted as saying. She described a shift happening in this area of thinking when all her efforts ceased to work, and she became ill. She realized God was all she had to depend on, so she learned to trust Him. This was taken years for her to do, but over time she accepted God’s love. She beamed as she shared about her trauma no longer controlling her life. She also attributed her growth to see a Christian counselor.

Participant Four served as the women’s ministry director. She counseled women struggling through various trials. She realized that it was good to render to God even if one does not see how to overcome life’s circumstances. She believed casting her cares and surrendering brought her to a place to be confident in God. She proclaimed she had no more limiting beliefs about God’s love for her. This truth has not long been planted in her heart; it has been lived out in her life.

Participant Five

Participant Five was a 37-year-old Black woman who served in the Armed Forces and worked as a coordinator for mental health services. She was in college studying to become a licensed Christian therapist. She had been married for two years and had no children. After leaving the military, she decided to make Savannah, Georgia her home and became a part of Kingdom Life Ministries in September 2015. She served as the young adult ministry leader and also participated on the community engagement team.

Participant Five completed the ACEs questionnaire and scored seven out of ten. Her first memory of shame involved being sexually abused by a cousin at age seven. Although she was sexually abused; she never experienced a stable home environment growing up. Her biological mother released custody to her sister due to having a severe mental disorder. She was never

adopted, only given to someone else to care for her. She never knew her biological father and was abused by her aunt's husband. She reported sleeping in a coat closet for a year until they could make proper room for her. In her home environment, she experienced domestic violence and was removed from the home several times.

She recalls feelings of inadequacy throughout middle school and high school. Feelings of inadequacy are common among individuals who have experienced trauma (Hahn, 2009). At one point she believed she suffered from a mental health disorder because she lost her ability to feel or express emotions. She received therapeutic services to address her limitations while in the military. However, she does not believe she received adequate care to address the deep feelings of shame she experienced from not being wanted by her biological mother and being abused by her family.

Moving into a relationship with God came by way of tragedy for Participant Five. She experienced what she believed to be a nervous breakdown. She said she experienced loss after loss and felt she was being punished by God. She shared that visiting Kingdom Life and the teaching on that night saved her life. She was contemplating suicide and changed her mind because she had what she described as a spiritual encounter where she felt a warm and loving presence. She concluded her experience was the presence of God. From that point, she said she became a believer.

Theme Development

Themes were developed using the procedures developed by Braun and Clarke (2006). Data were gathered through an unstructured interview. Individual data sets were reviewed, verbatim transcripts were created, and initial codes were identified, refined, and paired with corresponding data. The coded statements were sorted into categories and analyzed for

connections, similarities, and differences to develop multiple thematic maps. These mappings were reviewed and revised several times. After the development of themes and subthemes, another review for accuracy was conducted. Table 3 describes coded themes and subthemes that emerged from the data.

Table 3

Themes and Subthemes

Theme	Description	Subtheme
Poor Parental Bond	The connection between mother and child results in well-being or neglect, abuse, violence, etc.	Absent Un-involved
Environmental Stressors	The external threat or harm that may lead to physiological or psychological discomfort or health	Unsafe (*violent and unprotective*)
Identification with God	Relational perception of God	Insecure Attachment Secure Attachment

Theme One: Poor Parental Bond

At birth, children have instinctual drives and needs, with the greatest of these being the desire to bond (Ainsworth, 1989; Ainsworth & Bowlby, 1991; Bowlby, 1946, 1950, 1954; Swartz, 2015). Parental bonding is an attachment between a child and the parent. Throughout life, social relationships, and in particular attachment relationships, are powerful physiological and psychological regulators (Matos et al., 2013). If the experience of attachment bonding is positive, the development of a healthy emotional state takes place and could last throughout life (Ainsworth, 1989; Reisz, et al., 2018). The lack of secure bonding because of unsafe and inconsistent caregiving fuels a sense of shame in the child.

Studies highlight that parents play a key role in the well-being and functioning of the developing child, including identity formation, positive self-image, life satisfaction, and social competence (Pérez-Fuentes, 2019). Parental bonding is a relevant predictor, for not only the aforementioned factors but also organizing judgments toward self (Pérez-Fuentes, 2019). This aspect supports Bowlby's (1969, 1982) assertion that the quality of attachment relationships modulates children's understanding of themselves and others. Bowlby (1969) also suggested that early bonding with parents create an internal working model, which is later used as a guide for future relationships and experiences. Data from the study interviews demonstrated a connection between the quality of early bonds and the quality of future relationships, even with God. Subthemes of parental absenteeism and low-nurtured parents emerged as data was reviewed and coded for further understanding.

Absentee Parent

The experience of an absentee parent has an intense effect on the psychological development of a child. Absenteeism develops a sense of insecurity, feeling alone, and shows immaturity in their behavior (Mao et al., 2020). The reasons for a parent's absence range from loss of parental rights, abandonment, negligence, grief due to another child's illness, substance abuse, incarceration, divorce, and mental or personal illness of some sort (Lander et al., 2013). Absentee parents refer to parents being not physically available, as well as lack of emotional and psychological stimulation needed for development and well-being (Mao et al., 2020). Participant Two described what it was like living with her mom and her mother's boyfriend:

> My mother never spent time with me. I remember my mom constantly being on the phone with her friends or boyfriend. I would stand at her door wanting her attention and she could not stop for one second to even notice me. I knew not to call out to her. She

> would give me this as she would kill me. I also remember her promising to do things with me, but always have an excuse. This excuse usually involved her boyfriend. So, it's like my mom was there, but she wasn't there.

All the participants in the current study described at least one parent not being present. Three of them never knew their fathers and three were removed from their mother's custody at an early age due to abuse and/or neglect. After reviewing the transcripts, Participant Five statement regarding parental absenteeism stood out. Her response depicted the next subtheme to be discussed, low-nurture parents. Participant Five explained that:

> I remember meeting my biological mom for the first time. Before that, I was told she was unable to care for me. I was never told why. I knew she lived in a home where people took care of her. The man, whom I called uncle, the brother of my foster mom was my biological father. I know this sounds confusing. It is sad when I think about it, so I try not to. I never knew my biological mother and the lady I lived with and called mom was so neglectful. I wonder if my schizophrenic mother would have been a better parent to me. My bio mom was very nice, and quiet yet seemed to be hollow inside. That was a great difference from my foster mom who yelled and cursed 24/7.

Participant Five's statement arouses a reflection on the impact of having a physically and emotionally absent parent. Not having access to the ability to bond could pose one set of problems but having access to the opportunity to bond and being denied that access could lead to even graver consequences. Rejection of this kind perpetuates a lack of attunement to needs and an inability to verbalize them (Spiegel et al., 2000). The next theme expands on the experience of having a parent present but preoccupied with their life and problems causing minimal nurture to be shown.

Uninvolved Parent

Parents are generally expected to be nurturing and emotionally connected to their children. Feeling connected encourages relationship building and sets the foundation for support and trust for future interactions (Purvis et al., 2013). Nurture entails the process of caring for and encouraging the growth or development of someone or something (Vaughn, 2019). Research shows nurture is a marker of relationship quality, and a higher quality of a relationship leads to a great sense of self (Thomas et al., 2017). However, neglecting to respond to a child's needs hinders their emotional and relational development later in life (Young & Widom, 2014).

When parents are stressed and often working through their trauma, their quality of interaction is limited, if any at all. Uninvolved parents are not just busy people preoccupied with life, there is an ongoing pattern of emotional distance that occurs between the parent and child (Morris et al., 2007). This concern was expressed poignantly by Participant One during her interview:

> My mother was never available. I remember her being there but never having time for me. Even when I think about it now, it makes me so sad when I think about it. I feel like the "streets" raised me. I did whatever I wanted to do. I remember being very disrespectful to my mother. For a very long time, I followed in my mother's footsteps. I was not present in my son's life at first, but when I met God that changed. I love spending time with my son, I can't imagine a parent not showing love to their child. Although my mother and I have a good relationship, I don't feel close to her as my mother.

The statement by Participant One illustrates the long-term impact of being emotionally detached from a mother. As an uninvolved parent, she provided little to no affection and no guidance for

her daughter. Having uninvolved parents primes children to repeat the same pattern as adults with their children (Harris et al, 2017). To cope with their sense of abandonment from having an uninvolved parent, they become unaware that they could be absent from their children's life. Their lives could be always busy thus, becoming hands-off parents as well. In this can children would tend to display deficits in cognition, attachment, emotional skills, and social skills (Fenning, 2011).

Theme Two: Environmental Stressors

A child's environment is their greatest sphere of influence. Stress is a major contributor to mental, emotional, and physical disparities (Johnstone, 2016). If it occurs continuously, or is triggered by multiple sources, it becomes detrimental to a child's overall development (Orth & Luciano, 2015). Children raised in high-stress environments are at high risk for learning and behavioral deficits (Johnstone, 2016; Orth & Luciano, 2015; Schore, 2002). Furthermore, research suggested that ACEs are associated with poorer childhood mental health, attendance at school, educational attainment, and anti-social and violent behavior (Loudermilk et al, 2018).

All the participants in this study experienced environmental stress throughout their childhood. From family burdens such as violence in the home to being left unprotected from sexual abuse, all had encountered continued environmental stressors, leading to the predictable outcomes of negative relational conditions. Data from the study interviews demonstrated a connection between environmental stressors and the quality of future relationships, even with God. The subtheme "unsafe" emerged as data was reviewed and coded for further understanding.

Unsafe

All five participants spoke in-depth about their environment being unsafe. Even from the data in their journal entries, feeling unsafe as a child was common. An unsafe environment could

be any settings that pose threats to the child, including physical abuse, neglect, domestic violence, failure to supply food or medical attention, use of illegal drugs, and sexual contact with a child (Schutze et at., 2020). As the data illustrated, parental figures assumed the lack of protection was normal. Most participants were expected to thrive in conditions of domestic violence and neglect. For example, Participant Three shared a recollection of violence at her home when she was 10 years old:

> I remember the first time I saw my mom and her boyfriend fighting. Being ten, you think I would be scared, but I wanted to fight him. As an adult with children, I could never imagine fighting in front of my children. I thank God every day that he has changed me. I can't even imagine my children growing up the way I did. I was always surrounded by some kind of violence, whether verbal or physical. I know this impacted my early relationships. I can remember being very angry for no reason. Most of my relationships, even friendships, ended because I would lash out. It took a very long time for me to understand this was happening because I did not feel safe. The way I protected myself was to be aggressive verbally and even physically. I think it impacted my self-esteem the most.

Violent

Growing up in a violent home is one of the most traumatic experiences a child could go through. Not all children respond to their environment the same. Violence could affect every aspect of a child's life, growth, and development. Children exposed to a violent environment are most likely to have psychological, emotional, social, and behaviors than those who are not (Schore, 2002). These impacts also transition into adulthood and become barriers to thriving in life. Patterns of violence could cause children to eventually become abusers themselves and

continue the cycle of violence (Kivisto et al., 2002). Victims of childhood violence often have higher unemployment rates in the society (Grady et al., 2017). They could be full of anger, mistrust in relationships, are more apt to be bullies, commit road rage, and more horrific violent acts, and contribute to the high cost of mental health and welfare programs (Norman et al., 2012)

Unsupervised

Being unsupervised also emerged as a subtheme. Every participant indicated they were unsupervised as a child. The lack of supervision was cited due to parents working, partying, or simply leaving the child in the room alone or with siblings for extended periods. Leaving a child unsupervised could be considered neglect and could lead to injury (Springer et al., 2007). Injury is not always physical, children left unsupervised could also endure psychological and emotional injury (Young & Widom, 2014). These children lack sufficient time to play with their caregivers, a correlate to emotional well-being, and higher levels of self-esteem (Norman et al., 2012).

Theme Three: God Attachment

The third theme that emerged focused on how the participants attached or related to God or the significance of their perceived spiritual well-being. The religious aspect of life represents an important source of human strength, meaning, and coping for people. The construction of one's spiritual identity is closely associated with the individual's attachment to their spiritual figure (Beck & McDonald, 2004). Attachment to any other figures resembles or follows the pattern of attachment development to parental or caregiving figures (Pan et al., 2016). Researchers Birgegard and Granqvist (2004) posited that attachment to God or a spiritual figure is usually viewed in one or two ways, (1) as compensation for a deficit in caregiver bonds or (2) remain the same across all attachment domains. However, when one establishes a relationship with God, previous attachments might begin to diminish.

Insecure Attachment

Research suggests if attachment to parents is insecure, teaching about God would be filtered through the experiences and expectations of insecure attachment (Rowatt & Kilpatrick, 2015). Three participants shared that they had the experience that feeling God's love was difficult and felt conditional. None expressed having a positive relationship with religion or God while growing up. However, only one participant did not belong to a religious community. The other four participants remembered feeling forced to participate in a religious community. Insecure attachment to God is marked by anxiety and is associated with increased psychological distress (Bradshaw et al., 2010).

Secure Attachment

Individuals with secure attachment have greater empathy, creativity, stability, and sense of self-worth, effective interpersonal function, social competence, satisfaction in relationships, healthy emotional expression, ability to cope with negative emotions, and capacity to respond well to challenges (Mikulincer & Shaver, 2007; Mikulincer et al., 2010). Seeing God as a secure base, one of the foundations for attachment bonds might vary depending on how God has been presented to the individual. Individuals with a secure attachment with their primary caregivers have a positive relationship with spirituality and religion and move closer to God in times of distress (Rowatt & Kilpatrick, 2015). If God was viewed as loving, supportive, and stable, bonding would be possible and uninterrupted; but if God was seen as punitive and only loving when an individual was good, one might not establish a secure attachment (Beck & MacDonald, 2004). An anxious style of attachment to God reflects faith challenges, whereas a secure attachment style to God portrays spiritual maturity (Hart et al., 2010). All participants reported to

forming a secure attachment to God was experienced through biblical counseling and completing inner healing work, in addition to their daily lifestyle of prayer and bible reading.

Summary

Several experiences emerged during the examination of early shame and self-esteem of the evangelical Christian women. In addition to the ACE's questionnaire as a criterion for the study, an unstructured interview was conducted with the following research question guiding the research: "How do evangelical Christian women describe their experiences with adverse childhood shame experiences?" After interviews were conducted, themes were developed using the procedures developed by Braun and Clarke (2006). Data was reviewed, coded, and categorized into themes. After the development of themes and subthemes, another review for accuracy was conducted. Three themes emerged from the data: poor parental bond, environmental stressors, and identification with God.

The identified themes were congruent with the concepts found in the previous literature. Participants' interviews revealed various experiences with shame and rejection within the context of their parental relationships. The interpersonal consequences of experiencing shame were predominantly negative. One of the major interpersonal relationships depicted in the current study is a parent-child relationship. At an interpersonal level, shame has been associated with the tendency to socially withdraw, hide, disappear, inhibit social interactions, and isolate oneself from others (de Hooge et al., 2018). The impact of parental relationships was discussed in length during the interview and participants made connections between their bond with parents and God. A primary focus of religion was to offer answers that address human questions about meaning (Koenig, 2012). Participants admitted having a relationship with God provided the much-needed answers to the sufferings they endured.

Chapter Five: Discussion

Overview

Shame is central to identity and could be a source of low self-esteem and a diminished sense of the self (Kaufman, 1989). When experienced early in life, it disrupts ongoing activities, stimulate an inability to talk, act, or think clearly, and promote a passive self (Farr et al., 2021). Adverse childhood experiences have the possibility of being overshadowed by the experience with a loving deity such as Jesus Christ. However, not all Christian experience is loving and therefore could often mirror early adverse experiences. Some Christians live continually with internalized shame, unaware of its presence and negative effect on their relationship with God and others (Bradshaw, 2005). If shame is not acknowledged or resolved, it might hinder the Christian's relationship with God and others.

In this study, a single unstructured interview question was asked during the interview process to gain a better understanding of evangelical Christian women, shame, and self-esteem. The researcher set out to explore evangelical Christian women's low self-esteem rooted in early childhood adverse shame experiences. Chapter Five includes addressing the findings, implications, limitations, and recommendations. The findings are used to emphasize data surrounding the experiences of evangelical Christian women with early adverse childhood shame. The research question was addressed through a specific unstructured interview question (See Appendix G). The study presented three emerging themes, which are significant for the research and connected to the theoretical framework applied.

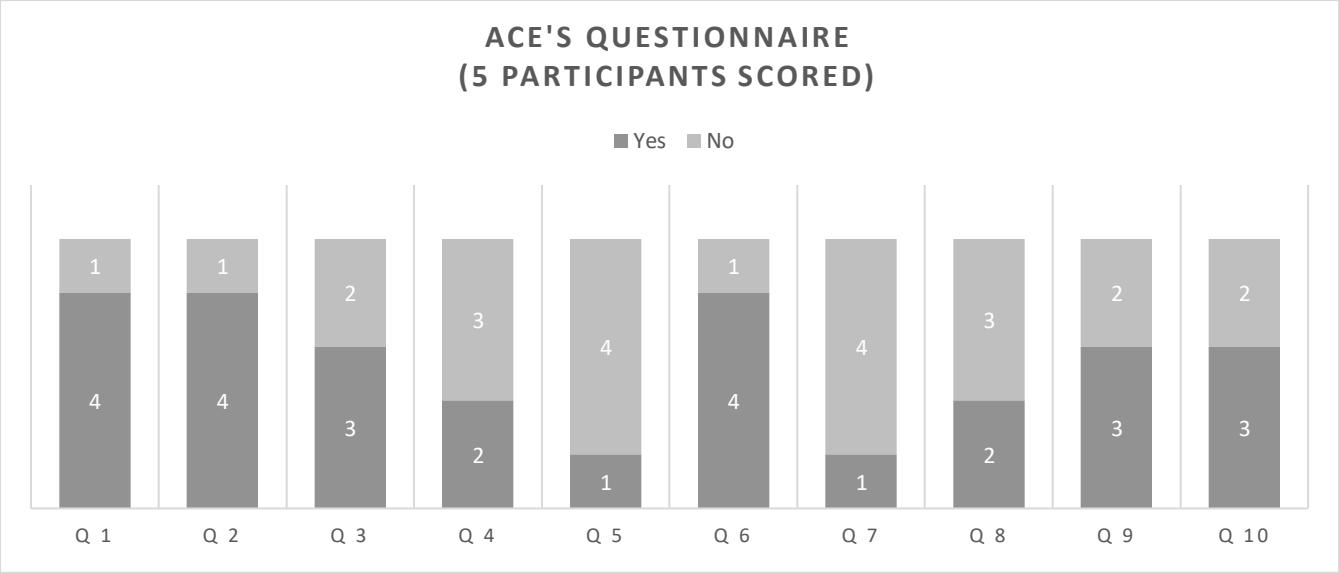
Summary of Findings

This study involved 5 evangelical Christian women from Kingdom Life Ministries in Savannah, Georgia who completed the ACE questionnaire. The women had to score at least one

out of 10, with each question having a value of 1. (See Table 4). Most people (57.8%) experienced at least one with 21.5% experiencing 3-ACEs's (Loudermilk et al., 2018). Women tend to score higher on the ACE's questionnaire than men. Women from this study scored an average of 8. While African American and Caucasian races were represented in this study, multiracial individuals score significantly higher than any other race (Loudermilk et al., 2018).

Figure 2

ACEs Questionnaire Participants Score



Evangelical Christian women were chosen for this study because of their negative religious coping mechanisms associated with mental health found in religious culture. Floyd (2021) found that negative interactions surrounding mental distress included being rejected by the Church, broader teachings that mental distress was exclusively associated with the work of demons, and that mental distress was the consequence of personal sin. There was an interest in the dynamic of whether those with early shame would struggle with religion or find it positive for one's self-esteem and a conduit for healing shame. In addition, the researcher was

specifically curious about what set of experiences surrounded overcoming or remaining hindered by early childhood shame.

RQ. How do evangelical Christian women describe their experiences with adverse childhood shame experiences?

A thorough analysis showed participants shared experiences of abandonment or neglect from parents, being abused by a parental, caregiving figure, or authority figures, unsafe home environments, and relational perception of God. Participants in this study experienced a range of neglect and abuse as children. Within this range, three respondents experienced sexual abuse, and four went through physical abuse. All participants experienced some form of emotional abuse. The interviewees described emotional abuse mainly as lack of parental presence or engagement while present. Violence in the home was also an experience shared by all participants. They also shared that seeking God was a form of relieving childhood pain. Three participants viewed God as loving with unconditional positive regard towards them. The other two participants perceived God's love as conditional. Consistent connection to their faith community and personal devotional time were significant contributors to increased connection to God as a secure base.

Discussion

This section examines the study findings as they relate to the theoretical literature. The discussion explores how the finding reflects the theoretical underpinnings of attachment theory (Ainsworth, 1989; Ainsworth & Bowlby, 1991; Bowlby, 1946, 1950, 1954, 1977, 1982; Schwartz et al., 2016). In addition, the discussion considers how the findings relate to current research on shame, self-esteem, and Christian women. All findings from this study either: (a)

supported findings from previous studies, (b) extended findings from previous studies, or (c) deviated from findings from previous studies.

Attachment Theory

Attachment theory served as the foundation for this research. It provided a framework where the impact of relational trauma from early neglect or caregiver rejection resulting in having negative internalized views of self could be examined (Ainsworth, 1989; Ainsworth & Bowlby, 1991; Bowlby, 1946, 1950, 1954, 1977, 1982; Schwartz et al., 2016). Humans are biologically predisposed to form attachments with others (Bowlby, 1969). If the experience of attachment bonding is positive, the development of a healthy emotional state takes place and could last throughout life (Ainsworth, 1989; Reisz, et al., 2018). This was proven by all the five participants. They shared that their lack of bonding with parental figures and the absence of healthy connection resulted in dysfunctional relational patterns in subsequent relationships.

The central component of the origins of attachment theory suggested that mothers or primary caregivers, readily available and responsive to the needs of the child assisted in the development of a sense of security and emotional well-being within the child (Ainsworth, 1989; Ainsworth & Bowlby, 1991; Bowlby, 1946, 1950, 1954, 1977, 1982; Schwartz et al., 2016). The research respondents experienced adverse childhood shame that negatively impacted their adult relationships. They reported having been divorced, thought about being divorced, or not wanting to marry because they feared divorcing. The participants also experienced relational dysfunction with family and friends. No participants revealed having a consistent healthy relationship before establishing a bond with God. Even after accepting Christ, all participants admitted they struggled to heal and transform how they thought about love and relationships.

Attachment and Relationships

Fitzgerald et al. (2020) found that trauma experienced during childhood led to diminished quality relationships. Not only did these early attachment deficits contribute to negative relationship quality, but also each participant struggled with having an inherent sense of self-worth. Poor attachment fosters a negative sense of the self that propagates subsequent insecurities projected in future relationships (Fitzgerald, 2021). Positive attachment increases self-esteem and helps individuals discover their potential as they evolve (Akin & Radford, 2018). Participant Three shared an experience with a high school history teacher who saw great potential in her as a student. She stated, "it was so difficult to receive a compliment from my teacher because nothing good was ever said to me at home. It took some time before I started to believe the things, he said about me." Given the evolved power of relationships, to feel safe, fit in, belong, and engage in advantageous social roles, humans could be motivated to stimulate positive affect and images of themselves in the mind of others.

Attachment and God

Attachment theory asserts that people's attachment shapes their perceptions of God and influences how religion might be used to manage emotions (Granqvist, 2005). People who rated their relationship with God as secure or who attributed warmth, affection, and stability to God performed better on life satisfaction tests and had lower levels of loneliness, sadness, and anxiety (Kirkpatrick & Shaver, 1992). This was true of the participants in this study. Three women described God as being loving and compassionate, always desiring the best for them. Participant Two quoted Jeremiah 29:11, "For I know the plans I have for you, declares the Lord, plans to prosper you and not to harm you, plans to give you a hope and a future," when describing how she believes God views her. Granqvist et at. (2007) opined that a correlation between the

experience of loving parents and positive images of God exists. This finding supports the connection between attachment styles and perceptions of God as positive or negative, safe or unsafe, loving or unloving. However, participants' responses from this study did not support this finding. They all experienced being unloved but reported healing parental wounds through Christian therapy as a major component in having a positive relationship with God.

Implications

Human relationships are threaded throughout one's everyday existence. Whether these relationships are personal, professional, close, distant, or estranged, they impact people's well-being. Throughout life, social relationships, and in particular attachment bonding, are powerful physiological and psychological regulators (Matos et al., 2013). Although this study involved adult women and caregivers, community liaisons involved directly with a child's development would benefit from the implications of this study. A child's attachment quality has repeatedly been linked to the child's development (Groh et al., 2017; Vaughn et al., 2019). Research supports the idea that a negative sense of self from insecure attachment propagates subsequent insecurities projected in future relationships (Ainsworth, 1989; Ainsworth & Bowlby, 1991; Bowlby, 1946, 1950, 1954, 1977, 1982; Schwartz et al., 2016). Assessing and addressing attachment deficits early could provide a foundation for timely intervention and the development of future treatment modalities for therapeutic professionals.

The implications for people, agencies, or organizations, which are directly involved with first-time parents starting a family are also important. The family is the first and arguably most significant spot for emotional connection, development, and regulation for later in life. The education system runs a close second. The earlier caregivers understand the impact of attachment, the more likely they are to make secure attachment a priority. It is vital to understand

that secure attachment leads to nervous system regulation. Individuals' nervous systems are constructed to be captured by the nervous system of others as if they were as close as their skin (Mills et al., 2010). Nature has built into humans, tracking systems that are essentially their biological basis for empathy, emotional connection, and modeling (Bowlby, 1964, 1973); Therefore, caregivers should mirror other people, especially children with a sense of safety and security. A failure in this area leads to poor relational health throughout the lifespan.

The religious community could also advance from the implications of this study. Relationships are crucial to one's survival and well-being (Bowlby, 1969; Matos et al., 2013). It is imperative to understand that deficits in bonding also impact how individuals relate to God. People seek religion to feel a sense of wholeness in their life (Hall et al., 2009). Religion, be it ridged or liberating, involves having a relationship with a deity. Individuals who felt their relationship with God was stable or who credited God with providing warmth, affection, and stability did better on tests of life satisfaction and reported feeling less lonely, depressed, and anxious (Kirkpatrick & Shaver, 1992). With this knowledge and the shared experiences of the participants, religious communities fostering an image of a loving God as opposed to a critical God would enhance the overall well-being of participants.

Lastly, the role of mental health professionals in helping individuals through childhood trauma is monumental (Johnson, 2018). Theoretical and practical competence brought into a session is as important as the concerns the client shares. Understanding adverse early shame in relation to attachment also helps mental health professionals recognize problematic mental and behavioral indicators as well as their impact on relational dynamics. This consideration would influence the therapeutic process, providing an additional lens to understand the root cause of the presenting issues to design an appropriate and effective treatment.

Delimitations and Limitations

The current study included several delimitations. The researcher chose only to include evangelical Christian women 30 years of age and older to participate. The study focused only on women who had experienced adverse early shame. The women also had to practice evangelical faith. Possible participants from other religions such as Catholic or Jewish were excluded, or were not of interest for this study. In addition, women were gathered from only one Church within the metroplex of Savannah, Georgia. This was done to understand the shared experiences of women within these given parameters.

Within this current study, one major limitation was the demographics of the sample population. Participants only included churchgoers of a specific faith. Choosing individuals with certain religious beliefs limits the generalization to a broader population (Fincham et al., 2011). Only exploring the homogenous group of women is another limitation. This allowed for only one gender perspective to be discussed. Another limitation was potential memory failure (Bell & Bell, 2017). Asking participants to remember events from over 40 years ago for some and 20-plus years for others could alter the authenticity of the results. Most participants remembered significant events but found some details to be forgotten. The researcher asked clients not to make up information if details were not clear. The last limitation observed was the race of the women participating. Out of five participants, three were African American, and two were Caucasian. No other ethnicities were represented.

Recommendations for Future Research

This study provided preliminary support for the notion that early adverse experiences of shame for Christian women impact their self-esteem and impede the development of healthy relationships in the future. Throughout the interview, non-secure attachment was reported as a

major indicator of childhood experience of shame. A key recommendation would be to have participants complete an attachment-style assessment scale in future studies to eliminate the researcher from assuming the participant's attachment style based on their interview responses. According to Collins and Read (1990), attachment research depends on a good assessment. Proper assessments or measurement scales help to better understand the description of what is being assessed and the reliability of the results (Mir et al., 2017).

In this study, relationships impacted were not only natural but also spiritual. No one reported having a secure base with their caregivers. This transitioned into their ability to connect with God a figure of love. They all reported initially struggling to develop a trusting secure relationship with God. While attachment and God have gained more attention in the last two decades (Krause, 2005) it is recommended that more research be conducted to gain a more in-depth understanding on attachment and God with women who have other religious beliefs.

Summary

The purpose of this phenomenological study was to understand the experiences of evangelical Christian women with adverse childhood experiences of shame. Within the research, early adverse shame was evaluated as a major phenomenon that impacts a Christian woman's self-esteem. The study was guided by attachment theory (Ainsworth, 1989; Ainsworth & Bowlby, 1991; Bowlby, 1946, 1950, 1954, 1977, 1982; Schwartz et al., 2016), which served as a lens by which to examine the impact of adverse childhood experiences on human development over time. This study involved five Christian women between the ages of 31 and 59; three identified as African American and two as Caucasian. They all completed the ACEs questionnaire to qualify as having experienced adverse childhood shame experiences.

This study answered the research question: “How do evangelical Christian women describe their experiences with adverse childhood shame experiences?” The findings yielded three areas of shared experiences among all participants: (1) poor parental bond, (2) environmental stressors, and (3) identification with God. The most significant implication of this study is that secure attachment early in life is vital and the lack of it contributes to substantial relational impairments in the future. Early adverse experiences of shame influence the quality of the attachment figure relationship and impacts a person’s expectations of all attachment relationships throughout the lifespan (Sroufe, 2005). These relational experiences are not subject to just human relationships, the level of attachment also translates to one’s relationship with God.

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Appendix A:

IRB Approval Letter

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

November 29, 2022

Teneka Miles
Jason Ward

Re: IRB Exemption - IRB-FY22-23-443 Early Shame, Self-Esteem, and Christian Women

Dear Teneka Miles, Jason Ward,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under the following exemption category, which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:104(d):

Category 2.(iii). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:
The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

Your stamped consent form(s) and final versions of your study documents can be found under the Attachments tab within the Submission Details section of your study on Cayuse IRB. Your stamped consent form(s) should be copied and used to gain the consent of your research participants. If you plan to provide your consent information electronically, the contents of the attached consent document(s) should be made available without alteration.

Please note that this exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us

at irb@liberty.edu.

Sincerely,
G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research
Research Ethics Office

Appendix B:

Recruitment Email

[Date]

Dear [Participant]:

As a graduate student in the School of Behavioral Health at Liberty University, I am conducting research as part of the requirements for a doctoral degree in Education. The title of my research project is *Early Shame, Self-esteem, and Christian Women* and the purpose of my research is to gain a deeper understanding of the lived experiences surrounding the self-esteem of evangelical Christian women with early adverse shame experiences (eligibility determined by Adverse Childhood Experiences (ACEs) questionnaire attached). I am writing to invite eligible participants to join my study.

Participants must be:

1. Women 25 years of age and older
2. Practicing Christian (i.e., attend weekly services, mission work, prayer, local ministry serving, etc.)
3. Experienced adverse childhood (eligibility determined by ACEs questionnaire attached)

Participants, if eligible and willing, will be asked to participate in an unstructured interview lasting approximately 90 minutes. Participants may be asked to conduct a short follow-up interview lasting approximately 30 minutes for the purpose of member checking and clarification of unclear statements. Participants will have the option of their session being conducted at the church or via Zoom, the HIPPA-compliant version. If the participant chooses to meet at their church, the interview will be audio recorded and saved to a password-protected Voice Memo computer program. The interview will also be video-recorded if it is held via Zoom. Meeting times will be scheduled based on participants' availability Monday-Friday 8 A.M. to 12 P.M. and 5 P.M. to 7 P.M. Names and other identifying information will be requested as part of this study, but the information will remain confidential.

To participate, please contact me at [redacted] for more information or to schedule an interview.

A consent document is attached to this email. The consent document contains additional information about my research. If you choose to participate, you will need to sign the consent document and return it to me at the time of the interview.

Sincerely,

Teneka G. Miles, LCSW
Doctoral Candidate, Liberty University
[redacted]

Appendix C:

Recruitment Follow Up Email

[Date]

Dear Elder Charlena Brown:

As a graduate student in the School of Behavioral Health at Liberty University, I am conducting research as part of the requirements for a doctoral degree in Education. The title of my research project is *Early Shame, Self-esteem, and Christian Women* and the purpose of my research is to gain a deeper understanding of the lived experiences surrounding the self-esteem of evangelical Christian women with early adverse shame experiences (eligibility determined by ACEs questionnaire attached). I am writing to invite eligible participants to join my study.

Last week an email was sent to you inviting the women in your ministry to participate in a research study. This follow-up email is being sent to remind them to reply to email address provided if they would like to participate and have not already done so. The deadline for participation is November 15, 2022.

Participants must be:

1. Women 25 years of age and older
2. Practicing Christian (i.e., attend weekly services, mission work, prayer, local ministry serving, etc.)
3. Experienced adverse childhood shame (eligibility determined by ACEs questionnaire attached).

Eligible participants, if willing, will be asked to participate in an unstructured interview lasting approximately 90 minutes. Participants may be asked to conduct a short follow up interview for member checking lasting approximately 30 minutes for the purpose of clarification of unclear statements. Participants will have the option of their session being conducted at the church or via Zoom, the HIPPA compliant version. If participant choose to meet at their church, the interview will be audio recorded and saved to a password-protected Voice Memo computer program. Meeting times will be scheduled based on participants availability Monday-Friday 8 A.M. to 12 P.M. and 5 P.M. to 7 P.M. Participation will be completely anonymous, and no personal, identifying information will be collected.

To participate, please contact me at [redacted] for more information or to schedule an interview.

Sincerely,

Teneka G. Miles, LCSW
Doctoral Candidate, Liberty University
[redacted]

Appendix D:

Permission Request Email

[Date]

Dear Elder Charlena Brown,

As a graduate student in the School of Behavioral Health at Liberty University, I am conducting research as part of the requirements for a doctoral degree in Education. I am writing to request your permission to invite the women in your church to participate in my research study. The title of my research project is *Early Shame, Self-esteem, and Christian Women* and the purpose of my research is to gain a deeper understanding of the lived experiences surrounding the self-esteem of evangelical Christian women with early adverse shame experiences (eligibility determined by Adverse Childhood Experiences (ACEs) questionnaire attached).

I am writing to request your permission to contact members of Kingdom Life Ministries to invite them to participate in my research study.

Participants must complete the Adverse Childhood Experiences (ACEs) questionnaire to determine eligibility. If eligible and willing, participants will be asked to participate in an unstructured interview lasting approximately 90 minutes. Participants may be asked to conduct a short follow-up interview for member checking for accuracy of the interview lasting approximately 30 minutes. Participants will have the option of their session being conducted at the church or via Zoom, the HIPPA-compliant version. If a participant chooses to meet at their church, the interview will be audio-recorded and saved to a password-protected Voice Memo computer program. If the meeting is held via Zoom, it will also be video-recorded. Meeting times will be scheduled based on participants' availability Monday-Friday 8 A.M. to 12 P.M. and 5 P.M. to 7 P.M.

Participants will be presented with informed consent information before participating. Taking part in this study is completely voluntary, and participants are welcome to discontinue participation at any time.

Thank you for considering my request. If you choose to grant permission, respond by email to [redacted]. A permission letter document is attached for your convenience.

Sincerely,

Teneka G. Miles, LCSW
Doctoral Candidate, Liberty University

Appendix E:

Permission Response Email

[Date]

Dear Elder Charlena Brown

After a careful review of your research proposal entitled *Early Shame, Self-esteem, and Christian Women*, we have decided to permit you to invite the women in Kingdom Life Ministries to participate in your study.

Check the following boxes, as applicable:

☐ We will provide our membership list to Teneka G. Miles, and Teneka G. Miles may use the list to contact our members to invite them to participate in her research study.

☐ We grant permission for Teneka G. Miles to contact women in our church to invite them to participate in her research study.

☐ We will not provide potential participant information to Teneka G. Miles, but we agree to provide her study information to all the women in our ministry on her behalf.

Sincerely,

Elder Charlena Brown
Church Administrator
Kingdom Life Ministries

Appendix F:

Consent Form

Title of the Project: Early Shame, Self-Esteem, and Christian Women

Principal Investigator: Teneka G. Miles, EdD Candidate, Liberty University

Invitation to be part of a Research Study

You are invited to participate in a research study. To participate, you must be:

- Female
- Christian
- 25 years of age or older
- Participate in faith practices (regular church attendance, bible reading, prayer, missions, fasting, etc.)
- Experienced adverse childhood (eligibility determined by ACEs questionnaire attached)

Taking part in this research project is voluntary. Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about and why is it being done?

The purpose of this phenomenological study is to gain a deeper understanding of lived experiences. Significant research has been conducted on self-esteem, shame, and women, but there is a lack of research on the self-esteem of evangelical Christian women with adverse early shame experiences. This study will address that gap in research and seek to understand what specific faith practices serve as a supporter of well-being, especially in areas of mental and emotional health.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following things:

- Participate in two interviews: the first interview lasting approximately 90 minutes and a follow-up interview for member checking and further clarification lasting approximately 30 minutes.

All interviews will be recorded using the Voice Memo app on my computer. Quick Time program application will also run in the background to record audio for backup. If the interview is held via Zoom, it will also be video-recorded.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study.

Benefits to society include an increased awareness of how adverse early shame impacts self-esteem and identity development of individuals of faith, specifically women. Women are wives, mothers, and leaders in the workplace and faith community. All these areas are relational. This

study will provide an understanding of how early parental relationships shape future relationships. This study will give verbalization to the experience of many women of faith who struggle with believing God's love and promises in the Bible because of not feeling worthy. This study will be a support to faith leaders seeking to understand the underlying issues of those they counsel with self-esteem issues.

What risks might you experience from being in this study?

The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life. Discussing adverse childhood experiences could potentially trigger a traumatic response. Participants will be provided with professional counseling resources and crisis agency information should they need them.

How will personal information be protected?

The records of this study will be kept private on a password-protected hard drive. The hard drive is 3x5 in size and will be kept with the researcher during interview and data transcription and locked in the researcher's work office after use. The researcher will be the only person with access to the office and participant records. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely on a password-protected hard drive, and only the researcher will have access to the records.

- Participant responses will be kept confidential through the use of pseudonyms.
- Recordings will be transcribed and kept on a password-protected hard drive for three years after the completion of the study.
- Video recordings and transcription will be kept on the password-protected hard drive for three years after the completion of the study.
- Data will be stored on a password-protected hard drive with access only granted to the researcher.
- The researcher will delete all data and discard the hard drive after three years.

Is study participation voluntary?

Participation in this study is voluntary. Your decision to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Teneka G. Miles. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at [redacted] or [redacted]. You may also contact the researcher's faculty sponsor, Jason Ward, at [redacted].

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515, or email at irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted ethically as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy of the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio-record/video-record me as part of my participation in this study.

_____

Printed Subject Name

_____

Signature & Date

Appendix G:

Adverse Childhood Experiences (Aces) Questionnaire

Before your 18th birthday:

1. Did a parent or other adult in the household often or very often…
   Swear at you, insult you, put you down, humiliate you? or
   Act in a way that made you afraid that you might be physically hurt.
   ◯ Yes ◯ No

2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
   ◯ Yes ◯ No

3. Did an adult or person at least 5 years older than you ever…
   Touch or fondle you or have you sexually touched their body? or
   Attempt or have oral or anal intercourse with you?
   ◯ Yes ◯ No

4. Did you often or very often feel that …
   No one in your family loved you or thought you were important or special. or
   Your family didn't look out for each other, feel close to each other, or support each other
   ◯ Yes ◯ No

5. Did you often or very often feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   ◯ Yes ◯ No

6. Was a biological parent ever lost to you through divorce, abandonment, or other reasons?
   ◯ Yes ◯ No

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her? or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   ◯ Yes ◯ No

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   ◯ Yes ◯ No

9. Was a household member depressed or mentally ill? or

Did a household member attempt suicide?

◯ Yes ◯ No

10. Did a household member go to prison?

◯ Yes ◯ No

Appendix H:

Unstructured Interview Question

1. Describe your lived experiences as a Christian woman with an adverse childhood.