

St. Catherine University

SOPHIA

Master of Social Work Clinical Research Papers

School of Social Work

5-2016

Women, Shame, and Mental Health: A Systematic Review of Approaches in Psychotherapy

Vienna Miller-Prieve
St. Catherine University

Follow this and additional works at: https://sophia.stkate.edu/msw_papers



Part of the [Social Work Commons](#)

Recommended Citation

Miller-Prieve, Vienna. (2016). Women, Shame, and Mental Health: A Systematic Review of Approaches in Psychotherapy. Retrieved from Sophia, the St. Catherine University repository website:
https://sophia.stkate.edu/msw_papers/630

This Clinical research paper is brought to you for free and open access by the School of Social Work at SOPHIA. It has been accepted for inclusion in Master of Social Work Clinical Research Papers by an authorized administrator of SOPHIA. For more information, please contact amshaw@stkate.edu.

Running head: WOMEN, SHAME, AND MENTAL HEALTH

Women, Shame, and Mental Health:
A Systematic Review of Approaches in Psychotherapy

by

Vienna N. Miller-Prieve, B.A.S.

MSW Clinical Research Paper

Presented to the Faculty of the

School of Social Work

St. Catherine University and the University of St. Thomas

St. Paul, Minnesota

In Partial Fulfillment of the Requirements for the Degree of

Master of Social Work

Committee Members

Robin R. Whitebird, Ph.D., (Chair)

Carol Burling, D-Min

Helen Raleigh, LICSW Emeritus

The clinical research project is a graduation requirement for MSW students at SCU/UST School of Social Work in St. Paul, MN and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university IRB, implement the project and publicly present the findings of the study. This project is neither a Master thesis nor a dissertation.

Abstract

Shame is a self-conscious emotion that affects self-esteem, self-concept and evaluation of the self. Shame is seen more often in women than men; in part due to societal and cultural standards placed upon women that create negative self-evaluations in women when those standards are not met. Shame is seen in mental health diagnoses such as depression, anxiety, substance use disorders and eating disorders. When a woman presents for therapy or counseling, shame may be apparent and necessary to work on during therapy. This systematic review was designed to answer the research question: what therapeutic approaches are used in psychotherapy targeting shame in women with a mental health diagnosis? The review was set up using peer-reviewed articles published between 2000 and 2016. Using the database of PsycINFO, 11 peer-reviewed articles met the search criteria and were read and analyzed, which resulted in four themes being identified. These themes include: 1) the format of treatment, 2) increasing compassion, 3) mindfulness, and 4) acceptance. The research suggests using compassion focused therapies, mindfulness and acceptance skills to target shame in women with mental health diagnoses. Shame research is relatively new and more research is needed to replicate studies to ensure accuracy and validity of the results. Further research is also needed to understand the therapists' feelings about addressing shame in psychotherapy.

Table of Contents

Introduction	5
Literature review	6
Methods	14
Research Synthesis	19
Discussion	27
Limitations	29
Future research	31
References	32
Appendix A	39

Women, Shame, and Mental Health: A Systematic Review of Approaches in Psychotherapy

Shame is a common self-conscious emotion that many women and men experience but may not recognize immediately as shame. Shame has been described as an intense emotion accompanied by a negative evaluation of the self (Benetti-McQuid & Bursik, 2005). These negative evaluations of the self are in response to violating a societal or group norm. When an individual does not meet certain expectations set by oneself or societal norms, it can elicit feelings of shame. When a person feels shame, they experience feelings of inadequacy, worthlessness and a sense of being alone in their experiences (Hahn, 2009). Shame is central to conscience and identity and it lowers self-functioning. It can be a source of low self-esteem, poor body image and diminished self-confidence. It can also play a significant role in damaging an individual's sense of self (Kaufman, 1989).

Both men and women experience shame; however, women process the shameful experiences differently than men and identify the circumstances that cause shame differently than men. Women's experiences of shame relate to who they should be, how they should be and what they should be (Brown, 2008). Clients may intentionally seek psychotherapy and support regarding an issue laden with shame, such as sexual abuse or physical abuse. Clients may hesitate to reveal the impact of shame within psychotherapy due to wanting to disguise shame (Hahn, 2009). Being cognizant of the impact of shame on clients is necessary and important for clinical social workers. When shame is intertwined and co-occurring with what brings an individual into therapy, it is especially necessary to be aware of not to shame the individual about being in therapy. The stigma of seeking assistance for a mental health issue can result in a client having shameful feelings about needing support. Being mindful of the possible shameful

experience of being in therapy is necessary for clinical social workers to understand when providing therapy to clients.

The purpose of this systematic review is to examine the literature regarding women and therapeutic approaches to target shame within the context of mental health diagnoses.

Literature review

In the Oxford Online Dictionary (n.d.), shame is defined as “a painful feeling of humiliation or distress caused by the consciousness of wrong or foolish behavior.” Shame is a common human feeling and emotion, but it is not well understood or even mentioned once it has occurred (Brown, 2008; Kaufman, 1989; Hahn, 2009). Individuals understand that the feeling of shame is unwanted and they do everything to avoid or move away from the feeling of shame (Lewis, 2003). Shame has also been described as a sense of unworthiness to be in connection and an awareness of wanting to connect with another (Jordan, 1997). Being alone and not being able to disclose shame is a large factor in why individuals feel shame as such a difficult emotion.

Sigmund Freud viewed shame as painful affect intertwined with condemning thoughts, a sense of impending harm, and feelings of being exposed (Hahn, 2009). Freud recognized the negative affect, ruminative cognitions and an unbalanced sense of internal and external judgment relevant to shame. He regarded shame as a reaction formation against displaying certain desires (Tangney & Dearing, 2004; Hahn, 2009). From this, shame has moved forward to include the differences between the ego and superego in the psychoanalytic perspective and to an anthropological perspective that describes how certain situations may lead to shame (Tangney & Dearing, 2004).

Shame has been noted to typically develop early due to ineffectiveness from a caregiver to provide adequate love and attention (Morrison, 2011). Building mutual interest between

caregivers and children demonstrates the value of the relationship (Morrison, 2011; Kaufman, 1989). Shame can also occur during adulthood when considered through the adult attachment viewpoint (DeYoung, 2015).

Shame has also been noted as an emotional response to feeling like one's relational and emotional connections are being threatened (DeYoung, 2015). It begins with a relationship that an individual feels vulnerable to rejection. If the individual fails to meet the standards set by the other within the relationship, one feels rejected and shame is elicited from the rejection (DeYoung, 2015). The desire to shrink away from shame is an important feature of experiencing shame. This is followed by the intense discomfort and anger that individuals describe about their experiences of shame. From this, one feels inadequate and unworthy due to their experience of shame (Lewis, 2003).

The self-conscious emotions: Shame, guilt, humiliation and embarrassment

The self-conscious emotions include shame, guilt, humiliation and embarrassment. These emotions are related and often intertwined or confused when describing an event or experience. Shame is elicited in response to social rejection and other events that threaten an individual's self esteem, social status and sense of belonging. When a transgression or event is attributed to the global self, people experience shame and judge the self as violating group norms (Wong & Tsai, 2007; Eftheim, Kenny & Mahlik, 2001). Individuals have described shame as feeling worthless, powerless, and small.

Guilt. Guilt on the other hand, has been described as feeling a tension, remorse and anger (Tangney & Dearing, 2004). When the transgression or event is attributed to something outside of the global self, people experience guilt and it involves a responsibility for doing something wrong (Wong & Tsai, 2007; Eftheim et al., 2001).

In a study of 65 undergraduate students, Tangney and Dearing (2002) asked students to anonymously describe personal experiences with shame, guilt, pride, and depression. After the description, students were asked to rate each experience using a seven-point scale across 22 dimensions. From this, Tangney and Dearing (2002) found that the students' ratings of shame experiences were more painful and more difficult to describe than their experiences of guilt.

Humiliation. Humiliation involves an event between two people. Typically, it is an event that is done to another person. Humiliation is associated, similarly to shame, with negative judgements by others and the desire to hide from the humiliation (Gilbert, 1998). There is no acceptance that the negative judgment is correct and a negative self-evaluation is not done to justify the negative evaluation from others. . Following being humiliated, individuals give attention to solving the problem, which may involve avoidance or revenge (Tantam, 1998). Being humiliated may be confused with shame due to the negative evaluation from others, but is not as intense or harmful as shame can be.

Embarrassment. Embarrassment is at times confused with shame as well. It is related to being socially inappropriate or behaving differently in social contexts that do not meet societal views of behavior (Kaufman, 1989). Embarrassment lasts only a short time and often times occurs quickly. Embarrassment can be small or large but can be replayed inside the mind of an individual when it is harmful enough to inhibit one's functioning in social situations.

Women and Shame

Both men and women experience shame, although it has been postulated throughout the literature that women experience shame differently due to cultural, societal and relational norms that are expected of women (Brown, 2008; Jordan, 1997; Gross, & Hansen, 2000). Women may have more intense feelings of shame from the negative evaluations of self (Sanftner & Tantilillo,

2011). Men and women process shameful feelings and experiences differently. Men tend to feel guilt more often than shame due to the dimensions of perfectionism that is prescribed to men (Lutwak & Ferrari, 1996). Women describe shame deriving from the socially prescribed perfectionistic standards placed upon them that creates a negative self-evaluation (Lutwak & Ferrari, 1996; Jordan, 1997).

Judith Jordan (1997) postulates that there are three major reasons women feel more shame than men; one, patriarchy is actively involved in shaming of women and silencing their reality; two, women are more open about their wish for connection and are especially vulnerable to a broken connection, such as a broken relationship; and three, women more frequently have a feeling of letting other people down within their interpersonal relationships. From this, women can tend to have a broad sense of “being” wrong; not fitting in with the prescribed reality, not having appropriate or good relationships and failing in those relationships when one is let down by another. Shame then leads to a feeling of disempowerment within a woman’s life and may develop into a loss of respect and inability to bring forth any needs or wants within their lives (Jordan, 1997).

Brene Brown (2008) found twelve categories in which women struggle the most with feelings of shame. These include: appearance and body image, motherhood, family, parenting, money and work, mental and physical health, sex, aging, religion, being stereotyped and labeled, speaking out and surviving trauma (pp.73). These sources of shame include unwanted identities that go along with each area. Women recognize being vulnerable in an area and that it encompasses feelings of confusion, fear and judgment within it when attempting to talk openly about their feelings of shame (Brown, 2008). From this, women use the fight, flight or freeze

mechanism to protect them from greater harm. One of these responses can bring with it the feeling of shame for shutting down or shutting out following the shameful event or experience.

The ascribed gender roles may have an influence on being more prone to guilt or shame and may develop over time as a habitual response to certain stimuli (Benetti-McQuid & Bursik, 2005). The experience of shame may reflect a perceived violation of stereotypical gender role norms. In study of 104 undergraduate students, Benetti-McQuid and Bursik (2005) sought out to measure if experiences and reactions to guilt and shame are a function of gender views of the self. The undergraduate students completed the Bem Sex Role Inventory, a guilt subscale from the Guilt Inventory, The Test for Self Conscious Affect (TOSCA) and the Guilt and Shame Vignettes to assess reactions and experiences of guilt and shame. Benetti-McQuid and Bursik (2005) found that women reported a higher tendency for guilt and shame feelings than men. This study supports other research findings of the gendered differences in shame and guilt experiences.

Efthim, Kenny and Mahalik (2001) completed a study of 207 college students to look at gender role stress and the relation that stress has to shame, guilt and externalization. This study was completed with both men and women. Efthim, Kenny and Mahalik (2001) found that for women, shame proneness was the dominant response related to living up to female gender role norms. These studies suggest that stereotypical gender roles for women led to shame proneness and thus signify a possible inaccurate coping strategy in response to shameful events.

Shame and mental health

Shame has been linked to several mental health diagnoses such as, depression, anxiety, eating disorders, post-traumatic stress disorder and substance use disorders (Brown, 2006; Gutierrez, & Hagedorn, 2013). It is important to understand the role shame plays in an

individual's mental health as well as how shame may exacerbate certain mental health symptoms. When shame is associated with a mental health diagnosis it is most likely maladaptive shame. This means that the shame a person is feeling is impacting their wellbeing and functioning (Scheel et al., 2014). Shame can underlie the presenting issue for why a client is seeking psychotherapy or support. Clients may not discuss or bring up shame, but it can become apparent in how they talk about themselves or others around them.

Anxiety and Depression. Anxious and depressive cognitions are related to shame. It includes a negative self-evaluation and thought process that involves high self-criticism. Due to the difficulties individual's with anxiety and depression face regarding their cognitions means there is a higher chance of an individual feeling shame. In depression there is a decrease in self-esteem, which in turn leads to feeling shame towards oneself (Scheel et al., 2014). Anxious individuals experience increased self-criticism in situations and feel high shame when they do or say something wrong. Individuals then ruminate on the situation and experience feelings of shame increase when thinking of the situation again.

Eating disorders. Shame is central to women and men's feelings about their bodies. Women, typically compare themselves to extreme standards of body images. These images portray women as being ideal when underweight, which sets unrealistic expectations for women. When women compare their bodies to the images set forth by society and the media, shame arises for not meeting the expectations. From this, individuals may gravitate towards restricting their eating or begin dieting to try to meet the expectations (Sanftner & Tantillo, 2011). For individuals' with eating disorders, shameful feelings are evolving throughout their treatment and recovery. The fluctuations are associated to regulation of negative emotional experiences. High self-criticism and self-directed hostility are noted in the eating disordered population. Women

with eating disorders may continually shame themselves through their negative self-evaluations with desiring to be thinner (Gross & Allan, 2010). Individuals' with eating disorders present with difficulties related to shame due to their mental health diagnosis being directly tied to feelings of shame about their bodies.

Post-traumatic stress disorder. Shame and guilt has been noted in post-traumatic stress disorder (PTSD) due to an event occurring that an individual could not help with and could not fix. Having thoughts of being weak and at fault is typically how shame is portrayed in individual with PTSD (Gutierrez & Hagedorn, 2013). This causes an internal struggle of guilt and shame. While guilt and shame are different from one another, both shame and guilt are intertwined in PTSD and have an impact on symptoms.

Substance use disorders. The stigma of substance use disorders and an inability to seek treatment often is experienced as shame in individuals' with substance use disorders. This is also true while continuing treatment and involving possible relapse. Shame impacts help-seeking behaviors initially because individuals do not want to be labeled due to their substance use (Gray, 2010). By not seeking out help an individual avoids possible feelings of shame but also possibly being blamed by others for their condition. Individuals' also feel inadequate and bad about themselves due to their substance use. This can also be reinforced through judgment from others for substance abuse.

Shame and psychotherapy

Psychotherapy is defined as "a practice whereby communication between a professionally trained therapist and a help seeking client is aimed towards the relief of the client's psychological or emotional problem" by Anderson, McClintock, & Song (2014). Shame in psychotherapy has been noted in regards to mental health diagnoses, such as eating disorders,

depression, anxiety, post-traumatic stress disorder (PTSD) and substance used disorders (Brown, 2008; Kaufman, 1989; Gutierrez & Hagedorn, 2013).

Shame in psychotherapy has been noted in the above mental health diagnoses but is underlying and secondary in treatment due the initial client reported problem. Addressing only the mental health aspect does not allow for information regarding shame that may underlie the mental health diagnosis (Gutierrez & Hagedorn, 2013). Certain therapeutic approaches have been recognized as possibly useful when working with shame underling a mental health diagnosis.

When the painful emotion of shame is present in mental health concerns, it may make treatment difficult or exacerbate symptoms (Gutierrez & Hagedorn, 2013). For victims of abuse, for example, shame can be seen as an attack on the self or a desire to hide. From this, individuals trying to no longer feel the pain of shame may become more aggressive, self-harm or display symptoms of severe depression (Gutierrez & Hagedorn, 2013). Due to this impact, mental health clinicians need to be aware of the implications shame has on clients as well as within treatment to appropriately address both the mental health diagnosis and shame.

Therapy itself can be a shameful experience due to the stigma associated with mental health issues in society. Individuals who seek out therapy may view themselves as deficient and in need of repair (Tangney & Dearing, 2004). Individuals assume that by entering therapy, the people around them will see them as weak, flawed, and unable to handle the stressors of every day life. The very nature of therapy addresses shame and shameful experiences due to discussing issues that make people feel the most uncomfortable. These are often issues that client's may feel unable to speak with anyone else about.

Shame is a harmful, debilitating emotion that negates an individual's view of self. A negative self-evaluation that includes the global self is felt as shame. Guilt is different from shame in that it is a feeling in relation to "doing something wrong." Women are more shame prone than men due to social and cultural norms. Shame is important to be cognizant of within therapy due to the highly relational nature of wanting to rebuild connection following a shameful event or experience. Therapists, including clinical social workers working with women in any type of setting will have clients who present with themes of shame, with varying sources of the shame. Possessing knowledge of approaches to use with a client who presents with shame allows clinicians to be more prepared when this occurs.

The purpose of this study is to examine the literature regarding therapeutic approaches to target shame with women who have a mental health diagnosis. Co-occurring disorders often make diagnosis and treatment difficult when shame is intermingled with a mental health issue. Clinical social workers in multiple settings routinely interact with women who have shame underlying their mental health diagnosis. Bringing forth an understanding of therapeutic approaches that target shame within the context of the mental health diagnosis allows for best practices for clinicians to provide more accurate and appropriate services to clients.

Conceptual Framework

The focus of this systematic literature review is to identify therapeutic approaches that target shame in women and have a mental health diagnosis. The goal is to provide social workers with possible therapeutic approaches to use within clinical practice when women in therapy bring up shame. Identifying research theories that support the information being gathered allows for perspective on the information gathered. It also provides a frame for the type of information gathered and how it does or does not apply within the limits of the research being conducted.

The main theory that guided this review was relational-cultural theory (RCT). RCT suggests that individuals grow through and towards relationships throughout the lifespan (Jordan, 2014). Humans have a need for connection and the development of healthy relationships that contain mutual empathy, trust and responsiveness. RCT was originally created to better understand and represent women's experiences and now recognizes that all people grow towards connection throughout their lifespan. RCT has also contributed to the practice of relational and contextually sensitive therapy. Bringing into a practice an understanding of the relationships one does or does not have is necessary to build better relationships (Jordan, 2014). From a research standpoint, RCT can help to understand why the therapeutic relationship and alliance are important when working with women, especially if they are disclosing instances of shame. This study will specifically determine therapeutic approaches clinical social workers can use when working with women about shame.

The other theory that guided this review is object relations theory. Object relations theory's main premise is that humans are social beings that depend upon and relate to other humans. When an individual begins to relate to another individual, there is an unconscious process of internal cognitions that create multiple representations of the self and others that form the inner world view (Stadter, 2011). Each individual has an inner view of himself or herself that is composed of several pairings of the individual self and other connected through thoughts and feelings. These pairings can affect present functioning of the individual through unconscious actions, having similar relationships from past experiences and projecting unconscious ideas onto another within the relationship (Stadter, 2011). Object relations theory is also important to recognize in a therapeutic relationship with an individual who has feelings of shame because it allows for exploration of past experiences of shame.

Methods

Research Purpose

The purpose of this systematic review was to explore the question: what therapeutic approaches are being used in psychotherapy targeting shame in women within the context of a mental health diagnosis?

This study was conducted using systematic literature review. Systematic literature reviews are a method of making sense of large bodies of information and synthesizing the information gathered relevant to answer a particular question (Petticrew & Roberts, 2006). This method will allow for a collection of articles to analysis with data regarding women, shame and approaches to working with women and shame in a therapeutic context. The focus on women was chosen due to the higher number of women who experience shame than men.

For the purpose of this study, shame will be the focus of the intervention and other self-conscious emotions, including guilt, humiliation, and embarrassment, will not be the focus of this study. While it may be researched in the studies used for this systematic review, these findings will not be reported in the present study.

Types of Studies

To answer the question of what therapeutic approaches are being used in psychotherapy targeting shame in women with a mental health diagnosis, only empirically based, qualitative and quantitative studies were considered. Single case studies, focus groups and in-depth interviews were taken into consideration. The focus of this study was on therapeutic approaches with participants. Experiences of practitioners were not included

Search Strategy

In a preliminary search of academic journals and online search sites including SocINDEX, Google Scholar, and PsycINFO, no systematic literature reviews were found addressing therapeutic approaches used with women targeting shame. Due to the possibility of high numbers of irrelevant article, a search for both sensitivity and specificity was conducted. A search for sensitivity permits researchers to examine a broad range of the research topic. A search for specificity allots researchers to narrow the focus of the research to create a search with a high percentage of relevant articles.

Review Protocol

Peer-reviewed, full-text articles were considered in this review. Since shame is a relatively new topic of research, articles published in the last 10 years are included in this review. Articles were found using the search engine PsycINFO. Articles were searched and collected during January 2016.

Inclusion Criteria. In the database of PsycINFO, searches were carried out using the following combination of search terms; “shame” or “women” AND “shame” “women” or “psychotherapy” or “therapy.” All articles that came up in this database using these search terms were published after 2000. In PsycINFO, 14 peer-reviewed articles met the specific search criteria. A search was also performed using the database SocINDEX using the same research terms but it produced no new articles that met the specific search criteria. Of these 14 articles, three articles met the initial inclusion criteria but after thorough review, they did not meet the specific criteria for inclusion in this systematic review.

Exclusion Criteria. Of the 250 peer-reviewed articles that met the initial search criteria, only 11 met the criteria to be included in this literature review. Articles that were excluded from

the research review include: studies that focused on mental health symptoms versus shame and mental health symptoms; and articles that focused on shame but provided no therapeutic approaches utilized to address shame. Selected articles were also limited to those written in English.

Inclusion and exclusion decisions were made based on the title and abstract of the articles. The final review consisted of 11 peer-reviewed articles. See table 1 for a complete list of included articles. A more detailed list of included articles with content summary can be found in Appendix A

Table 1: Included Articles

Author (year)	Therapy	Format of treatment	Country	Sample	Diagnoses
Balcom, Call, & Pearlman, (2000)	EMDR	Individual	United States	10 female 3 male	Did not collect information
Boersma et al., (2015)	CFT	Individual	Sweden	5 female 1 male	Social anxiety disorder
Gilbert & Procter (2006)	CFT	Group	United Kingdom	5 female 4 male	Personality diagnoses and mood disorders
Ginzburg et al., (2009)	TFGT/PFTGT	Group	United States	166 female	PTSD
Goldsmith et al., (2014)	MBSR	Group	United States	11 female 3 male	PTSD
Hedman et al., (2013)	CBT	Individual or group (randomly)	Sweden	43 female 24 male	Social anxiety disorder and depression
Hernandez & Mendoza (2011)	SRT	Group	United States	19 female	Substance use disorders
Judge et al., (2012)	CFT	Group	United Kingdom	28 female 14 male	Depression, anxiety, social anxiety, bipolar, OCD and personality diagnoses

Kelly, Carter, & Borairi (2014)	CFT	Group	Canada	97 female	Eating disorders
Luoma et al., (2012)	ACT	Group	United States	61 female 72 male	Substance use disorders
Van Vliet, (2008)	None (qualitative)	None	Canada	9 female 4 male	Did not collect information

Research Synthesis

The purpose of this systematic literature review was to explore the question: what are the therapeutic approaches used in psychotherapy with women that target shame in the context of their mental health diagnosis? Using the databases of PsychINFO and EBSCO, and using the inclusion and exclusion criteria described above, 11 peer-reviewed articles met criteria and were reviewed. Of the articles used in this review, 3 articles had only women participants and 7 had both men and women participants. One article did not collect demographic information including gender. Of the 11 articles included in this study, four (36%) used compassion-focused therapy to address shame. Two of the articles included (18%) used mindfulness based therapy to address shame in participants. The remaining four (36%) articles included in this study used a variety of therapeutic techniques to address shame. These interventions include trauma-focused group therapy and present focused group therapy, shame resilience (such as *Connections* psychoeducational curriculum), cognitive behavioral therapy and eye movement desensitization and reprocessing therapy. The final article included in this study was a qualitative research study that considering the ways adults recover from shameful experiences with implications for psychotherapy (Van Vliet, 2008).

The articles included in this systematic review considered a variety of diagnoses in relation to shame. The diagnoses studied include: depression, anxiety, social anxiety disorder,

substance use disorders, post-traumatic stress disorder and eating disorders. The majority of the research included in this review used quantitative methods to collect data on participants involved in the research. Eight articles, or 72% of the research, included only quantitative data, two studies used a combination of qualitative and quantitative measures to collect data, and one utilized qualitative approaches to collect data. One single case experimental study was included in this review as well.

All articles considered in this systematic review focused on therapeutic approaches targeting shame in participants with a mental health diagnosis. This review considered several different interventions with focus on shame due to the relational nature of shame. The majority of articles for this review, included compassion focused, present focused and acceptance based interventions to target shame in participants.

Thematic analysis

After thorough analysis of the literature, four themes emerged from this systematic review of approaches used in psychotherapy targeting shame in women with a co-occurring mental health diagnosis. These themes include: 1) the format of treatment; 2) increasing compassion; 3) mindfulness; and 4) acceptance.

The format of treatment. Shame research has identified that providing treatment in a group format increases an individual's feelings of connection and acceptance from other group participants. This in turn decreases shame and creates space for acceptance in individuals (Gilbert & Proctor, 2006; Judge, Cleghorn, McEwan, & Gilbert, 2012). Seven articles included in this review used group interventions to address shame. Compassion-focused therapy and compassionate mind training (CMT) utilize group participants to share common fears and experiences, support one another and develop compassion towards others to decrease shame

(Gilbert & Proctor, 2006; Judge et al., 2012; Kelly, Carter, & Borairi, 2014). This can have a powerful effect for participants because it creates a sense of shared meaning for group participants.

Group psychotherapy is similar when considering shame with people who have substance use disorders. In targeting shame in substance use disorders, Luoma, Kohlenberg, Hayes, and Fletcher (2012) utilized an acceptance and commitment therapy (ACT) group to offer connection to participants with similar experiences, opportunities to speak in a group about core values and receive support and provide accountability from others in how to use values to live life. Likewise, in using the psychoeducational intervention, *Connections*, based on shame resilience theory, Hernandez and Mendoza (2011) provided space for participants to feel supported, heard and to build connections with others facing similar challenges or thoughts. Providing the building blocks to create connections and empathy with others allows participants to feel less alone with shame.

Using a group psychotherapy format has also been noted to be effective with participants with post-traumatic stress disorder. Goldsmith et al., (2014) considered a mindfulness based stress reduction (MBSR) group for individuals diagnosed with post-traumatic stress disorder (PTSD) to explore if participation in a MBSR group changes negative trauma-related appraisals, including shame. The group format allowed participants to learn MBSR skills and have a space to practice the skills without judgment from other group members. Ginzburg et al., (2009) also considered group treatment for adult survivors of childhood sexual abuse with a PTSD diagnosis. Two group psychotherapy approaches were utilized, trauma-focused group psychotherapy (TFGT) and present-focused group psychotherapy (PFGT). TFGT highlights the link between symptomatology and the past environment. This is done by going back to traumatic memories

and working through the memories to reconstruct what happened. PFGT focuses on the link between symptomatology and the immediate distress (Ginzburg et al., 2009). Group psychotherapy with both treatment models may reduce shame due to the social dimension of shame that involves the devaluation from others.

Using a combination of group psychotherapy and individual psychotherapy, Hedman, Ström, Stünkel, & Mörtberg (2013) sought to investigate if cognitive behavioral therapy (CBT) contributed to a reduction in shame in participants with social anxiety disorder. Participants were randomized to receive CBT in individual or group format. The participants receiving group CBT had a lower social anxiety ratings as assessed with the Liebowitz Social Anxiety Scale Self Report (LSAS-SR) and shame score, as assessed from the Test of Self-conscious Affect (TOASCA) from pre to post treatment assessment. For participants receiving individual CBT there was no significant change in shame scores (Hedman et al., 2013). Using a group CBT format allowed for participants to learn CBT skills to use to lessen shame as well as having others to connect with about their shameful feelings.

Individual therapy only was utilized for individuals with social anxiety using compassion focused therapy and a random client population from outpatient psychotherapy practices using eye movement desensitization and reprocessing (EMDR) (Balcom, Call, & Pearlman, 2000; Boersma, Håkanson, Salomonsson & Johansson, 2015). EMDR was utilized to investigate if internalized shame would be decreased through the access and processing of distressing memories via the involvement of EMDR. Balcom et al., (2000) found that the participants had a decrease in internalized shame between the pre and post-test. While EMDR is completed in individual psychotherapy, it offers insight into an approach that may be beneficial to use with clients experiencing high levels of internalized shame.

Bosersma et al., (2015) used compassion focused therapy in an individual format to determine if using compassion focused therapy in face to face therapy sessions would increase participants completion of homework and practicing the exercises provided. Bosersma et al., (2015) found that participants had an increase in self-compassion (being kind and understanding to oneself instead of being self-critical) following the eight weekly one-hour sessions. This demonstrates that compassion-focused therapies can be utilized individually as well as in a group format as mentioned above. While the format of treatment varied, group psychotherapy treatment demonstrated the importance of participants building connections with others in targeting shame.

Increasing compassion. Compassion is noted as having an impact on decreasing client's feelings of shame. Four articles used compassion-focused therapy to address shame in clients. Compassion focused therapy focuses on developing a warm, compassionate and accepting attitude towards self and others (Boersma et al., 2015). This also encompasses empathy, which is related to compassion to self and others (Hernandez & Mendoza, 2011). Compassion towards self is important when attempting to counteract shame in individuals with high levels of shame. Increasing compassion and empathy also allows individuals to build connections that are often not available following a shameful event (Hernandez & Mendoza, 2011). Shame has been recognized to be the opposite of self-compassion, and includes high levels of self-criticism, rumination on shameful feelings, an inability to self soothe and offer warmth to self (Gilbert & Proctor, 2006; Judge et al., 2012; Kelly, Carter, & Borairi, 2014). Compassion focused therapies focuses on shame and self-criticism while at the same time increasing an individual's ability to experience other emotions that are present (Judge et al., 2012; Gilbert & Proctor, 2006).

In a pilot study with individuals with high shame and self-criticism, Gilbert and Proctor (2006) taught compassionate mind training (CMT) to participants in a mental health day

treatment center to decrease shame and self-criticism. CMT includes identifying the safety strategies in self-criticism, the consequences from self-criticism, and developing compassionate images to counteract the shame and self-criticism (Gilbert & Proctor, 2006). From assessment scores at week one to assessment scores at week 12, participants had a reduction in self-criticism and shame. Using imagery and increasing compassion towards self teaches individuals how to lessen their negative evaluations of themselves. Negative evaluation of self is an important factor when considering shame in clients with eating disorders. Increasing self-compassion and compassion towards others is an optimal way to regulate shame as it relates to eating disorder symptoms (Kelly et al., 2014). While CFT provided in a group format offers these findings, similar results were found using CFT to reduce shame in individual psychotherapy with individuals with social anxiety (Bosersma et al., 2015). Using compassionate imagery and focus on the self-attacking cognitions as described in the Gilbert & Proctor (2006) study, Bosersma et al., (2015) found that CFT decreases shame in individual psychotherapy as well.

Judge et al., (2012) used compassion-focused therapy with individuals seeking counseling at a community mental health agency to look at the effectiveness in providing a compassion focused therapy group. Judge et al., (2012) found that shame was reduced by using CFT as well as discovered that participants were ambivalent in attending the group due to the possibility of being shamed from other group members. The facilitators addressed these feelings with the group and found that by bringing it up, fears were alleviated and participants were reassured that they would not be shamed in the group. Through the process of sharing common fears, supporting one another and developing compassionate feelings towards others Judge et al., (2012) found that these elements combined to produce a reduction in shame. At the end of the CFT program participants “felt better about themselves, thought others felt better about them,

compared themselves less unfavorable and were less submissive” (Judge et al., 2012, p. 427). These are all important in reducing feelings of shame.

Mindfulness. Two articles in this review focused on mindfulness based therapies to reduce shame. Mindfulness based stress reduction (MBSR) was utilized to investigate if participation in a group treatment program would reduce shame in individuals with post-traumatic stress disorder (PTSD). Goldsmith et al., (2014) found that participants reported a significant decrease in shame based trauma appraisals. Mindfulness and awareness of present moment experiences allowed individuals to recognize when they were using shame based trauma appraisals in their daily lives and when remembering their traumatic experiences. Similarly, using an acceptance and commitment therapy (ACT) to target shame in substance use disorder, Luoma, Kohlenberg, Hayes, & Fletcher (2011) found that when using mindfulness and being aware of current experiences, participants used less experiential avoidance to regulate behavior and use of substances. Participants being aware of their urge to use substances while completing residential treatment allowed individuals to understand their substance use behaviors more in depth. Mindfulness also impacted participants’ adherence to follow up after discharge from treatment (Luoma et al., 2011). Mindfulness is being aware of the present moment and being nonjudgmental towards current experiences. Mindfulness is an important skill for individuals to have when experiencing shame to decrease their self-criticism and negative evaluation of self.

Acceptance. Increasing an individual’s ability to accept what is and to not struggle against the emotion and feelings of shame allows an individual to fully experience their emotion as well as to be open to other experiences (Gilbert & Proctor, 2006; Luoma et al., 2011; Judge et al., 2012). Acceptance and commitment therapy (ACT) has been utilized with participants with substance use disorders. In ACT, rather than attempting to reduce shame, it encourages

participants to use psychological acceptance techniques to notice and experience shame (Luoma et al., 2011). The negative self-evaluations that accompany shameful feelings are addressed through cognitive defusion. Cognitive defusion entails recognizing the process of thinking, letting go of attachment to the content of the thoughts and responding to thoughts with the behavior tied to the thought (Luoma et al., 2011). In this study, ACT exercises were modified to focus on how to respond to shame and self-stigmatizing thoughts that may get in the way of recovery from substance use disorders. Reductions in shame were noted in this study by Luoma et al., (2011) as well as an increase outpatient treatment attendance after discharge from residential treatment. Building acceptance of self, others and behaviors related to shame allows individuals to move away from negative self-evaluation.

In completing a qualitative study on adults and shameful experiences, Van Vliet (2008) found that adults who moved towards and accepted a shameful event created less shameful feelings and negative self-evaluations related to the shameful event. Acceptance would come with the realization that the shameful event had not disappeared. This is then followed by ruminating on the event until accepting nothing they can do will change the past (Van Vliet, 2008). Acceptance of one's feelings also impacted adult's ability to overcome shameful events. This means that individuals have control over their emotional response to events. After one has accepted the feelings, there is willingness to work through the difficult feelings associated with the shameful event. After this, being able to express the feelings one has related to the shame-producing event allows individuals to gain more acceptance in their life about the shameful event (Van Vliet, 2008). Building acceptance, recognizing feelings and expressing those feelings can be addressed and encouraged in psychotherapy. While this may be a difficult task at first, being

able to work through the difficult feelings allows individuals to begin to gain more acceptance about the shameful event.

Discussion

This systematic review was developed to explore the contemporary body of scholarship available on the topic of therapeutic approaches used with women targeting shame with a mental health diagnosis. The goal of this research was not to answer the question with a simple sampling of the literature, but rather to consider the whole relevant body of literature on the subject. This review was set up using inclusion and exclusion criteria, as well as both sensitivity and specificity searches, as a means of finding pertinent and current research. What emerged from this review are the approaches best suited to address shame in psychotherapy with women and a mental health diagnosis. These approaches also support additional areas of the participant's lives, including interpersonal relationships, feelings about the self and participant's interactions with the world around them. These findings suggest that while interventions addressing shame are relatively new there are approaches to utilize that target and decrease shame.

The first theme found was the format of treatment. The format of treatment involved group psychotherapy, individual psychotherapy and combined individual and group psychotherapy. Group therapy is an exceptional and appropriate way to approach shame due to the validation and support received from other group members. It also creates a social network of individuals who have been through similar experiences. Targeting shame in group psychotherapy also allows participants to build compassion towards others and themselves in a safe space to explore letting go of negative evaluations of the self (Gilbert & Proctor, 2006; Kelly et al, 2014; Goldsmith et al, 2014; Judge et al., 2012). Beginning to express feelings and fears that are similar to others allows understanding and insight into the shameful experiences an individual

has had. Individual psychotherapy was also used to target shame. While the intervention used is typically done with groups, it can also be done individually to lessen the fear of being a group participant and the possible shaming experiences that may occur in a group (Bosersma et al., 2015; Balcom et al., 2000). Individual psychotherapy does not allow for additional connections to others with similar feelings or experiences to occur, but it does provide a safe space for a client to express their feelings and to process their shameful experiences.

In combination, individual and group modalities allow individuals to experience the group environment as well as receive one-on-one psychotherapy to address additional concerns or feelings that were not brought up in the group setting. Individual psychotherapy again does not allow for building connections to others with similar experiences but the addition of group psychotherapy along with individual therapy creates opportunity for those connections as well as outside feedback about negative self-evaluations (Hedman et al., 2013). Group psychotherapy appears to address shameful experiences and feelings more effectively due making connections with others.

The second theme found was increasing compassion. Self-compassion is the opposite of shame; it is being gentle and empathic with the self instead of being self-critical or negatively evaluating the self. Research suggests that being compassionate towards oneself and others allows for a reduction in self-criticism, as well as a reduction in criticism of others and being able to self-soothe (Gilbert & Proctor, 2006; Judge et al., 2012). Using imagery to cultivate compassion allows individuals to begin to lessen their negative evaluations and negative cognitions related to a shameful experience.

The third theme found was mindfulness. Mindfulness encompasses being aware of the present moment with a nonjudgmental stance. By increasing mindfulness, individuals with high

shame can ground themselves in the moment and not get caught up in revisiting the shameful experience or negative self-talk. Being able to tolerate difficult experiences follows learning and understanding mindfulness. By recognizing when shame based cognitive appraisals are being used, individual can use mindfulness skills to bring themselves back to their breath and the moment they are currently in (Goldsmith et al., 2014). Bringing awareness away from uncomfortable or undesirable feelings, thoughts and memories helps individuals to break the cycle of these unhelpful thoughts that signify feelings of shame (Goldsmith et al., 2014; Luoma et al., 2011).

The forth and final theme found from analyzing the literature was acceptance. Increasing acceptance of what is instead of what is not allows individuals to see that accepting their shameful experiences may help them overcome their feelings of shame (Luoma et al., 2011; Van Vliet, 2008). It also opens individuals up to other emotions that they may not be fully experiencing due to resisting the unwanted emotions (Gilbert & Proctor, 2006; Luoma et al., 2011; Van Vliet, 2008). By fully experiencing a range of emotions, individuals can begin to understand their behavioral reactions to the shameful experience and how to react differently next time.

This systematic review suggests that there are additional therapeutic approaches being used in psychotherapy to target shame and shameful experiences besides traditional talk therapy. Interventions are varied but focus on compassion towards the self and others, acceptance of situations and feelings and being aware of the present moment. These elements, along with being able to connect with others with similar experiences, provide a solid base for which it is possible to overcome feelings of shame.

Limitations

While this review was designed to include all relevant contemporary research on the topic of therapeutic approaches in psychotherapy to target shame, there were still a number of limitations to this study. First, interventions focusing on shame and targeting shame is a new area of research. Shame research has begun to gain more acceptance recently but the focus has primarily been on how to conceptualize shame and create valid tools to measure levels of shame. Shame is difficult to measure due to the individuality of feelings of shame. Descriptions and analysis of shame can be subjective instead of objective. Shame is also a topic that many participants and researchers may not want to discuss due to feelings of being uncomfortable with the vulnerability in disclosing shame or investigating the effects of shame.

This review was limited to articles and research that were peer-reviewed and written in English. This was done to ensure the rigor of the study but may have left out less structured research focused on other approaches to decrease shame. Focus on peer-reviewed and evidenced based research also meant that gray literature, or literature that has not been formally published, was excluded from this study. The focal point of this research was around approaches used in psychotherapy targeting shame within a mental health diagnosis. Articles were included that studied guilt and other self-conscious emotions due to their relation to shame. Articles were also included that did not specify mental health diagnoses of participants. While this review did not chose a certain mental health diagnosis to target shame, these studies within information on mental health diagnosis were included due to the intervention targeting shame.

This systematic review focused several different approaches used to decrease shame, not one singular approach. This systematic review focused on participants' self-reported decrease in shame, not the clinician or group leader's comfort level with discussing or targeting shame. The

clinician's feelings towards targeting shame can have a large impact on being therapeutically present and able work with their clients effectively. Countertransference is necessary for the clinician to understand, be aware and be effective in their use of self with their clients.

Further Research and Implications

One of the first implications to emerge from this systematic literature review was how limited the research is around approaches used in psychotherapy to decrease shame. Interventions are just beginning to be recognized as being able to target or decrease shame. Initially, several of the approaches mentioned in this review were created to focus generally with a population or mental health diagnosis. One approach was created to address shame, but it is an offshoot of a broader therapeutic approach. The approaches targeting shame are still new and the efficacy of treatment approaches need to be further evaluated.

One reason for the limited nature of research on this topic could be the tools used to measure shame. While certain tools are valid and tested empirically, not all tools described in the literature are valid tools to measure shame. This is partly due to the difficulty in conceptualizing shame and the effects shame has. Feelings of shame can be different for each individual. Experiences that create shameful feelings are different for each person as well.

An additional reason for limited research could be people's unwillingness to discuss, disclose or consider shame. While shame is an experience and feeling that some people want to talk about, the majority of people want to stay far away from examining their feelings of shame because it is too difficult and uncomfortable. Therefore, even if there are researchers interested in conducting shame research, they may have a difficult time finding participants.

References

- Anderson, T., McClintock, A.S., & Song, X. (2014). *Psychotherapy*. *Oxford Bibliographies*. doi: 10.1093/OBO/978019928340-0154
- Balcom, D., Call, E., & Pearlman, D.N. (2000). Eye movement desensitization and reprocessing treatment of internalized shame. *Traumatology (6)*2. Retrieved from <http://www.apa.org/pubs/journals/trm/>
- Benetti-McQuid, J., & Bursik, K. (2005). Individual differences in experiences of and responses to guilt and shame: Examining the lenses of gender and gender role. *Sex roles*, 53(1/2). doi: 10.1997/s11199-005-4287-4
- Boersma, K., Håkanson, A., Salomonsson, E., & Johansson, I. (2015). Compassion focused therapy to counteract shame, self-criticism and isolation. A replicated single case experimental study for individuals with social anxiety. *Journal of Contemporary Psychotherapy*, 45 (2). doi: 10.1007/s1089-014-9286-8
- Brown, B. (2006). Shame resilience theory: A grounded theory study on women and shame. *Families in Society: The Journal of Contemporary Social Services*, 87(1). doi: 10.1606/1044-3894.3483
- Brown, B. (2008). *I thought it was just me (but it isn't): Making the journey from "what will people think?" to "I am enough."* New York: Gotham.

DeYoung, P. (2015). *Understanding and treating chronic shame: A relational/neurobiological approach*. New York: Routledge.

Efthim, P.W., Kenny, M.E., & Mahalik, J.R. (2001). Gender role stress in relation to shame, guilt and externalization. *Journal of Counseling and Development*, 79(4). Retrieved from <http://onlinelibrary.wiley.com/journal/>

Gilbert, P. What is shame? Some core issues and controversies. In P. Gilbert and B. Andrews (Eds), *Shame: Interpersonal behavior, psychopathology, and culture*, (3-30). Oxford University Press, New York.

Gilbert, P., & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: Overview and pilot study of a group therapy approach. *Clinical Psychology and Psychotherapy*, 13(6). doi: 10.1002.cpp.507.

Ginzburg, K., Butler, L.D., Giese-David, J., Cavanaugh, C.E., Neri, E., Koopman, C., Classen, C.C., & Spiegel, D. (2009). Shame guilt and posttraumatic stress disorder in adult survivors of childhood sexual abuse at risk for human immunodeficiency virus: Outcomes of a randomized clinical trial of group psychotherapy treatment. *The Journal of Nervous and Mental Disease*, 197(7). Retrieved from <http://journals.lww.com/jonmd/Pages/default.aspx>

Goldsmith, R.E., Gerhart, J.I., Chesney, S.A., Burns, J.W., Kleinman, B., & Hood, M.M. (2014).

Mindfulness-based stress reduction for posttraumatic stress symptoms: Building acceptance and decreasing shame. *Journal of Evidence-based complementary & Alternative Medicine, 19*(4). doi: 10.1077/2156587214533703.

Gray, R. (2010). Shame, labeling and stigma: Challenges to counseling clients in alcohol and other drug settings. *Contemporary Drug Problems, 37*(4). doi: 10.1177/0091

Gross, C.A., & Hansen, N.E. (2000). Clarifying the experience of shame: The role of attachment style, gender and investment in relatedness. *Personality and Individual Differences, 28* (5).doi: 10.1016/S0191

Gross, K., & Allan, S. (2010). Compassion focused therapy for eating disorders. *International Journal of Cognitive Therapy, 3*(2). Retrieved from www.guilford.com/journals/International-Journal-of-Cognitive-Therapy/John-Riskind/19371209

Gutierrez, D. & Hagedorn, W.B. (2013). The toxicity of shame: applications for acceptance and commitment therapy. *Journal of Mental Health Counseling, 35*(1). Retrieved from: <http://www.amhca.org/?page=jmhc>

Hahn, W.K (2009). Shame. In W. O'Donohue and S.R. Graybar (Eds.), *Handbook of contemporary psychotherapy*. California: SAGE Publications Inc.

Hedman, E., Ström, P., Stünkel, A., & Mörtberg, E. (2013). Shame and guilt in social anxiety disorder: Effects of cognitive behavior therapy and association with anxiety and depressive symptoms. *PLoS ONE*, 8(4). doi: 10.1371/journal.pone.0061713.

Hernandez, V.R., & Mendoza, C.T. (2011). Shame resilience: A strategy for empowering women in substance abuse treatment. *Journal of Social Work in the Addictions*, 11 (4). doi: 10.1080/1533256x.2011.622193

Jordan, J. (1997) Relational development: Therapeutic implications for empathy and shame. In J. Jordan (Ed.), *Women's growth in diversity: More writings from the stone center*. New York: The Guilford Press.

Jordan, J. (2014). Relational-cultural theory. In D. Coghlan, & M. Brydon-Miller (Eds.), *The SAGE Encyclopedia of action research*. Retrieved from <http://srmo.sagepub.com>

Judge, L., Cleghorn, A., McEwan, K., & Gilbert, P. (2012). An exploration of group-based compassion focused therapy for a heterogeneous range of clients presenting to a community mental health team. *International Journal of Cognitive Therapy*, 5(4). Retrieved from <http://www.guilford.com/journals/International-Journal-of-Cognitive-Therapy/John-Riskind/19371209>

Kaufman, G. 1989. *The psychology of shame: theory and treatment of shame-based syndromes*. (2nd ed.). New York, Springer Publishing.

Kelly, A.C., Carter, J.C., & Borairi, S. (2014). Are improvements in shame and self-compassion early in eating disorder treatment associated with better patient outcomes? *International Journal of Eating Disorders*, 47(1). Retrieved from <http://onlinelibrary.wiley.com/journal/10.1002/%28ISSN%291098-108X>

Lewis, M. (2003). The role of self in shame. *Social Research*, 70(4). Retrieved from <http://www.jstor.org/>

Luoma, J.B., Kohlenberg, B.S., Hayes, S.C., & Fletcher, L. (2012). Slow and steady wins the race: A randomized clinical trial of acceptance and commitment therapy targeting shame in substance use disorders. *Journal of Counseling and Clinical Psychology*, 80(1). doi: 10.1037/a0026070

Lutwak, N., & Ferrari, J.R. (1996). Moral affect and cognitive processes differentiating shame from guilt among men and women. *Personality and Individual Differences*, 21(6). doi: 10.1016/s0191-8869(96)00135-3

Morrison, A. (2011). The psychodynamics of shame. In Dearing, R.L & J.P. Tangney (Eds.), *Shame in the therapy hour* (23-33). doi: 10.1037/1236-001

Petticrew, M., & Roberts, H. (2006) *Systematic Reviews in the social sciences: A practical guide*.

Retrieved from <http://www.mylibrary.com?ID=23790>

Sanftner, J., & Tantillo, M. (2011). Body image and eating disorders: A compelling source of shame for women. In R.L. Dearing and J.P. Tangney (Eds.), *Shame in the therapy hour* (277-299). doi: 10.1037/12326-012

Scheel, C.N., Bender, C., Tuschen-Caffier, B., Brodführer, A., Matthies, S., Hermann, C., Geisse, E. K., Svaldi, J., Brakemeier, E.L., Philipsen, A., & Jacob, G.A. (2014). Do patients with different mental disorders show specific aspects of shame? *Psychiatry Research*, 220(1-2). 490-495. doi: 10.1016/j.psychres.2014.07.062

Shame (n.d.). In Oxford Dictionary online. Retrieved from

http://www.oxforddictionaries.com/us/definition/american_english/shame

Stadter, M. (2011). The inner world of shaming and ashamed: An object relations perspective and therapeutic approach. In R.L. Dearing and J.P. Tangney (Eds.), *Shame in the therapy hour* (45-66). doi: 10.1037/1236-002

Tangney, J.P & Dearing, R.L (2004). *Shame and guilt*. The Guilford Press, New York.

Tantam, D. (1998). The emotional disorders of shame. In P. Gilbert and B. Andrews (Eds.),

Shame: Interpersonal behavior, psychopathology and culture (161-172). Oxford

University Press, New York.

Van Vliet, K.J. (2008) Shame and resilience in adulthood: a grounded theory study. *Journal of*

Counseling Psychology, 55(2). doi: 10.1037/0022-0167.55.2.233

Wong, Y., & Tsai, J. (2007). Cultural models of shame and guilt. In J. L. Tracy, R.W. Robins

and J.P. Tangney (Eds.), *The self-conscious emotions: theory and research*. New York:

The Guilford Press.

Appendix A: Article Analysis Form

Author year	Research Question	Sample	Data Analysis	Findings	Conclusions	Implications
Balcom, Call, & Pearlman (2000)	EMDR will reduce internalized shame and self-esteem will increase.	10 female 3 male	Standardized measure pre and post test.	Reduction in shame and increase in self-esteem.	EMDR may be beneficial to targeting shame.	EMDR in individual therapy beneficial to reduce shame and increase self-esteem.
Boersma et al., (2015)	Will CFT have an effect on self-compassion, shame and self-criticism in individuals with SAD?	5 female 1 male	Standardized measure pre and post test.	Increase self-compassion and effective in 3 of 6 participants	CFT addressing self-compassion in SAD is an effective approach to use.	CFT effective in SAD and increasing self-compassion to decrease self-criticism and shame.
Gilbert & Procter (2006)	Is CFT effective in a group format?	5 female 4 male	Self-report questionnaires, diary prompts and entries.	Decrease in depression, anxiety, self-criticism and social comparison.	CFT group format is effective in decreasing depression, anxiety, shame and self-criticism.	CFT used in groups an effective and approachable way to target shame.
Ginzburg et al., (2009)	Is TFGT or PFGT effective at reducing shame in PTSD?	166 female	Standardized measures pre and post test.	Decrease in shame and guilt in PTSD.	TFGT and PFGT effective in reducing shame in PTSD.	Group therapy effective to use when addressing shame in women with PTSD.
Goldsmith et al., (2014)	Will MBSR reduce shame and increase acceptance in PTSD?	11 female 3 male	Standardized measures pre and post test. Mindfulness practice log.	Decrease in shame and increase in acceptance in PTSD.	MBSR effective to reduce shame and increase acceptance in PTSD.	Group MBSR effective to use with PTSD addressing shame and increasing acceptance.
Hedman et al., (2013)	Can CBT reduce shame in SAD?	43 female 24	Standardized measures	Group treatment: decrease	Group CBT effective in decreasing	CBT, overall, effective in reducing shame. Group treatment best suited to

		male	pre and post test.	in shame. Individual treatment: no changes in shame.	shame in SAD.	target shame.
Hernandez & Mendoza (2011)	Is the connections curriculum effective in reducing shame and teaching approaches to overcome shame?	19 female	Standardized measures pre and post test.	Reduced shame, increase general health and wellbeing, increased self-esteem and reduced levels of shame talk.	Connections curriculum effective in reducing shame in group psychotherapy.	Connections curriculum effective with women receiving residential treatment for SUDs. Can be used and applied in other facilities to decrease shame.
Judge et al., (2012)	Is CFT effective in a community mental health agency?	28 female 14 male	Standardized measures pre and post test.	Decrease in shame, depression and anxiety.	CFT in group format is effective with clients form a community mental health agency.	CFT can be used in community mental health agencies to effectively reduce shame, depression and anxiety.
Kelly, Carter, & Borairi (2014)	Is targeting shame early in treatment beneficial to ED treatment? Does CFT increase self compassion in ED patients?	97 female	Standardized measure pre and post test.	Early shame treatment, better ED treatment. Early self-compassion treatment, better ED treatment.	CFT used early in ED treatment decreases shame and has better treatment outcomes for ED symptoms.	Decrease in shame and increase in self compassion early in ED treatment offers better overall treatment outcomes.
Luoma et al., (2012)	Is ACT effective in targeting shame in SUD?	61 female 72 male	Standardized measures pre and post test.	Reduction in shame, increase in general mental health and quality of	ACT used with SUD in treatment reduces shame and increases overall	ACT is effective to target and reduce shame in SUD while in treatment.

				life.	treatment adherence.	
Van Vliet, (2008)	How do adult overcome shameful experiences?	9 female 4 male	Qualitative questions asked	Connection, acceptance and rejecting negative self evaluations most important in overcoming shameful event.	When adults connect with others, accept what is and reject negative self evaluations, greater likelihood of overcoming shameful experiences.	Increasing connections, acceptance and rejection of negative self evaluation important in counseling and therapy.