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Arielle R. A. Marston

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Arielle R.A. Marston

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by

Arielle R.A. Marston

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Signatures:

M C Goodworth

Marie-Christine Goodworth, PhD, Chair

Glena Y Andrews, PhD

Glena Andrews, PhD, ABPP

Mark McMinn

Mark R. McMinn, PhD, ABPP

Date: 5·17·18

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Graduate Department of Clinical Psychology

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Abstract

Body shame and objectification of the female body are well known contributing factors in physical and mental health issues including high stress, eating disorder symptomatology, depression, anxiety, and low self-esteem. Religion plays a role in body shame and female objectification through both scripture and theological writings although this relationship remains inconclusive. Self-Compassion has been found to be a mitigating factor with regard to body shame in college and caregiver contexts. The Church of the Nazarene promotes itself as supporting female leadership and roles within the church. Since religion and gender roles seem to play a role in body shame and body shame impacts physical and mental well-being, the purpose of the present study is to examine the relationship between body shame, gender roles, religiosity, and self-compassion among female members of the Church of the Nazarene. Results of this study indicate that self-compassion is a significant predictor of body shame, as well as control beliefs and body surveillance. The only significant variable in religious identification was

non-organizational religiousness, which had a significant relationship with control beliefs and body surveillance. Gender norms were found to have a small significant predictive relationship with body shame. Self-compassion helps with all aspects of objectified body consciousness and therefore may be considered as a focus of intervention. However, religiosity and gender norms did not have a strong relationship with Objectified Body Consciousness. Theological perspectives were not evaluated within this study, and could be a focus of further study with regard to self-compassion.

Keywords: Self-Compassion, Objectified Body Conscious, Body Shame

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Chapter 1

Introduction

The human experience can only exist through our physical bodies. The physical body is made up of organs, bones, nerves, and muscles, and is used to move about and experience the world. Bodies are ways in which humans are able to express themselves, feel sensations, and give parameters to life. Bodies can also cause problems within a society. Problems with the body may result in death. Privilege is assigned to able bodied people who are able to move about the world without disability. Society and privilege combine to create the concept of the ideal body, a body that is socially desired and free of the feared, nonconforming body (Lelwica, 2017). Nonconforming bodies represent a "lack of control, dependence, inefficiency, and unpredictability that certain traits or conditions represent" (p. 17). Bodies are judged, categorized, and compared by societal standards seen in pop culture, friendly conversations, family standards, and medical offices. This judgment and comparison is a factor that creates of body shame (Mills & Fuller-Tyszkiewicz, 2016).

Body shame and the personal and societal impact have been a defining factor of western society. Body shame is the internalization of perceived physical shortcomings as core deficits of a person's worth (Lelwica, 2017; Markham, Thompson, & Bowling, 2005; McKinley & Hyde, 1996). According to objectification theory and the tripartite influence model, body shame and objectification stems from the sociocultural influences of parental figures, peers, and mass media (Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999). These influences create a society that

objectifies bodies through television, the internet, music videos, and magazines (Fardouly, Diedrichs, Vartanian, & Halliwell, 2015). Body shame and objectification have detrimental impacts on individuals' physical and mental health (Bailey & Ricciardelli, 2010; Gervais, Holland, & Dodd, 2013; Markham et al., 2005; Pila, Sabiston, Brunet, Castonguay, & O'Loughlin, 2015).

The religious connotations of body shame are seen in both the Bible and in theological writings throughout the history of Christianity. In the book of Genesis after eating of the tree of the knowledge of good and evil, there was shame of nakedness of the body that caused Adam and Eve to hide from God. However, self-compassion has been found to be a mediating variable for body shame (Daye, Webb, & Jafari, 2014). Therefore, the relationship between Christianity and self-compassion are important factors to explore in the context of body shame.

Objectification Theory

Objectification theory is a theoretical framework examining what occurs when female bodies are viewed through a sociocultural framework and provides understanding of what happens when women encounter sexual objectification. Objectification theory posits that though the human body is biological, the experience of having a bodied existence is developed through gender roles and sexual objectification (Fredrickson & Roberts, 1997). This theory is derived from feminist critical theory and describes the negative feelings women have towards their bodies, and how those feelings impact women's economic, personal, and political lives (McKinley & Hyde, 1996). According to Bartky (1990), sexual objectification occurs when a woman's humanity is reduced to her physical body or sexual functions. When this happens, it creates the objectifying gaze towards a female body or body parts. The effect of the objectifying

gaze has adverse consequences for women including anxiety, decreased cognitive performance, and self-silencing (Gervais et al., 2013).

Objectified body consciousness. Objectification can be measured with the Objectified Body Consciousness (OBC) Scale developed by McKinley & Hyde (1996). This is a three-subscale measure that examines the relationship between the main components of objectification theory. There are three components to OBC as defined by the Objectified Body Consciousness Scale: Body Surveillance, Control Beliefs, and Body Shame.

Body surveillance. Body surveillance is a central tenant of OBC, defining the female body as an object of male desire and meant to receive the gaze of men (Fredrickson & Roberts, 1997). To ensure that the female body is within cultural standards, constant self-surveillance is needed. OBC defines body shame as the result of internalized cultural body standards (McKinley & Hyde, 1996). As cultural standards are impossible to attain, a sense of shame and isolation is created. Body surveillance and body shame are known to have a small association with physical appearance due to self-worth and self-esteem (Noser & Zeigler-Hill, 2014). This suggests that women who believe their self-worth and self-esteem is based on their appearance will more closely monitor their bodies and experience shame when they do not meet their internalized standards. Researchers believe that appearance contingent self-esteem is a predictor to negative body experiences.

Control beliefs. Control beliefs stem from the assumption that women are responsible for the look of their bodies and must control the body's appearance to comply with societal standards (McKinley & Hyde, 1996). This examination increases the internalized objectification of the body. Instead of bodies being manipulated by a variety of factors, they quickly become

objects that can easily be controlled by the individual (Fredrickson & Roberts, 1997). Control beliefs also contribute to the thin ideal in both internal and external objectification, because they place blame and responsibility on the individual more than other external factors (Martin, Rhea, Greenleaf, Judd, & Chambliss, 2011). Very few studies have been done on role of control beliefs in objectification theory and objectified body consciousness.

Body shame. Body shame is an increasing concern in our society. Body shame is best defined as occurring when someone generalizes shortcomings, specifically in relation to their physical appearance, as core defects in the entire self (Markham et al., 2005). Body shame has been linked with eating disorder symptomatology, the internalization of the thin ideal, poor self-worth, and problematic parental bonding practices (Markham et al., 2005).

A component of body shame is the idea of the internalization of the thin ideal. Through media messages, caregiver relationships, and social pressure, more people are believing that their bodies are not good enough and they are ashamed of their physical features (Bailey & Ricciardelli, 2010; Brún, McCarthy, McKenzie, & McGloin, 2013; Choma et al., 2010; Daye et al., 2014; Fardouly et al., 2015; Homan, 2012). The thin ideal is based on the western ideal of unachievable thinness. This ideal is internalized when women and men integrate it as a sociocultural value into their belief system. When this occurs, many view their bodies negatively after they fail to meet the beauty standard set by the media (Bailey & Ricciardelli, 2010; Ura & Preston, 2015). When one experiences the discrepancy between their actual and ideal body, it can lead to decreases in self-worth and body-image esteem, as well as increased vulnerability to depression (Grabe, Ward, & Hyde, 2008; Markham et al., 2005). Another component of body shame is body image esteem and its relationship to global self-worth. Low body image esteem

has been linked to contributing to anxiety, depression, low self-worth and eating disorders. This negative relationship also encourages those who desire to change their appearance to expect this to enhance their overall self-worth (Markham et al., 2005).

Weight bias, a contributing factor to the internalized thin ideal, can occur on individual and global levels. In examining personal bias, Marini et al. (2013) found that people regardless of their weight experience negative bias against overweight people. Individuals who are overweight also experience internal and external bias against overweight people. However, the greater degree of obesity the weaker the internal bias against overweight people. Whereas, nations where there is more obesity and overweight individuals, show higher levels of implicit weight bias and external stigma (Marini et al., 2013). This may be associated with increasing internal weight bias of overweight people and in turn, increasing body shame.

Another major component of body shame is early experiences with primary caregivers, which influences an individual's vulnerability to psychopathology. Low levels of parental care (warmth, affection, empathy) and higher levels of overprotection are related to lower self-concepts (Markham et al., 2005). Critical researchers and theorists explored how familial body surveillance and family shaming experiences promote internal bias, as well as experience body weight control shame regulation dynamics (Daye et al., 2014).

Effects of body shame. Body shame is the only component of the OBC that received in-depth study in the research literature. Therefore, body shame will continue to be a primary focus of OBC in this research study. Body shame is important to examine because of the negative psychological and physical health effects on the individual**.** There is a correlational relationship between higher weight and elevated levels of body shame (Pila et al., 2015). Body shame and

guilt mediates the path between different weight status indicators and self-esteem. Pila et al. (2015) believe that understanding this relationship is a step in understanding the role body-related emotions play in the relationship between weight status and self-esteem. Higher body shame also has a slight relationship with higher cortisol response (Lupis, Sabik, & Wolf, 2015). Trait shame and body esteem are important predictors of cortisol response, as well as potential contributors to stress-related negative health outcomes. Body shame is also a contributing factor in eating disorder symptomatology. Body shame is both a mediating and predicting factor in eating disorder symptomatology, and is therefore a major variable in possible health problems (Greenleaf & McGreer, 2006; Markham et al., 2005; Tylka & Sabik, 2010). Overall, body shame is associated with numerous health outcomes, and further research is needed in this area.

Objectified Body Consciousness and Gender

Objectified Body Consciousness, while based on feminist theory and the experiences of women, has also found applications to the experiences of male individuals. Self-surveillance and self-esteem through body shame did not differ across genders. Masculinity was found to be a buffering factor between self-surveillance and body shame, as well as appearance anxiety (Choma et al., 2010). Another finding with OBC theory and men show that when body surveillance and body shame levels were higher, perceptions of body attractiveness and sport competence were lower as well as lower levels of physical self-worth and general self-esteem (John & Ebbeck, 2008).

Body and Christianity

The physical body has been the focus of Christianity since Biblical times. There are attempts in church culture to create a mythos regarding physical appearance and spiritual

practices. Reagan (2013) outlines ways in which the modern evangelical church has perceived and manipulated the understanding of the body using scripture. One of these ways involves the treatment of women in Church history. Reagan (2013) discusses how much of the narrative involving the founding of the Church focuses on the disciples, the role of Paul, and other prominent male figures. Many mainline Christian denominations do not ordain women, creating an idea that the male body is privileged over the female, trans, or non-gender binary body.

Christianity's relationship to body shame. Many researchers examined the relationships between religion and shame, and some have expanded on that connection to examine body shame and self-esteem. When examining these studies there is not a clear or comprehensive understanding of the role that religious belief has on body shame and self-esteem. Overall, researchers are not in agreement in how to examine, measure or write about this relationship.

Inman, McKeel, & Iceberg (2014) examined the relationship between religious commitment and body esteem. Using the Religious Commitment Scale and the Body Esteem Scale, they found a correlational relationship between higher religious commitment and body esteem when reading body affirming messages. For women who doubt or have a lower religious commitment experience higher levels of anxiety and body shame (Inman et al., 2014). The authors found that for the religiously committed women, religious affirmations buffered messages regarding the societal thin ideal.

Sanctification is a theological theme in Christian traditions, specifically holiness traditions in the American Church. When examining the role of sanctification and views of the body, sanctification is positively correlated with body satisfaction in a study by Jacobson, Hall,

& Anderson (2013). Researchers noted that the idea of sanctification can differ between Christian denominations and focusing on people finding sacred qualities within their bodies.

Exline, Homolka, & Harriott, (2016) studied the relationship between struggles with the divine and self-esteem. They found that body image concerns, binging, and compensatory behaviors over three months had a positive correlation with current anger/disappointment toward God. They also found a positive correlation between negative body image and fear of God's disapproval. Exline et al. showed that the relationship between struggling with God and body image concerns remained significant when controlling for a variety of variables such as gender, BMI, and religious participation. They also had findings indicating that those with eating disorders had higher levels of spiritual grandiosity, believing they were exceptional in some way.

A religious factor that is negatively related to body appreciation is radical dualism (Jacobson, Hall, Anderson, & Willingham, 2016a). Radical dualism sees the body as corrupt and separate from oneself. Jacobson et al. (2013, 2016a, 2016b) define sanctification as viewing "the body as holy, worthy of respect, and integral to one's being" (2016a, p. 52). This drastically differs from the stance of the Church of the Nazarene's definition of sanctification, which defines sanctification as an act of God where believers become free from original sin and depravity, and are brought to a state of holiness (Church of the Nazarene, 2013). According to the 2017-2021:

> Christians are both called and enabled by the transforming and sanctifying work of the Holy Spirit to glorify God in and with our bodies. Our senses, our sexual appetites, our ability to experience pleasure, and our desire for connection to another are shaped out of the very character of God. Our bodies are good, very good.

The relationship of the self being shaped out of the character of God, aligns with a monist view of the body and the soul being one. Jacobson, Hall, Anderson, & Willingham, (2016b) describe this view of a combined body and soul, as a sanctified view of the body. Within their study, sanctification was a predictor of body appreciation.

Many of the above themes were explored in a meta-analysis examining 22 studies examining relationship with God, eating disorders, psychopathology, and body image concerns (Akrawi, Bartrop, Potter, & Touyz, 2015). Researchers reported that while a secure and satisfying relationship with God is correlated with lower levels of the eating disorders, psychopathology, and body image concerns either a superficial faith or a doubtful and anxious relationship with God is related to greater levels of disordered eating, body image concerns, and psychopathology. Researchers encouraged further to research to be done in this area, including ways to reduce the risk. Overall, it appears that Christianity buffers against the thin ideal if there is a strong level of religious commitment and a secure attachment to God.

Gender Roles and Christianity

Gender is a component of the main world religions and how societies are organized around them. Religion plays a role in how people form gender attitudes. Globally, there are no significant differences between gender inequality and the world's three largest major religions (Christianity, Islam, and Hinduism). However, the more non-religious people in a country, the more there is gender equality the country (Schnabel, 2016). According to the Pew Research Center (2015) *U.S. Religious Landscape Study*, 70.6% of Americans identify as Christians, with 25.4% identifying as Evangelical Protestant Christians and 14.7% identifying as Mainline Protestant. 55% of both Evangelical Protestants and Mainline Protestants are women. When

asked about the importance of religion 59% of women reported it being very important in their lives. A theme seen in the research literature is that women have higher religiosity than men (Gauthier, Christopher, Walter, Mourad, & Marek, 2006). Differences in gender roles extend to how women organize their lives.

Colander and Warner (2005) found that Christian women who have egalitarian (gender equality) gender roles are more likely to pursue careers than women with a complementarian (separate roles for men and women) gender role. Complementarian women may still work, but may not aspire to complete higher education or career promotions. Some of these gender roles are based in the Bible and affect every aspect of the female experience including social interactions, sexual experiences, biological health, etc. (Daniluk & Browne, 2008). At times the Christian experience is exemplified through a perfectionistic self-presentation, given when there is a list of moral codes (pornography, sexuality, alcohol, etc.) that must and must not be followed (Brodar, Crosskey, & Thompson, 2015). In examining scriptural codes of female attributes, as seen in Proverbs 31, modern theologians use this list outlaying attributes of a virtuous woman, is at times used as a prescriptive formula rather than celebrating a "woman of valor". Other prescriptive examples of how women are to behave is seen in the Old Testament (i.e. Levitical Law), as well as 1 Timothy 2:12, stating, "I do not permit a woman to teach or to assume authority over a man; she must be quiet." It is in these ways the Christian scripture has been used to outline and prescribe gender roles to women within an internal and external context.

The Church of the Nazarene

Within Christianity there are several systems of moral understanding and the relationship to self. Many of these systems were developed over the years by examining and adhering to the

writings of many great theologians as well as Christian scripture, the Bible. The Church of the Nazarene is an interesting case to examine due to its theological principles. The Church of the Nazarene is formed under the Wesleyan tradition. John Wesley was an Anglican cleric and missionary in the 18th century (Rainey, 2010). He is the founder of the Methodist church and wrote several sermons that have formed the moral understanding for the modern Methodist, Nazarene and Wesleyan churches. The basis of this moral understanding and faith is the Wesleyan Quadrilateral. The Wesleyan Quadrilateral bases theological understanding as a relationship between scripture, tradition, reason, and Christian experience (Outler, 1985). For moral understanding to be created by scripture there needs to be a balance of influence from tradition, reason, and Christian experience. Due to the subjective nature of reason and the Christian experience, as well as an understanding of Christian tradition, this particular view of theology leaves room for various interpretations.

The Wesleyan Quadrilateral and an egalitarian structure created room for conversations regarding gender roles, views of the body, and the pursuit of holiness. While based in an 18th century theological method, the modern Church of the Nazarene was officially formed from a collection of churches from around the United States at a gathering in Pilot Point, Texas in 1907 (Ingersol, 2014). The overarching goals in the creation of the Church of the Nazarene were to "preserve John Wesley's religion of the warmed heart by preaching the substance of his spiritual theology; establish a democratic form of Methodism; maintain an apostolic ministry; align the church with the poor through ministry; and embrace a "mission to the world" (Ingersol, 2014, p. 13). The author of the book *Past and Prospect: The Promise of Nazarene History,* argues that for a time, the above purpose of the church became lost in a fundamentalist perspective of

scripture and holy living. Another area of possible fundamentalism impact in the Church of the Nazarene was in the involvement of women in ministry. One of the previous tenets of maintaining an apostolic ministry included the ordination and involvement of women in ministry.

The Pew Research Center (2015) *U.S. Religious Landscape Study*, reports that .3% of the United States population are members of the Church of the Nazarene. According to data kept by the Church of the Nazarene in 1994, the Church was at an all-time low with 1.4% of active clergy being women. As of 2016, over 20% of active clergy are women (Church of the Nazarene, 2013). Of those actively serving in ministry 9.1% of senior pastors are women, 35.5% of associate pastors are women, and 13.6% of evangelists are women. As of 2014, 51% of members of the Church of the Nazarene are women, displaying a discrepancy between women serving in leadership and the population. Therefore, surveying Nazarene women, whose leadership numbers have increased due to a purposeful effort by greater church leadership is important due to the issue of gender being raised and discussed by the church.

Self-Compassion

Self-Compassion is a practice that relies on openness to being moved by "one's own suffering, experiencing feelings of caring and kindness towards oneself, taking an understanding, nonjudgmental attitude toward one's inadequacies and failures, and recognizing that one's own experience is part of the common human experience" (Neff, 2003, p. 224). Self-Compassion is based in Eastern philosophical thought and Western psychology. Self-compassion acknowledges that part of the human condition that involves failing, suffering, and being inadequate, and that no matter what all people, including the self, are worthy of compassion (Neff, 2003). Self-

compassion involves practices aligned with mindfulness, involving a non-judgmental mental state where one's thoughts can be observed.

Effects of self-compassion. Self-compassion is seen to be a buffering agent between difficult recollections of negative caregiver messages and body surveillance and body shame (Daye et al., 2014). Studies have also shown people who have higher levels of self-compassion have lower levels of body shame, negative eating attitudes, and depression. BMI was not a factor between high and low self-compassion groups, thus eliminating the idea that weight is a factor in body shame (Liss & Erchull, 2015). A recent intervention shows that teaching self-compassion skills enhances participants psychological functioning, creating a strong link to self-efficacy (Smeets, Neff, Alberts, & Peters, 2014). Self-compassion not only protects and mitigates feelings of body shame and increases feelings of body appreciation, but it maintains over time (Albertson, Neff, & Dill-Shackleford, 2015). Researchers found that three weeks of self-compassion meditation podcasts, increased self-compassion and body appreciation in women, and maintained these feelings for at least three months.

Self-compassion and Christianity. While self-compassion has roots in Eastern religions, there is emerging research examining the role of self-compassion within Christianity. Brodar et al. (2015) examine the relationship between self-compassion and perfectionistic self-presentation, perceived forgiveness, and perceived social support. Researchers found that self-compassion is negatively associated with dimensions of perfectionistic presentations and positively with perceptions of forgiveness and support. Self-compassion has been found to be a buffer for burnout within a Christian clergy population. Clergy with higher self-compassion have higher levels of ministerial satisfaction and lower levels of emotional exhaustion (Barnard &

Curry, 2012). Further research is needed in how self-compassion interacts with the contemporary evangelical church and body shame. There is minimal research on the greater practice of Mindfulness within a Christian frame (Tan, 2011). However, there is no past research exploring the relationship that self-compassion has with religiosity, gender roles, and body shame. Therefore, this study seeks to explore the relationship of self-compassion has with religiosity, gender roles, and body shame in Christian Nazarene women.

Purpose of This Study

The purpose of this study is to examine the relationship between body shame, gender roles, and self-compassion in female members of the Church of the Nazarene.

The hypotheses for this study are as follows:

Hypothesis 1: Religious involvement, gender roles, and self-compassion will each make a unique contribution to predicting body shame.

Hypothesis 2: Religious involvement, gender roles, and self-compassion will each make a unique contribution to predicting control beliefs.

Hypothesis 3: Religious involvement, gender roles, and self-compassion will each make a unique contribution to predicting body surveillance.

Chapter 2

Methods

Participants

A total of 2,074 respondents completed part of the survey. A total of 1,822 women completed the survey measure. These women self-identified as currently attending or previously attended churches within the Church of the Nazarene denomination. The demographics is based on the full number of participants, however there was a range of participants who completed the entire survey 1,822 completed the demographic section, while the highest survey participant was 1,823 who completed the DUREL. The lowest completed survey was the AWS with 1,560 participants. The mean age of the sample was 46.54 (*SD* = 15.246) and ranged from 18 to 87 years of age. The majority of the sample self-identified as European-American (90.9%; *n* = 1,662). Other ethnic identifications included: Hispanic/Latino (3.3%; *n* = 61), two or more ethnicities (2.5%; *n* = 45), African American or Black (1.1%; *n* = 21), American Indian/Alaska Native (1%; *n* = 18), Asian American (.8%; *n* = 14), and Native Hawaiian/Pacific Islander (.1%; *n* = 1). A majority of participants identified as Heterosexual/Straight (95.9%, *n* = 1,754), with the second largest group identifying as Bisexual (1.7%, *n* = 31). Among respondents, 78% identified as married (*n* = 1,426) and 12% identified as single, never married (*n* = 219). A majority of respondents endorsed completing graduate school (33.6%; *n* = 615), with the second largest group identifying as college graduates (31.4%; *n* = 574).

A majority of the participants endorsed currently attending a Nazarene church (77.2%; *n* = 1412), with the mean length of attendance 31.68 years and ranged from 0 (beginning

attendance at birth) to 87 years. A majority of respondents also identified as being Church of the Nazarene members (82.3%; n = 1,497). Among respondents, 31.8% of respondents endorsed being on staff at a Nazarene church (n = 581) and 26.3% endorsed being ordained (n = 481).

Table 1

Participant Demographic Information

Item	Category	Frequency	Percentage
Ethnicity	European American	1662	90.90
	Hispanic/Latina	61	3.30
	Multiple Ethnicities	45	2.50
	Black/African American	21	1.10
	American Indian/Alaska Native	18	1.00
	Asian American	14	0.80
	Native Hawaiian/Pacific Islander	1	0.10
Marital	Married	1426	78.00
Status	Single, never married	219	12.00
	Divorced	81	4.40
	Widowed	58	3.20
	Unmarried, cohabiting with partner	19	1.00
	Other	13	0.70
	Separated	5	0.30
Children	Yes, all 18 or over	722	39.50
	Yes, one or more under 18	650	35.50
	No	450	24.60
Sexual	Straight/Heterosexual	1754	95.90
Orientation	Bisexual	31	1.70
	Other	23	1.30
	Lesbian	6	0.30
	Don’t Know	5	0.30
	Something Else	3	0.20
Education	Completed Graduate School	615	33.60
Level	Graduated from College	547	31.40
	Some College	324	17.70
	Some Graduate School	195	10.70
	Graduated from High School	91	5.00
	11th Grade	2	0.10
Employment	Employed, Full Time	950	51.90

Item	Category	Frequency	Percentage
	Employed, Part Time	288	15.70
	Retired	202	11.00
	Stay at Home Parent	128	7.00
	Other	123	6.70
	Student	29	2.70
	Not Employed, Looking for Work	34	1.90
	Disabled, not able to work	24	1.30
	Not employed, not looking for work	23	1.30
Household	Less than $10,000	41	2.20
Income	$10,000-$49,999	549	32.00
	$50,000-$99,999	711	41.6
	$100,000-$149,999	268	14.7
	More than $150,000	140	7.7
Naz. College	Yes	1244	68.0
Attendance	No	574	31.4
Naz. Church	Yes	1412	77.2
Attendance	No	406	22.2
Nazarene	Yes	1497	81.8
Membership	No	322	17.6
Naz. Church	Yes	581	31.8
Staff	No	817	44.7
	Former Staff	140	7.7
	Currently Looking for Staff Position	21	1.1
Nazarene	Yes, currently ordained	481	26.3
Ordination	In ministry, pursing ordination	224	12.2
	In ministry, not pursing ordination	99	5.4
	Formerly ordained	10	0.5
	Does not apply	1015	55.5

Instruments

Demographics. A survey was developed to gather demographic data. It consisted of 16 questions, gathering participants' age, ethnicity, relationship status, education level, income, occupation, children, geographic location, church membership, and affiliation to the Church of the Nazarene. Participants who are involved in ministry/church leadership were asked additional

questions regarding roles, ordination, length of service, and an open text box allowing participants to share "anything you would like the researchers to know about women in ministry in the Church of the Nazarene."

Self-Compassion Scale- Short Form. Participants were given the Self Compassion Scale-Short Form (SCS-SF; Filip, Pommier, Neff, & Van Gucht, 2011), which is comprised of 12-questions which examine the positive and negative aspects of the three main components of self-compassion. These components are Self-Kindness versus Self-Judgment, Common Humanity versus Isolation, Mindfulness versus Over-Identification. Responses are given on a 7-point Likert scale ranging from 1 (*almost never*) to 7 (*almost always*). The measure demonstrates valid internal consistency (Cronbach's alpha ≥ 0.86), as well as a strong correlation to the long form ($r \geq 0.97$). The reliability in this sample was .814.

Objectified Body Consciousness Scale. Participants were given the Objectified Body Consciousness Scale (OBC), comprised of 24-questions measuring body surveillance, body shame, and appearance control beliefs. Responses are given on a 7-point Likert scale ranging from 1 (*strongly disagree*) to 7 (*strongly disagree*). The Surveillance Scale consists of eight items measuring the extent a woman watches and objectifies her body. The Body Shame Scale consists of eight items and measures the extent a woman believes she is good or bad based on the cultural expectations of beauty. The Control Beliefs Scale consists of eight items and measures the extent a woman believes she can control her body weight and shape. In a previous study the OBC internal consistency (α) was found to be moderate to high (Surveillance Scale: .89; Body Shame Scale: .75; Control Beliefs Scale: .72). There were significant correlations between the scales ranging from .16 and .66. Test-retest reliability of the OBC is good with correlations of

.79 for Body Surveillance, .79 for Body Shame, and .83 for Control Beliefs. Permission was gained from Nita McKinley to use this measure for research purposes (McKinley & Hyde, 1996). The reliability in this sample was .79.

Attitudes Towards Women Scale. Participants were given the Attitudes Towards Women Scale-Short Form (AWS) measuring attitudes towards women's rights, roles, privileges, and responsibilities within society (Byrne, Felker, Vacha-Haase, & Rickard, 2011). The measure is composed of 25 questions on a 4-point rating scale ranging from A (*agree strongly*) to D (*disagree strongly*). The initial short form scale was developed and validated from the 55-question scale (Spence, Helmreich, & Stapp, 1973). Recent research reexamined the AWS from an intergenerational perspective (Byrne et al., 2011). Using a factor analysis college-age respondents interpret the scale as having five separate factors: "women's rights, position relative to men, freedom to act, family roles, and legal rights" (p.257). While later-life respondents indicated four separate factors: "women's rights, positive relative to men, freedom to act, and family roles" (p. 257), providing a multidimensional way to interpret AWS scores. The reliability in this sample was .86.

Duke University Religion Index. Participants were given the Duke University Religion Index (DUREL) using five items to measure organizational religiousness (OR), nonorganizational religiousness (NR), and intrinsic religiousness (IR). Responses have a 5-point response format. Organizational religiousness and non-organizational religiousness measure how many days a month the individual engages in religious activities. Intrinsic religiousness measures the extent religious belief has on the participant's life. The DUREL was found to be a valid and reliable measure of religiosity with a test-retest reliability being a high intra-class correlation

coefficient of 0.91, a strong internal consistency (Cronbach's alpha between 0.78-0.91), and convergent validity with other established measures of religiosity (*r's* = 0.71-0.86; Koenig & Bussing, 2010). The reliability in this sample was .85.

Procedure

Following IRB approval from George Fox University, participants were selected through two methods. For the first method, an email list of female clergy and lay leaders in the Church of the Nazarene was compiled by the General Secretary of the Church of the Nazarene. The survey was distributed electronically via Survey Monkey to 2,940 email addresses. Of emails sent, 61.4% of emails were opened, while 28.1% of people began the survey. In total, the email collector contributed 620 (22.9% of email response rate) participants to the survey. The second method of collection was through a web link distributed to email respondents and on social media (Facebook, Twitter, etc.). Based on email and social media response, it is determined that this link reached people in a "snowball" distribution pattern. The electronic survey included a demographic questionnaire, SCS-SF, OBC, DUREL, and AWS. As compensation for completing the survey, a $0.50 donation was made to Nazarene Compassionate ministry. In total a donation of $911 was made from the primary researcher and one donor.

Chapter 3

Results

A bivariate correlational matrix was computed to assess the relationships between body shame, control beliefs, surveillance, intrinsic religiosity, organizational religiousness, non-organizational religiousness, attitudes toward women, and self-compassion. There are slight variations in the *N* of the sample due to participants choosing not to answer specific questions. The descriptive statistics of the variables can be seen in Table 2. The relationships between these variables are shown in Table 3, and further explored in the additional analyses.

Table 2

Descriptive Statistics

Measure	*N*	Mean	*SD*
OBC-Body Shame	1708	3.23	1.17
OBC- Control Beliefs	1733	4.60	0.96
OBC-Surveillance	1737	4.06	1.09
DUREL-IR	1817	4.21	2.05
DUREL-OR	1821	1.66	1.08
DUREL-NOR	1823	1.43	1.02
AWS	1560	60.74	8.91
Self-Compassion SF	1774	3.22	0.63

Note. DUREL indicates Duke Religion Index, IR indicates Intrinsic Religiosity, OR indicates Organizational Religiousness, NOR indicates Non-Organizational Religiousness. AWS indicates Attitude Towards Women Scale. Self-Compassion SF indicates Self Compassion Scale Short-Form.

Table 3

Correlation of Objectified Body Consciousness, Religious Identification, Gender Roles, and Self-Compassion

	Measure	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
1	OBC-Body Shame	--							
2	OBC-Control Beliefs	-0.24*	--						
3	OBC-Surveillance	0.52**	0.50*	--					
4	DUREL-IR	0.13**	0.09**	0.13**	--				
5	DUREL-OR	0.08**	-0.09**	0.05*	0.57**	--			
6	DUREL-NOR	0.09**	-0.12**	0.11**	0.63**	0.56**	--		
7	AWS	-0.03	0.03	0.05	0.27**	0.26**	0.24**	--	
8	Self-Compassion SF	-0.54**	0.21**	-0.35**	-0.30**	-0.18**	-0.21**	-0.07**	--

Note. DUREL indicates Duke Religion Index, IR indicates Intrinsic Religiosity, OR indicates Organizational Religiousness, NOR indicates Non-Organizational Religiousness. AWS indicates Attitude Towards Women Scale. Self-Compassion SF indicates Self Compassion Scale Short-Form. * $p < .05$; ** $p < .01$.

To measure the first hypothesis, a multiple linear regression was calculated to predict Body Shame based on religious involvement, gender roles, and self-compassion. A significant regression equation was found $F(5, 1439) = 121.80$, $p < .000$, with an R^2 of .297. When Body Shame was predicted it was found that gender roles ($\beta = -.07$, $p < .004$), and self-compassion ($\beta = -.55$, $p < .000$) were significant predictors. Internal Religiosity ($\beta = -.044$, $p < .170$), Organizational Religiousness ($\beta = .018$, $p < .532$), and Non-Organizational Religiousness ($\beta = .021$, $p < .487$) were not significant.

Table 4

Summary of Multiple Regression Analysis for Body Shame (N = 1,445)

	B	SE	β	*t*	Sig. (*p*)
(Constant)	7.11	0.24		30.23	0.00
DUREL-IR	-0.02	0.02	-0.04	-1.37	0.17
DUREL-OR	0.02	0.03	0.02	0.63	0.53
DUREL-NOR	0.02	0.04	0.02	0.70	0.49
AWS	-0.01	0.00	-0.07	-2.89	0.00
Self-Compassion SF	-1.03	0.04	-0.55	-23.75	0.00

Note. DUREL indicates Duke Religion Index, IR indicates Intrinsic Religiosity, OR indicates Organizational Religiousness, NOR indicates Non-Organizational Religiousness. AWS indicates Attitude Towards Women Scale. Self-Compassion SF indicates Self Compassion Scale Short-Form. R^2=.297.

To measure the second hypothesis, a multiple linear regression was calculated to predict Body Control Beliefs based on religious involvement, gender roles, and self-compassion. A significant regression equation was found ($F(5, 1456) = 16.058$, $p < .000$, with an R^2 of .052.

When Body Control Beliefs was predicted, it was found that non-organizational religiousness (β = -.102, $p < .004$), and self-compassion (β = .191, $p < .000$) were significant predictors. However, gender roles (β = .002, $p < .914$), intrinsic religiosity (β = .038, $p < .295$), and organizational religiousness (β = -.033, $p < .325$) were not significant.

Table 5

Summary of Multiple Regression Analysis for Body Control Beliefs (N = 1462)

	B	SE	β	*t*	Sig. (*p*)
(Constant)	3.77	0.22		17.04	0.00
DUREL-IR	0.02	0.02	0.04	1.05	0.30
DUREL-OR	-0.03	0.03	-0.03	-0.99	0.33
DUREL-NOR	-0.09	0.03	-0.10	-2.92	0.00
AWS	0.00	0.00	0.00	0.07	0.91
Self-Compassion SF	0.29	0.04	0.19	7.13	0.00

Note. DUREL indicates Duke Religion Index, IR indicates Intrinsic Religiosity, OR indicates Organizational Religiousness, NOR indicates Non-Organizational Religiousness. AWS indicates Attitude Towards Women Scale. Self-Compassion SF indicates Self Compassion Scale Short-Form. $R^2 = .052$.

To measure the third hypothesis, a multiple linear regression was calculated to predict Body Surveillance based on religious involvement, gender roles, and self-compassion. A significant regression equation was found $F(5, 1460) = 44.171$, $p < .000$, with an R^2 of .131. When Body Surveillance was predicted, it was found that self-compassion (β = -.351, $p < .000$) and non-organizational religiousness (β = .070, $p < .036$) were significant predictors. However, gender roles (β = .021, $p < .419$), internal religiosity (β = -.015, $p < .664$), and organizational religiousness (β = -.026, $p < .408$) were not significant.

Table 6

Summary of Multiple Regression Analysis for Body Surveillance (N = 1466)

	B	SE	β	*t*	Sig. (*p*)
(Constant)	5.84	0.24		24.09	0.00
DUREL-IR	-0.09	0.02	0.02	-0.44	0.66
DUREL-OR	-0.03	0.03	-0.03	-0.83	0.41
DUREL-NOR	0.07	0.04	0.07	2.10	0.04
AWS	0.00	0.00	0.02	0.81	0.42
Self-Compassion SF	-0.61	0.04	-0.35	-13.73	0.00

Note. DUREL indicates Duke Religion Index, IR indicates Intrinsic Religiosity, OR indicates Organizational Religiousness, NOR indicates Non-Organizational Religiousness. AWS indicates Attitude Towards Women Scale. Self-Compassion SF indicates Self Compassion Scale Short-Form. $R^2 = .131$.

Additional Analyses

Comparison of clergy and non-clergy women. In addition to the above hypotheses, further analyses were conducted. To further understanding of the experiences of female clergy, a univariate analysis of variance was conducted to evaluate the relationship between ordination status and body shame. The independent variable included five levels: currently ordained, in ministry working on ordination, in ministry not working on ordination, formerly ordained, and non-clergy. The ANOVA was significant $F(4,1415) = 4.625$, $p = .001$. The strength of the relationship between ordination status and body shame as assessed by η^2, was not strong, with ordination status accounting for 1.3% of the variance of body shame. Post hoc comparisons using the Tukey HSD test indicated that the mean score for ordained clergy ($M = 3.0171$, $SD = 1.06$) was significantly lower than non-clergy ($M = 3.3079$, $SD = 1.19$). There were no significant

differences between currently ordained, and participants who were formally ordained, in ministry working towards ordination, and in ministry not working towards ordination.

OBC Population Norms. The Objectified Body Consciousness Scale has been normed in undergraduate female populations, as well as within undergraduate male and middle-aged women populations. For the purpose of this study, the middle-aged women norm is being used due to a mean age of 46.54.

A single sample *t*-test was conducted to determine a significant difference existed between OBC Body Shame from the mean score in the study and the reported norm for middle aged women. Study participants reported significantly more body shame ($M = 3.234$, $SD = 1.169$) compared to the reported norm (McKinley, 1999) of $M = 2.98$ ($SD = 0.97$, $N = 150$), $t(1707) = 8.984$, $p = 0.000$. The effect size is small, ($d = 0.236$, $r = .117$).

A single sample *t*-test was conducted to determine a significant difference existed between OBC Surveillance from the mean score in the study and the reported norm for middle aged women. Study participants reported significantly less surveillance ($M = 4.06$, $SD = 1.09$) compared to the reported norm (McKinley, 1999) of $M = 4.33$ ($SD = 1.03$, $N = 150$), $t(1736) = -10.39$, $p = 0.000$. The effect size is small, ($d = -0.254$, $r = -.126$).

A single sample *t*-test was conducted to determine a significant difference existed between OBC Control Beliefs from the mean score in the study and the reported norm for middle aged women. Study participants reported significantly less control beliefs ($M = 4.60$, $SD = 0.96$) compared to the reported norm (McKinley, 1999) of $M = 4.94$ ($SD = 1.02$, $N = 150$), $t(1732) = -14.84$, $p = 0.000$. The effect size is small, ($d = -0.343$, $r = -.169$).

Chapter 4

Discussion

This is the first study of its kind to specifically examine the experience of women with regards to self-compassion, objectified body consciousness, and religious identification within the Church of the Nazarene. It is the first attempt to understand the specific demographics of this population all the while providing information regarding objectified body consciousness, religious identification, and attitudes towards women in this distinct population. The original desired population was 200 respondents. That goal was met within an hour and had reached 1,100 respondents within 24 hours of its release. This was accompanied with several emails and social media messages describing participants' experiences with the survey, ranging between joy and disgust. In total, the principle researcher received 51 emails communicating thoughts and feels about the dissertation. The level of response and opinions from participants might an indicator of how the perspectives of women in the Nazarene church are under-explored and yet how women want to have a voice.

Discussion of the Sample

Pew Research Center (2015), conducted a survey of the religious landscape in the United States. Over 35,000 individuals surveyed and 101 identified as Nazarenes. This information creates a base for understanding some demographic and belief information.

Age. The Pew information available reports that, for both men and women, a majority of Nazarene's polled were in the 50-62 age range. This research study had age responses that were

similar, however the largest grouping of participants was within the 30-49 age range. Differences may be due to the use of online measures, an aging population, and gender differences.

Ethnicity. The Pew Research Center (2015) found that 88% of respondents identified as "White". This is comparable with this research demographic findings of: 90.8% of respondents identifying as "White." Within this study's sample, there were lower numbers of individuals identifying as Black and Latina. This may be due to gender differences within the Pew norm and research, as well as access to online materials. Another consideration is the structure of the American Church of the Nazarene and the amount of clergy and church leaders who identify as other than white.

Education. In examining the educational distribution among members of the church of the Nazarene, found by Pew Research Center (2015), showed that 43% of respondents had a high school education or less, 37% had some college, 11% had a college degree, and 9% had a post graduate degree. This was vastly different than the population within this study, which had higher levels of education: 5.2% had a high school education or less, 18.1% had some college, 31.8% had a college degree, 10.8% had some graduate school, with 34.1% had a post-graduate degree. There are several possibilities for this discrepancy. Part of the survey sample was gained through an email list from the Church of the Nazarene, targeting female clergy and leadership. In total 31.8% of respondents endorsed being on staff at a Nazarene church and 26.3% endorsed being ordained. This population, is required to complete a course of study to become ordained, which may involve receiving an education at a Nazarene Educational Institution.

Clergy. An additional analysis was conducted to examine body shame within the clergy population. It was shown that clergy, who are ordained, experience less body shame than clergy

who are in the ordination process, as well as respondents who are not clergy. Though being clergy does not strongly predict having lower body shame, it does appear that being ordained may be a protective factor against body shame. The Church of the Nazarene's growing support of female leadership may be a reason for these results, as well as completion of the course of study and mentorship required for ordination.

OBC Norms. Before exploring the meaning of the hypothesis and the impact on this population, the data found needs to be put in perspective with normed populations. This provides an understanding of this study's findings within the greater research knowledge. Research participants in this study experienced higher levels of body shame than the normed sample. Women with higher scores tend to report feeling like they are a bad person if they do not fulfill cultural expectations for their bodies. The study research participants experienced lower levels of body surveillance behavior than the normed sample. Women with lower scores tend to report lower levels of watching their appearance and often think of their body in terms of how it feels verses how it looks. The study research participants experienced lower levels of body control beliefs behavior than the normed sample. Women with lower scores tend to report beliefs of lower control of their weight or appearance and that these are controlled by factors such as heredity, and other biological, psychological, and social factors.

DUREL. The Duke Religion Index measures three areas of religious identification. These areas help describe an individual's religious activity, both organized and non-organized, as well as their intrinsic religiosity. The scores of the DUREL help shape the understanding of this sample of women. The data demonstrates that the average church attendance for this population is once a week or more. A majority of participants also engage in non-organizational religious

activities once a week or more. Combined this indicates that the population is committed to their religious activities as a lifestyle. This is further substantiated by examining the high intrinsic religiosity of this population. The intrinsic religiosity of this sample shows that participants are committed to experiencing God and having their religion influence areas of their life, and their approach to life.

AWS. The attitudes towards women scale examines attitudes towards women's rights, roles, privileges, and responsibilities within society. The mean for this study sample was in the lower half of the score range, indicating that on average, the women in this study endorse a feminine sex-role stereotypes (e.g., sensitive, affectionate) and a more traditional and conservative attitude. Women in this sample differ significantly from their normed counterparts indicating a more traditional and conservative view of the roles of women.

Self-Compassion. The self-compassion scale-short form scale examines how the individual acknowledges that "suffering, failure, and inadequacies are part of the human condition, and that all people, oneself included, are worthy of compassion" (Neff, 2003, p. 224). The normed population of the short-form scale were college students, which is a different mean age from this study's sample. The average mean of this study's sample was significantly higher than the norm, meaning that this sample experienced higher levels of self-compassion than their younger counterparts. The higher self-compassion may be due to age differences, as one ages, possibly they learn to give themselves greater compassion.

Objectified Body Consciousness Intra-Scale Relationship

Body shame, control beliefs, and surveillance were significantly correlated with one another. Body shame was positively correlated with surveillance, suggesting that when body

shame is higher so is surveillance. This might indicate that the greater shame one feels over their body, the more they will engage in body checking behaviors. Body shame, however, is negatively correlated with control beliefs. Suggesting that when an individual feels a higher level of body shame they will feel as though they have less control over their body. This may be a way to diffuse a sense of responsibility that can at times be found in shame. Finally, Body control beliefs was positively correlated with body surveillance, suggesting that the greater the belief in control over weight and appearance, the more body checking behavior the individual engages in.

Self-Compassion and DUREL

Another interesting finding of this study was the correlational relationship between self-compassion and religious identification. This relationship is inversely correlated, meaning that as someone rates their religious identification as higher (indicating less time spent in religious activities, and making their religion an importance aspect of their life), their score of self-compassion decreases. This presents an area of further study, exploring the relationship between belief in God, spiritual practices in Western Christianity, and self-compassion.

Discussion of the Hypotheses

Hypothesis 1. The first hypothesis posited that religious involvement, gender roles, and self-compassion will each make a unique contribution to predicting body shame. The results indicated that while religious involvement, gender roles, and self-compassion all are significantly correlated with body shame, only gender norms and self-compassion were found to be significant predictors of Body Shame. While religious identification has a unique relationship with Body Shame it does not have any predictive relationship with it. However, the correlational data indicates that when religious identification increases, and the individual spends less time, energy

and purpose attending religious activities, their body shame increases. The predictive relationship of self-compassion and body shame, demonstrates that those with lower self-compassion, experience higher levels of body shame. The predictive relationship between gender roles and body shame, is such that when someone has more traditional and conservative views of the role of women, they experience higher levels of body shame. This may be due to more traditional views of women, place their existence and bodies in a lower place in society, creating more space for shame.

Hypothesis 2. The second hypothesis posited that religious involvement, gender roles, and self-compassion will each make a unique contribution to predicting body control beliefs. This study found that non-organizational religiousness and self-compassion significantly predicted and individuals control beliefs. The relationship between self-compassion and body control beliefs is positive, indicating that when self-compassion is higher there is a higher control belief. This may be due to recognition of the imperfect and the lessening of shame. As body shame and control beliefs are negatively correlated, a possible interpretation is that the more an individual is kind to themselves, the lesser the feeling of shame, and the greater the sense of agency over one's body.

Non-organizational religiousness is found through the time a person spends in non-organized religious activities such as prayer, meditation, reading, etc. The more time an individual spends in these activities increases the individual's control beliefs. Both measures relate to the concept of self-efficacy. Self-efficacy is a person's ability to accomplish a task or set of actions within a situation. Non-organizational religious activity requires that an individual take time out of their lives to commit to a set of religious actions and activities. When developing

the OBC scale, researchers noted that an underlying assumption of OBC is "that women are responsible for how their bodies look and feel" (McKinley & Hyde, 1996, p. 184), and that this can be controlled through effort, or as one might say self-efficacy. Both control beliefs and non-organizational religiousness involve the cognitive choice to execute a behavior and take responsibility for the outcome.

Hypothesis 3. The third hypothesis posited that religious involvement, gender roles, and self-compassion will each make a unique contribution to predicting body surveillance. This study found that, as with control beliefs, non-organizational religiousness and self-compassion significantly predicted body surveillance. This relationship indicates that when self-compassion increases, body surveillance decreases. This may be due in part to the self-kindness that is fostered with higher self-compassion. Instead of thinking of the body in terms of how it looks, the focus becomes on how the body feels. Non-organizational religiousness is positively related to body surveillance, suggesting that when one decrease the time they spend in non-organizational religious activities, the amount of body surveillance increases. This may mean that the more time a person spends in prayer, meditation, and reading the less a person thinks about how their body looks.

Limitations

There are several limitations to this study. Some limitations are seen in the measures used to collect the data. The measures used to collect this survey were self-report measures, which is limited because it is difficult to independently verify the reports. In all of the measures, results relied on individuals reporting thoughts, feelings, and behaviors were social desirability and biases may have influenced respondents. It is possible that participants were not comfortable

disclosing shame, self-talk, religious attendance, body checking behaviors, etc. Within the survey. Anecdotally, several participants emailed concerns over the word "religion" being used, because it did not align with their values. Others objected to gender roles and/or body image being studied. It was evident from some of these correspondences that people who took the survey became activated by the emotional nature of the questions asked in the various surveys. The data was collected electronically, which assumed that participants had access to the internet and had email or were connect on social media to survey distribution methods (in a Nazarene Facebook group, or connected to someone who is in a group). Future research might seek to include paper surveys that are given to churches in randomized areas.

There was also a limitation with regard to survey structure. All participants were given the same order of surveys (demographics, SC-SF, DUREL, OBC, AWS). Nearly 300 fewer people completed the DUREL as compared to the AWS, which may have skewed results. By randomizing survey order, a greater understanding of the effect of previous surveys may have been understood, as well as more responses might have been gathered.

Another area of limitation is in the sample demographics. As previously mentioned, the sample demographics were possibly affected by the survey collection method. The largest area of difference from the possible norm of the population is that this sample was far more educated than most members of the Church of the Nazarene. This may limit some of the applicability to the average woman in the Church of the Nazarene. Sample demographics differed moderately regarding ethnicity and age. This may be due to percentage of church leaders in varying age and ethnicity categories. Future research might expand on creating a more inclusive collection method to include more voices of Nazarenes who are not white, or in the age 30-49 range.

Implications

Cognitive behavioral therapy is based in the belief that in order to enact change, the thoughts, behaviors, or emotions must be targeted and processed. Previous modalities focused on ways to target and change the thought patterns. Rational Emotive Behavioral Therapy (REBT) developed by Albert Ellis, focused on challenging irrational thoughts and beliefs. Cognitive Therapy developed by Aaron Beck, focuses on monitoring automatic thoughts, recognizing the relationship between cognition, affect, and behavior, testing the thoughts validity, substituting in more realistic thoughts, and finally identifying and altering underlying thoughts, beliefs and assumptions (Dobson & Dozois, 2010). Within the past thirty years, third wave contextual behaviorism has brought with it a philosophical difference in how change can be brought about. Contextual behaviorism takes a stance of stepping back to notice and observe the thoughts, behaviors, and emotions that are occurring. It is in this act of stepping back and observing that room for self-compassion is created. Objectified Body Consciousness recognizes that the relationship with one's body is made up of thoughts, as seen in control beliefs, behaviors, as seen in body surveillance, and emotions, seen in body shame. Self-compassion stance is to step back and acknowledge the hurt, pain, and frustration that come from having a difficult relationship with one's body. Acknowledging the context of objectified body consciousness allows one to have more freedom and flexibility to move away from the fusion of shame, control, and surveillance and move towards their freely chosen values.

Theologically, the act of self-compassion, putting things into context, and moving forward resonates with the principle of prevenient grace. Written into the Articles of Faith in the Church of the Nazarene is that God offers grace, through the sacrifice of Jesus, to all people. Grace is a

freely chosen act that people can move towards and creates a relationship with God. A part of this relationship is the recognition that there is pain, hurt, and trauma in our lives that may keep us from God. The act of accepting grace, is the act of being compassionate with ourselves. Further research may be able to build on targeting the exact theological beliefs that influence both OBC and self-compassion. Moving forward, the Church of the Nazarene should be able to talk about the freely chosen value of self-compassion, and the implications that value has on religious activity and identification, as well as on objectified body consciousness.

Future Directions

The study of how objectified body consciousness affects women within a religious context might be explored further the breadth of including more denominations and in the depth of examining specific theological beliefs. Due to the response of women connected with the Church of the Nazarene, this is a population that is seeking to have a voice in the greater denomination. It may be beneficial to have a needs assessment of the population completed to help determine future directions of research for this population. Due to the varied reactions to this research, it may be helpful for future researchers to determine if there are sub-groups within this population, and if the needs of those groups differ from one another.

Conclusions

Women in the Church of Nazarene have unique stances of their body shame, control beliefs, attitudes towards women, religious identification, and self-compassion. Previous research highlights the connection between self-compassion and body shame as a moderating variable. This study sought to further explore the relationship between self-compassion and

objectified body consciousness, as well as expand on previous research by incorporating religious identification and attitudes towards women.

All three hypotheses were supported by data, highlighting the unique contribution that variables make in understanding body shame, control beliefs, and surveillance. While not all of the variables made a unique contribution to understanding the three parts of OBC, self-compassion was significant in all areas. Interestingly, the only aspect of religious identification that made a unique contribution to OBC, was non-organized religiousness.

Overall, this study lends a voice to the women of the Church of the Nazarene who, given the volume of their responses, may have wanted their experience known. This study adds to a small research bank of the religious implications of body shame, control beliefs, and surveillance. Further research may lend understanding to the theological implications of self-compassion within Wesleyan-Arminian theology.

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Appendix A

Objectified Body Consciousness Scale (OBC)

INSTRUCTIONS:

Circle the number that corresponds to how much you agree with each of the statements on the following pages.

Circle NA only if the statement does not apply to you. Do not circle NA if you don't agree with a statement.

For example, if the statement says "When I am happy, I feel like singing" and you don't feel like singing when you are happy, then you would circle one of the disagree choices. You would only circle NA if you were never happy.

		Strongly Disagree			Neither agree nor disagree			Strongly Agree	Does not apply
1. I rarely think about how I look.	……	1	2	3	4	5	6	7	NA
2. When I can't control my weight, I feel like something must be wrong with me.		1	2	3	4	5	6	7	NA
3. I think it is more important that my clothes are comfortable than whether they look good on me.		1	2	3	4	5	6	7	NA
4. I think a person is pretty much stuck with the looks they are born with.		1	2	3	4	5	6	7	NA
5. I feel ashamed of myself when I haven't made the effort to look my best.		1	2	3	4	5	6	7	NA

	Strongly Disagree			Neither agree nor disagree			Strongly Agree	Does not apply
6. A large part of being in shape is having that kind of body in the first place.	1	2	3	4	5	6	7	NA
7. I think more about how my body feels than how my body looks.	1	2	3	4	5	6	7	NA
8. I feel like I must be a bad person when I don't look as good as I could.	1	2	3	4	5	6	7	NA
9. I rarely compare how I look with how other people look.	1	2	3	4	5	6	7	NA
10. I think a person can look pretty much how they want to if they are willing to work at it.	1	2	3	4	5	6	7	NA
11. I would be ashamed for people to know what I really weigh.	1	2	3	4	5	6	7	NA
12. I really don't think I have much control over how my body looks.	1	2	3	4	5	6	7	NA
13. Even when I can't control my weight, I think I'm an okay person.	1	2	3	4	5	6	7	NA
14. During the day, I think about how I look many times	1	2	3	4	5	6	7	NA
15. I never worry that something is wrong with me when I am not exercising as much as I should.	1	2	3	4	5	6	7	NA

	Strongly Disagree			Neither agree nor disagree			Strongly Agree	Does not apply
16. I often worry about whether the clothes I am wearing make me look good.	1	2	3	4	5	6	7	NA
17. When I'm not exercising enough, I question whether I am a good enough person.	1	2	3	4	5	6	7	NA
18. I rarely worry about how I look to other people	1	2	3	4	5	6	7	NA
19. I think a person's weight is mostly determined by the genes they are born with.	1	2	3	4	5	6	7	NA
20. I am more concerned with what my body can do than how it looks.	1	2	3	4	5	6	7	NA
21. It doesn't matter how hard I try to change my weight, it's probably always going to be about the same.	1	2	3	4	5	6	7	NA
22. When I'm not the size I think I should be, I feel ashamed.	1	2	3	4	5	6	7	NA
23. I can weigh what I'm supposed to when I try hard enough.	1	2	3	4	5	6	7	NA
24. The shape you are in depends mostly on your genes.	1	2	3	4	5	6	7	NA

Appendix B

Self-Compassion Scale-Short Form (SCS-SF)

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost never				**Almost always**
1	**2**	**3**	**4**	**5**

_____1. When I fail at something important to me I become consumed by feelings of inadequacy.

_____2. I try to be understanding and patient towards those aspects of my personality I don't like.

_____3. When something painful happens I try to take a balanced view of the situation.

_____4. When I'm feeling down, I tend to feel like most other people are probably happier than I am.

_____5. I try to see my failings as part of the human condition.

_____6. When I'm going through a very hard time, I give myself the caring and tenderness I need.

_____7. When something upsets me I try to keep my emotions in balance.

_____8. When I fail at something that's important to me, I tend to feel alone in my failure

_____9. When I'm feeling down I tend to obsess and fixate on everything that's wrong.

_____10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.

_____11. I'm disapproving and judgmental about my own flaws and inadequacies.

_____12. I'm intolerant and impatient towards those aspects of my personality I don't like.

Appendix C

Attitudes Towards Women Scale (Spence, Helmrich & Stapp, 1978) – Short version

Instructions: The statements listed below describe attitudes toward the roles of women in society which different people have. There are no right or wrong answers, only opinions. You are asked to express your feeling about each statement by indicating whether you (A) agree strongly, (B) agree mildly, (C) disagree mildly, or (D) disagree strongly.

1. Swearing and obscenity are more repulsive in the speech of a woman than of a man.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

2* Women should take increasing responsibility for leadership in solving the intellectual and social problems of the day.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

3.* Both husband and wife should be allowed the same grounds for divorce.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

4. Telling dirty jokes should be mostly a masculine prerogative.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

5. Intoxication among women is worse than intoxication among men.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

6.* Under modern economic conditions with women being active outside the home, men should share in household tasks such as washing dishes and doing the laundry.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

7.* It is insulting to women to have the "obey" clause remain in the marriage service.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

8.* There should be a strict merit system in job appointment and promotion without regard to sex.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

9.* A woman should be free as a man to propose marriage.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

10. Women should worry less about their rights and more about becoming good wives and mothers.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

11.* Women earning as much as their dates should bear equally the expense when they go out together.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

12.* Women should assume their rightful place in business and all the professions along with men.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

13. A woman should not expect to go to exactly the same places or to have quite the same freedom of action as a man.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

14. Sons in a family should be given more encouragement to go to college than daughters.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

15. It is ridiculous for a woman to run a locomotive and for a man to darn socks.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

16. In general, the father should have greater authority than the mother in the bringing up of children.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

17. Women should be encouraged not to become sexually intimate with anyone before marriage, even their fiancés.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

18.* The husband should not be favored by law over the wife in the disposal of family property or income.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

19. Women should be concerned with their duties of childbearing and house tending rather than with desires for professional or business careers.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

20. The intellectual leadership of a community should be largely in the hands of men.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

21.* Economic and social freedom is worth far more to women than acceptance of the ideal of femininity which has been set up by men.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

22. On the average, women should be regarded as less capable of contributing to economic production than are men.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

23. There are many jobs in which men should be given preference over women in being hired or promoted.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

24.* Women should be given equal opportunity with men for apprenticeship in the various trades.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

25.* The modern girl is entitled to the same freedom from regulation and control that is given to the modern boy.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

In scoring the items, A=0, B=1, C=2, and D=3 except for the items with an asterisk where the scale is reversed. A high score indicates a profeminist, egalitarian attitude while a low score indicates a traditional, conservative attitude.

Appendix D

Duke University Religion Index (DUREL)

1. How often do you attend church or other religions meetings?
    1. More than once a week
    2. Once a week
    3. A few times a month
    4. A few times a year
    5. Once a year or less
    6. Never

2. How often do you spend time in private religious activies such as prayer, meditation, or Bible study?
    1. More than once a week
    2. Once a week
    3. A few times a month
    4. A few times a year
    5. Once a year or less
    6. Never

The following section contains 3 statements about religious belief or experience. Please mark the extent to which each statement is true or not true for you.

3. In my life, I experience the presence of the Divine (i.e. God).
    1. Definitely true of me
    2. Tends to be true
    3. Unsure
    4. Tends *not* to be true
    5. Definitely *not* true

4. My religious beliefs are what really lies behind my whole approach to life.
    1. Definitely true of me
    2. Tends to be true
    3. Unsure
    4. Tends *not* to be true
    5. Definitely *not* true

5. I try hard to carry my religion over into all other dealings in my life.
    1. Definitely true of me
    2. Tends to be true
    3. Unsure
    4. Tends *not* to be true
    5. Definitely *not* true

Appendix E

Curriculum Vitae

Education

George Fox University; Newberg, OR **Anticipated Graduation July, 2019**

Graduate School of Clinical Psychology, 5th year student
Doctoral Candidate of Clinical Psychology
Dissertation:
Self-Compassion of the Body: Exploring the relationship between self-compassion, objectified body consciousness, religious identification, and gender norms.

Defended May 17th, 2018, Full Pass
Masters of Arts in Clinical Psychology **April, 2013**

University of Oklahoma; Norman, OK **May, 2013**

Masters of Arts in Communication Studies

Northwest Nazarene University; Nampa, ID **May, 2011**

Bachelor of Arts in Public Communication
Minors in Political Science and Psychology

Clinical Experience

Psychology Intern, Central Arkansas Veterans Health System 2018-Present
Director of Training: Dr. Courtney Ghormley, PhD

Currently training in a 2040 hour internship focusing on generalist internship in clinical psychology.

Major Rotations (Four Months, 24 hours per week)

- PTSD Clinical Team (August-November): Supervised by Dr. Kevin Reeder, PhD, Dr. Shanti Pepper, PhD, Dr. Laura Gambone, PhD, Dr. Nathaniel Cooney, PhD, and Lee Ann Welsh, LCSW.
    - Received training and supervision in Prolonged Exposure Therapy. Completed two protocols with Veterans diagnosed with PTSD in outpatient and residential settings.
    - Co-facilitated Women's Military Sexual Trauma (MST) Recovery Group.

Responsible for and teaching psychoeducational material and coping skills in a large group setting. Facilitated processing of material and led mindfulness activity at beginning of group.
    - Conducted MST Intakes with male and female veterans seeking consult to the MST Recovery Program. Intakes consisted of brief psychosocial interview and educating veterans on individual and group program options.
    - Co-facilitated Seeking Safety with outpatient Veterans.

- Mental Health Clinic (December-March): Supervised by Dr. Courtney Crutchfield, PhD
    - The focus of this rotation will be to experience training opportunities in Acceptance and Commitment Therapy, Couples Therapy, and other treatments within a diverse population.
    - Group Treatment may include: Mind Over Mood, DBT Skills, Living with Hope, Bipolar Maintenance, and Coping & Stress Management.
    - Creation and implementation of Acceptance and Commitment Therapy Group with fellow and another intern. This will be an 8 week, 90 minute group focusing on using ACT processes to help group members gain skills and move towards values based actions.

- Substance Use Disorders(April-July): Supervised by Dr. Gabrielle Pugliese, PsyD and Dr. Craig Rookey, PhD
    - Training opportunities are subject to change, but may include Seeking Safety; DBT-Skills; Motivational Interviewing and Enhancement; Harm Reduction; Relapse Prevention; psychoeducational groups; and process groups.
    - Additional opportunities may include diagnostic personality assessments and vertical supervision opportunities.

Minor Rotations (Six months, 12 hours per week)

- Integrative Medicine Patient Aligned Care Team (IMPACT) for Pain (August-January): Supervised by Dr. Daniel Broderick, PhD
    - IMPACT Clinic provides a whole health interdisciplinary team for Veteran with Chronic Pain. Services include psychology, yoga, tai chi, acupuncture, primary care, nutrition, and clinical pharmacology.
    - Provided individual therapy for chronic pain, stress management, cognitive behavioral therapy for chronic pain.
    - Co-facilitated groups in Acceptance and Commitment Therapy for Chronic Pain and Creating Your Plan for Health, a 9 week group focusing on psychoeducation and behavior change.
    - Future experiences may include co-facilitating a group in Behavioral Management of Irritable Bowel Syndrome and other individual therapy options.

- Acute Rehabilitation (February-July): Supervised by Dr. Alyssa Kolb, PsyD
    - This rotation provides training in brief, focused, and time limited assessment and

intervention services to assist veterans living with disability, activity limitations, and/or societal participation restrictions.
    - Training opportunities include: interdisciplinary team consultation, assessments, interventions, managing various barriers to participation and recovery.

Pre-Internship Student Therapist, George Fox Health and Counseling Center 2017-2018
Supervised by Dr. Bill Buhrow, PsyD

- Provided therapy and counseling services to undergraduate students at George Fox University using: Solution Focused Therapy, Acceptance and Commitment Therapy, and Dialectical Behavioral skills.
- Created training materials in Acceptance and Commitment Therapy for dialectical trainings.

Practicum 2 Behavioral Health Consultant Trainee, Lancaster Family Health Center 2016-2017
Supervised by Dr. Lola White, PsyD

- Provided brief, short-term interventions within a primary care setting. Interventions used include: Acceptance and Commitment Therapy, Motivational Interviewing, Cognitive Behavioral Therapy.
- Collaborated with Primary Care Providers, Registered Dietitian, and other medical staff to provide holistic medical and psychological care.

Practicum 1 Student Therapist, Rural Child and Adolescent Psychological Services 2015-2016
Supervised by Dr. Elizabeth Hamilton, PhD

- Provided therapy with students at Yamhill-Carlton High School by helping students address emotions, manage difficult family systems, and cope with school stresses.
- Assessed and wrote reports for IEP, 504, and TAG recommendations. Assessments used: Woodcock Johnson 4th Edition Achievement and Cognitive, and the Behavior Assessment System for Children 2nd Edition.

Pre-Practicum Therapist, George Fox University Spring 2015
Supervised by Dr. Glena Andrews, PhD

- Conducted person-centered therapy with two clients for ten sessions each. Skills used are: clinical interviewing, unconditional positive regard, building rapport, empathy, non-directive therapy.

Assessment Competencies

16 PF	MMPI-RF	WISC-V	WMS-IV	TOMM
FACES-IV	PAI	WJ-IV Ach	CVLT-II	RBANS
MCMI-III	WAIS-IV	WJ-IV Cog	BCT	CTONI-II
MMPI-II	WIAT-III	BASC-2	WCT	DKEFS
Grooved	Boston	Rey Complex	Booklet	NEPSY-Speeded
Pegboard	Naming	Figure	Categories	Naming

Supervision Experience

Graduate Coordinator, Rural Child and Adolescent Psychological Services 2017-2018

- Provides weekly on-site supervision at elementary, intermediate, and high school settings.
- Investigated and facilitated organizational changes by implementing a new electronic health record and document organizational system.
- Provide support and collaboration with Clinical Supervisor, Dr. Elizabeth Hamilton, PhD

Fourth Year Mentor, GSCP Clinical Team 2017-2018

- Meet weekly with second year student to provide supervision.
- Oversee clinical work, provide mentorship, guide professional development.
- Supervised by Dr. Winston Seegobin, PhD

Research Experience

Consultation Project: Does Gender play a role in Behavioral Health referrals at Primary Care Clinics?

- Research conducted in collaboration with Oregon Health and Science University.
- Significant differences found in gender of referring physician: Male providers referred older patients.

Research Team Member; Dr. Marie-Christine Goodworth, George Fox University 2015-Present

- Collaborate on dissertation and supplemental research as a team.
- Provide feedback to other members on research and writing.

Teaching Experience

Teaching Assistant; Clinical Foundations, Glena Andrews, PhD Fall 2017 & Spring 2018

- Mentoring and supervising four, first year graduate students. Involving teaching person-

centered skills, providing support and process theory during
- Grading and providing feedback to course assignments and filmed simulated therapy.
- Collaborating with professor for ideas and directions of class discussions

Teaching Assistant; Integrative Approaches to Psychotherapy, Roger Bufford, PhD Spring, 2017

- Grade and provide feedback for class assignments.
- Meet with students to facilitate deeper understanding of integration into psychological and personal worldviews.
- Create and Organize rubrics on CLAS (electronic competency system).

Teaching Assistant; Psychopathology, Elizabeth Hamilton, PhD Fall, 2016

- Create and edit weekly PowerPoint presentations for in class lectures.
- Organize, format, and publish online course related information such as: assignments, PowerPoints, and other supplementary information.
- Hold office two office hours a week to answer questions, give feedback, and assist students.
- Grade and give feedback for class assignments.
- Create and Organize rubrics on CLAS (electronic competency system).

Student Editor; Graduate Department of Clinical Psychology, Glena Andrews, PhD 2014-2018

- Editing peer submissions for grammar, sentence structure, and APA formatting.
- Organizing and managing student paper submissions, facilitating communication between other student editors.
- Edit and provide feedback on assessment reports for the Rural Child & Adolescent Psychological Services.

Adjunct Faculty; Department of Mass Communication; 2013-2014

University of Central Oklahoma : Fundamentals of Public Speaking

- Responsible for lecturing, grading, and testing course information

Adjunct Faculty; Department of Speech Communication; 2013-2014
Southern Nazarene University: Introduction to Speech Communication

- Responsible for lecturing, grading, and testing course information

Teaching Assistant; Department of Communication; University of Oklahoma 2011-2013

- Primary Instructor: Responsible for lecturing, grading, and testing course information.
    - Principles of Communication
    - Public Speaking
- Assisting: Responsible for creating and grading course examinations.
    - Non-Western Communication Perspectives

Publications

Cresswell, J., Askren, A., Barker, M., Hawn, A., & Wenner, B. (2011). Book Review: "Handbook of Cultural Psychology". Edited by S. Kitayama & D. Cohen. *British Journal of Psychology*, *102*(3), 684-686.

Conference Poster Presentations

Marston, A., Johnson, A, Wenger, A., David, A., Goodworth, M, (2018, August) *Body shame differences between clergy and non-clergy women in the Church of the Nazarene*. Poster session presented at the 2018 American Psychological Association Conference. San Francisco, California.

Manns, A., Dunbar, K., Marston. A, & Gathercoal, K. (2017, May) *Cultivating mindful eating: An intervention for college aged students*. Poster session presented at the 2017 Oregon Psychological Association Conference. Eugene, Oregon.

Hoelscher, C., & Askren, A. (2012, February*). Uncommon Americans: Examining identity negotiation in study abroad experiences*. Paper Presented at the 2012 Sooner Communication Conference. Norman, Oklahoma.

Askren, A., Barker, M., Cresswell, J., & Sullivan, K. (2011, May). *Drawing on acculturation psychology and anthropology to identify cultural brokers*. Poster session presented at the 2011 Western Psychological Association Conference. Los Angeles, California.

Hawn, A., & Askren, A. (2011, May). *A genre based comparative content analysis of American video games*. Poster session presented at the 2011 Western Psychological Association Conference. Los Angeles, California.

Skill Development & Professional Workshops

Intern Development Seminar, CAVHS, 2018-Present.

- Weekly presentations by staff, fellows, and interns.

Acceptance and Commitment Therapy Bootcamp; February 2017, San Diego, CA

- Intensive 4-day experiential and skill building training event led by Steven Hayes & colleagues.
- Topics Included: Orientation to core theoretical foundations of ACT, skill development and clinical utility of ACT, and application and development of ACT clinical skills.

George Fox Behavioral Health Bootcamp; August 2016, Newberg, OR

- Attended 5 day training to prepare professionals and students to work in

Integrated Care Behavioral Health.
- Topics included: Common Diagnoses, Diversity, Motivational Interviewing, and Evidence Based Interventions for Integrated Care.

Vogel, M. (2018, Feb). *Integration and Ecclesia*. Presentation presented at George Fox University, Graduate Department of Clinical Psychology Spring Diversity Grand Rounds, Newberg, OR.

Taloyo, C. (2018, Feb). H*istory and Application of Interpersonal Psychotherapy*. Presentation presented at George Fox University, Graduate Department of Clinical Psychology Spring Colloquium, Newberg, OR.

Sordal, J. (2017, Nov). *Telehealth*. Presentation presented at George Fox University, Graduate Department of Clinical Psychology Fall Colloquium, Newberg, OR.

Gil-Kasiwabara, E. (2017, Oct). *Using community based participatory research to promote mental health in American Indian/Alaska Native children, youth and families.* Presentation presented at George Fox University, Graduate Department of Clinical Psychology Fall Grand Rounds, Newberg, OR.

Seegobin, W., Peterson, M., McMinn, M. & Andrews, G. (2017, March) *Difficult Dialogues*. Presentation presented at George Fox University, Graduate Department of Clinical Psychology Spring Diversity Grand Rounds, Newberg, OR.

Warford, P. & Baltzell, T. (2017, March) *Domestic violence: A coordinated community response*. Presentation presented at George Fox University, Graduate Department of Clinical Psychology Spring Colloquium, Newberg, OR.

Brown, S (2017, Feb.). *Native self-actualization: It's assessment and application in therapy.* Presentation presented at George Fox University, Graduate Department of Clinical Psychology Spring Grand Rounds, Newberg, OR.

Bourg, W. (2016, Nov.). *When divorce hits the family: Helping parents and children navigate*. Presentation presented at George Fox University, Graduate Department of Clinical Psychology Fall Grand Rounds, Newberg, OR.

Kuhnhausen, B. (2016, Oct). *Sacredness, naming, and healing: Lanterns along the way*. Presentation presented at George Fox University, Graduate Department of Clinical Psychology Fall Colloquium, Newberg, OR.

Jenkins, S. (2016, Mar.). *Managing with diverse clients*. Presentation presented at George Fox

University, Graduate Department of Clinical Psychology Spring Colloquium, Newberg, OR.
Hall, T. & Janzen, D. (2016, Feb.). *Neuropsychology: What do we know 15 years after the decade of the brain? & Okay, enough small talk. Let's get down to business!*. Presentation presented at George Fox University, Graduate Department of Clinical Psychology Spring Grand Rounds, Newberg, OR.

Mauldin, J., (2015, Oct.). *Let's Talk about Sex: sex and sexuality with clinical applications*. Presentation presented at George Fox University, Graduate Department of Clinical Psychology Fall Grand Rounds, Newberg, OR.

Hoffman, M., (2015, Sep.). *Relational Psychoanalysis and Christian Faith: A Heuristic dialogue.*
Presentation presented at George Fox University, Graduate Department of Clinical Psychology Fall Colloquium, Newberg, OR.

McRay, B., (2015, Mar.). *Spiritual Formation and Psychotherapy.* Presentation presented at George Fox University, Graduate Department of Clinical Psychology Spring Colloquium, Newberg, OR.

Sammons, M., (2015, Feb.). *Credentialing, Banking, the Internship Crisis, and other Challenges for Graduate Students in Psychology.* Presentation presented at George Fox University, Graduate Department of Clinical Psychology Spring Grand Rounds, Newberg OR.

Dodgen-Magee, D. (2014, Nov.) *"Facetime" in an Age of Technological Attachment*. Presentation presented at George Fox University, Graduate Department of Clinical Psychology Spring Colloquium, Newberg, OR.

Doty, E.,& Becker, T. (2014, Oct.) *Understanding and treating ADHD and Learning Disabilities in the DSM 5.* Presentation presented at George Fox University, Graduate Department of Clinical Psychology Fall Grand Rounds, Newberg, OR.

Affiliations and Memberships

2017 Association of Contextual Behavioral Science, Student Member
2014 American Psychological Association, Student Affiliate
2011 Psi Chi, *International Honor Society in Psychology*, Northwest Nazarene University
Lamda Pi Eta, *National Communication Honor Society*, Northwest Nazarene University

Extracurricular Involvement

George Fox University
Gender, Sexuality, and Identity Student Interest Group
- Co-Leader and Facilitator

University of Oklahoma
Graduate Student Senate
- 2012-2013: Secretary to the Public Relations Committee, Graduate Student Senate
- 2012- 2013: Graduate Student Senator

Sooner Communication Conference
- 2011-2012: Communication Director, Sooner Conference Planning Committee

Search Committee for Intercultural Communication Position
- 2011-2012: Graduate Student Representative to Faculty Search Committee