Future directions for psychotherapeutic treatment of shame: A scoping study

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Abstract

This study uses Arksey and O'Malley's (2005) framework for scoping studies and references Rubin and Bellamy's (2012) discussion on evidence-based practice to scope the current literature concerning the use of psychotherapy to treat shame in adolescents and to develop a research question. The author focused on shame in adolescents and explored ways in which social work practitioners understand and treat shame during the "identity versus role confusion" stage of development. While definitions of shame vary across the scholarly literature, many of them include similar elements. Morrison (2011) defines shame as "a negative feeling about the state of the whole self, a noxious conviction that the self is bad, defective, a failure" and emphasizes the pervasive sense of self-condemnation (p. 25). Recurring themes and therapeutic approaches for managing shame in the therapeutic context are reviewed and summarized. The findings of this scoping study suggest that while the preponderance of the literature points towards the importance of addressing shame and its associated psychopathologies within the therapeutic context, there are few scholarly works that address how to reduce shame in a psychotherapy context and none that present data from studies whose designs were experimental. This paper calls for developing an evidence-based body of research into how best to treat shame in psychotherapy settings. Implications for social work practice, education, and research are discussed.

Keywords: shame, strategies, psychotherapy, treatment, adolescents, study design.

Introduction

In the classic text *Social Diagnosis* (1917), Mary Richmond established the framework for a systemized social work methodology. Richmond believed that the social work profession ought to be guided by a standardized, pragmatic epistemology. In an effort to make social work principles operative, she famously asserted the need for developing a scientific knowledge base and pooled way of thinking amongst social workers. Richmond's view was that social work knowledge must be grounded in a pragmatic approach that utilizes research-generated evidence. While practice wisdom, experience, and expertise in the field provide a foundation for one's social work practice, Richmond notably constructed the foundations for the scientific methodology development and "the use of research-generated facts to guide the provision of direct clinical services as well as social reform efforts" (Rubin & Bellamy, 2012, p. 4).

In the "age of accountability" and evidence-based practice eras, research-based evidence allows for clinicians to generate practice decisions based on available scientific evidence available (Rubin & Bellamy, 2012, p. 5). The term *evidence-based practice* (EBP) is defined as "a process for making practice decisions in which practitioners integrate the best research evidence available with their practice expertise and with client attributes, values, preferences, and circumstances" (Rubin & Bellamy, 2012, p. 7). The hope is that the combination of practice wisdom and credible evidence-based research will result in the best possible practice decisions.

This combination is critical to practitioners who work with adolescents dealing with shame. A better understanding of the phenomenon of shame in adolescents can assist practitioners and researchers to develop appropriate approaches to treating shame in adolescents. While the currently available research both examines and acknowledges shame as a primary emotion that commonly arises in psychotherapy treatment and consistently points towards the importance of understanding and addressing shame in therapy, there are few studies that address how to do this.

Methodology

Stage 1: Identifying the Research Question

As noted above, *shame* has been defined as "a negative feeling about the state of the whole self, a noxious conviction that the self is bad, defective, a failure" (Morrison, 2011, p. 25). Both the first (1913) and second (1989) editions of the *Oxford English Dictionary* defined *shame as*:

> [t]he painful emotion arising from the consciousness of something dishonouring, ridiculous, or indecorous in one's own conduct or circumstances (or in those of others whose honour or disgrace one regards as one's own), or of being in a situation which offends one's sense of modesty or decency (n.p.).

The earliest use of the word *shame* in a scientific context that this author found was by Charles Darwin (1872) in his book, *The expression of the emotions in man and animals*. Darwin (1872) considered the ways in which emotions were expressed in animals and found that blushing as a result of shame was uniquely linked to human beings.

Shame is considered to be a universal part of the human condition, (Brown, 2008; Heller, 2003). As such, it is imperative that social work practitioners and researchers understand the role it plays during the most formative years of a patient's life. To formulate the research question, the author first analyzed how shame is discussed in the extant literature on human development in order to properly situate the question within the current understanding of human development and the historical trajectory of the discussion of, and research into, shame.

Erikson (1959) posited that identity formation is a process that continues throughout one's life but noted that "the formation of a strong and coherent sense of identity represents the crucial developmental step associated with the transition from adolescence to adulthood" (Phoenix, 2001, p. 350). Erikson (1959) also noted that teenagers are tasked with resolving the crisis of "identity versus role confusion" (Erikson, 1959/1980, p. 94). While Erikson (1959) focused on the transition from adolescence to adulthood, it is elucidating to also explore how shame interacts with the process of identity formation during the transition from childhood to adolescence and even earlier.

According to Bennet, Sullivan, and Lewis (2005), shame is an experience that begins as early as toddlerhood at 3 ½ years of age and continues to develop well into adolescence. As adolescents undergo changes in their cognition, physical appearances, and sexuality, it is possible that experiences of shame may be particularly prominent during this stage of development (De France, Lanteigne, Glozman, & Hollenstein, 2017). Cognitively, adolescents are actively involved in developing a sense of identity and experience increased ability to self-evaluate and reflect on their actual self versus an ideal self (De France et al., 2017). As adolescents begin to experiment with their sense of self, they may be prone to greater self-consciousness, susceptibility to the influence of their peers, and experiences of shame (De France et al., 2017). Thus, it appears from that literature that adolescents seem susceptible for experiencing increased shame and self-criticism due to the likelihood that they are considering "others' interpretations of themselves to be trait-like, meaning that a negative evaluation implies flaws reflective of the self, rather than the behavior" (De France et al., 2017, p. 770). Adolescents are prone to becoming concerned about their outward appearances and body image as it pertains to specific cultural standards of attractiveness (De France et al., 2017). As maturation continues, adolescents may develop dissatisfaction with their physical attractiveness, generating feelings of shame regarding their entire self-identity. Lastly, sexual development and sexual behaviors that are common in adolescence begin to emerge as adolescents begin exploring and understanding their sexuality. Adolescents begin to reference and rely on their peers rather than on their parents or caregivers and aim to achieve their individual identities through a group identity (Berzoff, Flanagan, & Hertz, 2011).

As a whole, "adolescence may be a crucial time for the assessment and monitoring of shame experiences" (De France et al., 2017, p. 770). Given that adolescents are more likely to take part in self-evaluations, Reimer (1996) suggests that the shift toward experiencing shame occurs during adolescence as a result of the maturational shifts and the growing prominence of peer evaluation. Social workers must develop an understanding of the evolution of shame during this developmental stage and create strategies for treating shame and its related disorders (De France et al., 2017).

Research Question

The author would like to understand the nature and effectiveness of strategies that therapists have used to treat shame and its concomitant disorders. This author's research question is: What treatments currently exist to treat adolescents presenting with shame and its concomitant disorders? This research question includes elucidating which of these treatments are evidence-based and which of them have been shown to be effective.

Question Significance. This research question is important because it is a first step in the process to integrate, as noted previously, the best research evidence available with the treating professionals' "practice expertise" and their clients' "attributes, values, preferences, and circumstances" to develop a best-practices approach to treating shame (Rubin & Bellamy, 2012, p. 7).

Working within the framework of Reimer (1996), this author first examined the historical, foundational literature on shame with the goal of understanding the continuum techniques used to treat shame within the psychotherapeutic context. This examination revealed that there are only a few treatments that are specifically shame-focused. Tangney and Dearing (2011) note only four treatments that they describe as being shame-focused therapies: Gilbert's compassion focused therapy (CFT); Linehan's dialectical behavioral therapy (DBT); Brown's Shame Resilience Curriculum: Connections; and emotion-focused therapy (EFT). Tangney and Dearing (2011), however, note that the empirically validated research on shame-based treatment was in its early stages and opined that research grounded in randomized experimental designs could clarify the effectiveness of shame-based treatments in psychotherapy (Tangney & Dearing, 2011). To date, there is a dearth of such randomized, experimental designed studies.

Erik Erikson (1964) developed a psychosocial timeline that looked at the stages of development over the course of a person's life cycle (Berzoff, 2008). He posited that people are constantly changing over the course of their entire lives and suggested that there are identifiable stages of change within this continuum: the Epigenetic Stages include Infancy, Early Childhood, Play Stage, School Age, Adolescence, Young Adulthood, Adulthood, and Old Age (Berzoff et al., 2011). For the purposes of this study, the author will focus on what Erikson (1964) named the "adolescent" stage as there is a dearth of literature regarding the psychotherapeutic treatment of shame during this developmental stage.

Berzoff et al., (2011) defines adolescence as a period of hormonal, biological, and sexual changes and impulses taking place between the ages of eleven to eighteen. During Erikson's (1964) adolescent stage of development, there is a tension between identity and role confusion. From childhood to adulthood there is a continuum of development as individuals feel more independent, question their identity, struggle with social interactions, and grapple with moral issues (Berzoff et al., 2011). As individuals transition to being adolescents, they ask themselves who they are (Berzoff et al., 2011). Erikson (1964) suggests that adolescents must integrate a basic sense of trust, a strong sense of independence, competence, and control over their lives. During this stage, the most significant relationships are with peer groups. Individuals who receive reinforcement and validation during this stage will develop a strong sense of self. Erikson (1964) states that completing this stage leads to fidelity, which he described as "the ability to sustain loyalties freely pledged in spite of differences in values" (Berzoff et al., 2011, p. 112). Adolescents navigate physical, intellectual, social and emotional changes and, while some of these experiences are empowering and liberating, they can also result in confusion, pressure, and challenge (Berzoff et al., 2011).

An issue seen frequently by this author in her current psychotherapy practice is the feeling of shame among adolescent patients. It is common that adolescents referred to this author for psychotherapy have a combination of mood disorders such as anxiety and depression, however, a common issue seen by this author is the feeling of shame. Therefore, this author intends to investigate the clinical approaches that would enable a psychotherapist working with adolescents to help patients who present with similar issues.

Stage 2: Identifying Relevant Studies

This author chose to scope the social work, psychology, and sociology literature in the following six electronic databases: ProQuest Central, PsycInfo, PsycBOOKS, PsycARTICLES, MEDLINE, and the Academic Search Premier.

In the initial phase of the author's research, the author searched across the platform database by using the Basic Search option. The author searched under keywords and phrases, as well as under selected peer-reviewed articles. In the next phase, the author formulated a specific research question pertaining to the psychotherapeutic treatment of shame; this guided the search process as it provided a targeted and more detailed search. Each database offered the option to browse articles in specific publications and journals. In each phase, the search was limited to peer-reviewed articles only.

Keywords such as *shame* and *adolescence* were used initially to search for articles and the Advanced Search options were utilized to look for specific terms and fields. Key search questions were also generated that yielded more key words and terms and that catalyzed additional searches. For example, the question "What are the psychoanalytic roots of shame?" generated the search items 'psychoanalytic' and 'shame.' Word variations, synonyms, and alternate terminologies that were associated with the key search terms were used as well. For example, 'psychotherapeutic treatment' is synonymous with 'therapy.' The population parameter of adolescence was at times expanded to include terms such as 'children,' 'teenagers,' and 'young adults.' Boolean operators such as 'and,' 'or,' and 'not' were used between search items; this typically served to broaden the search results. Lastly, the author also found it helpful to read primary sources from seminal shame researchers. This process yielded articles that were then organized into three broad categories, the first two of which comprise the majority of the research reviewed in this paper.

The first category consists of articles that were found through ProQuest Central. This database provided the author access to full-text articles from thousands of scholarly journals. ProQuest Central presented the author with a wide range of focused topics within the broad subject areas of the social sciences, psychology, and social work. The basic search tool bar was used to explore literature across the available topics. The author used quotation marks when looking for an exact phrase.

The second category consists of the information obtained from the PsycInfo database including PsycBOOKS and PsycARTICLES. The search of the PsycInfo database yielded full-article access to a wealth of psychological literature and content; it contained high quality literature from an array of disciplines ranging from psychiatry, social work, and psychology. PsycInfo articles contained citations,

abstracts, cited references, and descriptive information such as the page count, ISBN, language, keywords, and publication type.

The third broad category consisted of the information gleaned from the database MEDLINE as well as a search of the Academic Search Premier database. MEDLINE provided the author with research studies published in journals such as the *Journal of Clinical Psychology, The International Journal of Psychology & Psychological Therapy, and The Journal of Evidence-Based Social Work.* The Academic Search Premier search yielded only one relevant article.

Stage 3: Study Selection

The author sought to read research articles that examined the therapeutic treatment of shame in adolescents. From among the more than 100 articles that the author's search criteria yielded, 44 peer-reviewed articles were selected for this study. In addition, the author read three seminal books: *The expression of the emotions in man and animals* by Darwin (1872), *Shame and guilt in neurosis* by Lewis (1971), and Tangney and Dearing's (2011) *Working with shame in the therapy hour: Summary and integration*. The list of research articles, theoretical articles, and books that this author chose for this study can be found in Table 2: Article by Category.

Of the 44 articles selected, ten were research articles and 34 were theoretical articles. Four of the ten research articles chosen for this study targeted the adolescent population while five of the research articles examined young adults or adults. Several common themes recurred across the ten research studies including one's susceptibility to shame, shame and psychopathology, the impact of shame on the therapeutic relationship, and assessments of shame using different scales. These ten research articles provided the author with important background information on shame and the diversity of the scales along which it is assessed. While these articles were informative, they did not provide the author with solutions to the question of how to treat patients presenting with shame. This author was particularly intrigued by more recent, theoretical works written, or co-authored, by Brown (2006; 2008; 2009; Brown, Hernandez, & Villarreal, 2011), and sought out all of her work.

In addition, the author was interested in learning which standardized measures of shame were most often used in the research studies. The author's research yielded information about 22 different shame scales; the scale most commonly referred to in the ten research studies selected for this study was the Test of Self-Conscious Affect for Adolescents (TOSCA-A) (De Rubeis & Hollenstein, 2009; Feiring & Taska, 2005; Schoenleber & Berenbaum, 2010; Tangney, Wagner, & Gramzow, 1992). Two other scales that were noted in these research studies as being commonly used were the Impact of Event Scale-Revised (IES-R) (Cunha, Matos, Faria, & Zagalo, 2012; Pinto Gouveia & Matos, 2011) and the Other as Shamer (OAS) (Cunha et al., 2012; Pinto Gouveia & Matos, 2011).

Six of the 44 articles did expound on treatment techniques: Van Vliet (2009), Feiring and Taska (2005), Gilbert and Procter (2006), Rizvi, Brown, Bohus, and Linehan, (2011), Brown (2006; 2009), and Yard's (2014) research. Both Van Vliet (2009) and Feiring and Taska (2005) recommended using cognitive behavioral approaches.

All 44 articles are categorized in Table 2: Article by Category according to whether they are research articles or theoretical articles and/or whether they set forth information regarding treatment

techniques. The ten articles were deemed by this author to be research articles because they examined shame in some capacity. Methodologies used in past studies were identified, which assisted the author in discovering where there were gaps in the research. These research studies are listed under the column in Table 2: Article by Category, labeled as "Research Articles." The second column in Table 2: Article by Category, labeled "Theoretical Articles," lists the 34 theoretical articles the author read. These articles explored the work of influential theorists who had written about shame and identified key questions about the topic. These articles enabled this author to learn about the ways in which shame research has developed over time and in discovering areas in need of further exploration. This author also read three seminal books; they are listed in the third column of Table 2: Article by Category labeled "Seminal Books." These books acted as key resources for this author's research. Lastly, the fourth column lists the six articles that consider psychotherapeutic treatment techniques of shame.

Stage 4: Charting the Data

In line with Arksey and O'Malley's framework (2005), data were charted in Table 1: Research Articles, which highlights literature that met inclusion criteria for this study. The purpose of charting the data, as described by Arksey and O'Malley (2005), is to synthesize the data gathered in order to illuminate key themes that were presented in the various research articles. The chart includes general information about the study, including the author(s), year of publication, study location, the study population, the general aim of the study, the methodology, outcome measures, and important results concluded from the study.

Stage 5: Collating, Summarizing, and Reporting the Results

Of the 44 articles and three books included in this scoping study, sixteen examined shame within a psychotherapeutic setting, and eleven noted the importance of addressing shame within the therapeutic context. Seventeen of the articles reviewed did not highlight the importance of addressing shame within the therapeutic context.

The author identified three major themes from the ten research studies: (1) the importance of examining ways in which individuals resolve and recover from shame; (2) the connection between shame and psychopathology, and; (3) the connection between identity development and shame. Across the 34 theoretical articles, several articles that the author read outlined developmental stages (Berzoff et al., 2011; Curtis, 2015; Erikson, 1959; Erikson, 1980; Levin, 2015, Phoenix, 2001; Reimer, 1996), while others outlined important practices such as evidence-based studies (Creswell, 2013; McNeece & Thyer, 2004; Rubin & Bellamy, 2012) and scoping studies (Arksey & O'Malley, 2005). A frequent theme was the examination and relationship between adolescent identity development and shame (Bennett et al., 2005; Klimstra, Hale, William, Raaijmakers, Branje, & Meeus, 2010; Phoenix, 2001). Several theoretical articles examined shame in psychotherapeutic settings (Brown, 2008; Brown, 2009; Brown et al., 2011; Candea & Szentagotai, 2013; Gilbert & Irons, 2005; Gilbert & Procter, 2006; Gilbert, 2011; Greenberg, 2002; Hayes, Strosahl & Wilson, 1999; Morrison, 2011; Nathanson, 1987; Steiner, 2015; Urdang, 2010; Yard, 2014), while others simply note the importance of addressing shame within the therapeutic context but do not delineate specific ways to do so (Goldberg, 1990; Kaufman, 1992; Middleton-Moz, 1990; Reimer, 1996; Witkin, Lewis & Weil, 1968). Two articles used case examples and vignettes to demonstrate the presence of shame in the therapeutic relationship (Goldberg, 1990; Steiner, 2015). Specific therapeutic techniques for addressing shame were explored in six articles.

Among the three research articles that spoke to the issue of the importance of examining ways in which people resolve and recover from feelings of shame (Brown, 2006; Feiring & Taska, 2005; Van Vliet, 2009), Brown (2006) used Grounded Theory to generate a new theory entitled the Shame Resilience Theory (SLT), which is used to understand shame in women. Brown (2006) also explores practice implications for resolving shame. Feiring and Taska (2005) examine the long-lasting impact of feelings of shame on those who experience sexual abuse and raise the question of whether the emotional experiences of shame is a barrier to healing from sexual abuse. Van Vliet (2009) examines the ways in which individuals recover from shameful events.

A different set of three research articles explored the connection between shame and psychopathology (De Rubeis & Hollenstein, 2009; Schoenleber & Berenbaum, 2010; Tangney et al., 1992). Specifically, De Rubeis and Hollenstein (2009) examined shame-proneness and depressive symptoms; Schoenleber and Berenbaum (2010) examined the associations between shame and Cluster C personality disorders including avoidant, dependent, and obsessive-compulsive personality disorders; Tangney et al., (1992) assessed the links among shame, guilt, psychopathology, and whether those who experience shame have difficulties with interpersonal relationships.

A further two of the ten research articles spoke to the connection between identity development and shame (Cunha et al., 2012); Pinto-Gouveia & Matos, 2011). Cunha et al., (2012) examined adolescent identity development, the impact that shame has on adolescents memories, and common negative emotional states they may experience as a result of shame such as depression and anxiety. Pinto-Gouveia and Matos (2011) investigated whether shame memories become central components of a person's identity. Neither of the final two research articles contained themes that were reflected in the other nine articles. Black et al., (2013) examined the presence of shame within the therapeutic relationship. De France et al., (2017) utilized The Shame Code to examine when adolescents found situations to be stressful.

However, what is missing from the literature is a focused discussion of specific assessments scales and treatment techniques that have been shown to be effective in addressing shame in the therapeutic context. The author is left wondering (1) what specific clinical strategies would help in assessing the pervasiveness of a client's feelings of shame and (2) what specific techniques and strategies have been shown to be effective in helping clients who present with shame (Table 1: Research Articles).

Few articles addressed *how* to reduce shame in a psychotherapy context. Only six out of the ten research studies explicitly explored the treatment of shame in psychotherapy. Of the 34 theoretical articles, only four spoke specifically about treatment techniques (Gilbert & Procter, 2006; Rizvi et al., 2011; Brown, 2009, Yard, 2014) and only five noted the importance of addressing shame within the therapeutic relationship (Goldberg, 1990; Kaufman, 1992; Middleton-Moz, 1990; Reimer, 1996; Witkin et al., 1968).

Among the research articles, Van Vliet (2009), Feiring and Taska (2005), Gilbert and Procter (2006), Rizvi et al., (2011), Brown (2006; 2009), and Yard (2014) all pointed to different treatment modalities but failed to answer the research question of which tools and specific approaches within these modalities were effective in treating adolescents who present with shame. Van Vliet (2009), in a discussion of various approaches, mentions several modalities that other researchers have posited as being

useful in a therapeutic setting: CBT approaches, acceptance and commitment therapy (Hayes et al., 1999) and emotion-focused therapy (Greenberg, 2002). Feiring and Taska (2005) also recommend CBT as a modality of treating shame in children and adolescents. Techniques such as cognitive restructuring and the creation of a list or hierarchy of experiences that were shameful can be used to help children create a narrative around their shame-based experience(s) (Feiring & Taska, 2005). The therapist is instrumental in this process in helping the client confront their shame and fear.

Compassion focused therapy (CFT), which was initially developed for individuals with high levels of shame, focuses on acceptance and understanding which is a powerful and corrective experience for those who are shame-prone (Gilbert, 2011). There have been various nonexperimental evaluations of CFT that indicate positive results. Specifically, a study conducted in the UK included patients who had severe mental health diagnoses and were participating in a day treatment program; the study showed that participants who participated in compassion training experienced decreased shame, self-criticism, feelings of inferiority, depression, and anxiety (Gilbert & Procter, 2006). CFT is a relatively new treatment modality. Leaviss and Uttley (2015) conducted a study that measured the effectiveness of CFT that included fourteen studies and three randomized controlled studies. CFT was found to be an effective treatment for people who were high in shame and self-criticism.

While Linehan's (1993) dialectical behavioral therapy (DBT) is also noted as an effective treatment for individuals with borderline personality disorder (BPD), which is commonly related to chronic and intense feelings of shame, Rizvi et al., (2011) summarize a growing body of research that indicates an association between BPD and shame. Studies that seek to opine about the effectiveness of treatments for BPD and the associated shame must first wait until more research is conducted that explores the role that shame plays in BPD.

Although the majority of the research Brown (2006) conducted was qualitative, a formal evaluation of her curriculum was conducted in three residential substance abuse facilities in California. Brown et al., (2011), citing Hernandez's study (2010), noted that:

> statistically significant differences were detected between pre and posttest measures for general health, depression, internalized shame, and self-conscious affect. Statistically significant differences were also detected for each of the elements of shame resilience, indicating that the women involved in this research experienced gains in recognizing and understanding shame; identifying the individual, familial, and societal expectations that fuel shame; understanding the importance of reaching out for social support; and speaking out about shameful feelings and what they needed to reach treatment goals and sustain recovery (p. 356-357).

Brown (2006) introduced Shame Resilience Theory (SRT) which was developed to address the impact that shame has on adult women's mental health. SRT provides a framework for understanding how individuals can cope with shame. Brown (2009) suggests that part of treating shame is understanding one's triggers and building an awareness of one's areas of vulnerability. Connections is a 12-session psychoeducational shame resilience curriculum developed by Brown (2009) in 2006. The curriculum notes that the most significant barrier to working with individuals with shame is fear. Brown (2009) refers to "three quick things about shame: (a) we all have shame, (b) we're all afraid to talk about it, and (c) the

less we talk about it, the more we have it" (p. 360). Brown (2009) focuses a great deal on understanding that shame is pervasive and must be overcome, as well as on the importance of sharing one's shameful experience with someone you trust, acceptance of the experience, and understanding triggers. What Brown (2009) seems to suggest, though, is that shame must be eliminated from one's life. This author was not able to find any studies that confirmed that Brown's approach is effective.

Lastly, Yard (2014) makes two significant points about the treatment of shame. First, she emphasizes the importance of embracing three therapeutic skills in competently treating shame, containment, toleration, and empathy. To reduce worsening shame, Yard (2014) stresses the importance of curiosity, collaboration and sensitive timing in the pace and content of interpretations. Secondly, Yard (2014) emphasizes the importance of therapists recognizing their own experiences of shame, which can easily get in the way of being present and empathic. Shame has the ability to place clinicians in vulnerable positions, interrupting the treatment. Yard (2014) does not discuss ways for clinicians to manage their own shame within their practices, however.

Implications for Practice, Education, and Research

Implications for Practice

The literature on shame is spread across several academic disciplines and is, consequently, varied in its approach to the subject. The majority of the literature reviewed in this study points towards the importance of reducing shame through therapeutic intervention; it is clear that the impact of shame on mental health is extensive (Cunha et al., 2012; De Rubeis & Hollenstein, 2009; Schoenleber & Berenbaum, 2010; Tangney et al., 1992; Nathanson, 1987; Nathanson,1992; Candea & Szentagotai, 2013). To date, there has been a dearth of well-designed and well-executed studies that could yield clear data about the effectiveness of any given treatment modality. As a consequence, current practitioners must rely on the limited scholarly literature on treatment options, literature that may present nothing more than anecdotal and self-reported "data" and may, however inadvertently, rely on post-hoc reasoning. Practitioners should be aware of the limitations of the extant research into the effectiveness of treatment modalities and the consequent lack of evidence-based treatment strategies that practitioners can deploy. In summary, future researchers and clinicians must be cautious with the treatment strategies that they employ with vulnerable patients given the insufficient data regarding the effectiveness of the currently available treatments.

Implications for Education

While many educational institutions offer practice sequences that teach clinical social work skills that are widely applicable to many practices, exploring concentrated skills for clinical social work, undergraduate and graduate students may not receive instruction on what shame is, how to identify it, and how to work with it. For example, Tangney and Dearing (2011), who have done extensive research on shame, have noted that client shame was never a focus of their clinical training. Similarly, Brown (2009) states that limited psychotherapy training merely mentions client shame.

The implications for education are deeply rooted in shame-focused evidence-based treatment research studies, which are scarce. In order for clinicians to effectively treat shame, experimental research designs that will yield reliable data are needed to evaluate effectiveness of shame-focused interventions.

The psychotherapeutic treatment of shame has been a long-overlooked clinical area in the field of social work. What is needed next are effective treatment modalities for addressing shame in therapy in which to ground appropriate curricula (Tangney & Dearing, 2011).

Implications for Research

In conducting this study, this author became aware that the scholarly research into shame and how to treat it is dominated by study designs that are non-experimental and cross-sectional. This study revealed that there is a lack of specific instruments available to measure shame that can yield data that is broadly applicable or that can reveal causation rather than simply correlation. While there are several shame scales that use scenario-based measures such as Self-Conscious Affect and Attribution Inventory (SCAAI), Test of Self Conscious Affect (TOSCA), and Attributional Style Questionnaire (ASQ), these measures lack internal consistency. The data that is derived from such situation-based measures has its own unique variance and cannot reliably be extrapolated to other non-identical scenarios. Other studies employ various methods of self-report data collection such as surveys and questionnaires including, but not limited to, the Experience of Shame Scale (ESS), Guilt and Shame Proneness Scale (GASP), Test of Self-Conscious Affect (TOSCA), and The Shame Inventory. While much is learned from these scales, they are unable to capture the experience of shame as it occurs and is observed by others.

Whether the lack of specific instruments or the complexity of shame is the cause of, or is independent of, the decisions made by researchers when formulating their research designs, this scoping study has elucidated the fact that there is a dearth of randomized, experimental designed research studies that examine the psychotherapeutic treatment of shame.

Given that causal inferences cannot be drawn from the data yielded by these types of studies, it is not possible to make an evidence-based assessment regarding the effectiveness of the interventions described in studies such as these. Van Vliet (2009) and Brown (2006), recognizing the problematic nature of such research, used grounded theory for their studies. As discussed by Creswell (2013), grounded theory research moves beyond narrative research, allowing the researcher to develop a theory that offers an explanation or framework for future research. Limitations of using grounded theory, however, include research bias, insufficient details within very large volumes of data, and questionable trustworthiness of the findings (Rubin & Bellamy, 2012, p. 252).

As a whole, researchers have found that shame is difficult to measure and evaluate. For researchers who opt to use scenario-based instruments to study shame, the usefulness of their results could be enhanced if the chosen scenarios were specifically targeted to the population being studied. It is critical that future researchers make attempts to study shame in a more systematic, evidence-based approach (Van Vliet, 2009).

Conclusion

Shame presents with many different faces, including feelings of inferiority, worthlessness, and a global sense of self-condemnation and is not infrequently seen in psychopathology such as depression, bipolar, schizophrenia, and narcissism (Morrison, 1989; Nathanson, 1987). The literature reviewed in Table 1: Research Articles reflects a great deal of shame research within the psychotherapeutic context, however, there is a dearth of randomized, experimental designed studies that specifically address and/or assess the effectiveness of shame-focused interventions in psychotherapeutic contexts involving

adolescents. While there are some, albeit few, studies that posit strategies for exploring shame within the psychotherapeutic context, more exploration is needed to elucidate how shame reduction can actually be achieved. Researchers must take steps to develop a deeper understanding of treating adolescent shame in psychotherapy. Future studies using scientifically informed, randomized experimental designs can clarify the effectiveness of shame-based treatments in psychotherapy (Tangney & Dearing, 2011).

Table 3: Research Articles

AUTHOR(S), PUBLICATION YEAR, STUDY LOCATION	STUDY POPULATION	AIM OF THE STUDY	METHODOLOGY	OUTCOME MEASURES	IMPORTANT RESULTS
Black, R.A., Curran, D., & Dyer, K. F. W. (2013). Primary care adult mental health service.	50 treatment-receiving adults ages 21-67 with an assortment of mental health diagnoses.	To examine the presence of shame and its associated coping styles within the therapeutic relationship and intimate relationships.	Questionnaire measures of shame states, shame coping styles, intimate relationship functioning, and the therapeutic alliance.	*Compass of Shame Scale*, *State Guilt and Shame Scale*, *The Working Alliance Inventory—Short Form*, *The Multidimensional Relationship Questionnaire* (MRQ*).*	Using withdrawal to cope with shame made individuals less likely to have a valuable therapeutic alliance and to have dissatisfying intimate relationships.
Brown, B. (2006). The University of Houston.	215 women with a mean age of 40 years old.	To generate a theory about women's experience of shame, and to understand strategies women use to resolve shame.	Conversational interviews via telephone or e-mail.	N/A.	Shame resilience theory (SRT) emerged from the data.
Cunha, M., Matos, M., Faria, D., & Zagalo, S. (2012). Public schools in the district of Coimbra, Portugal.	354 adolescents (157 boys and 197 girls) from 7^{th}-12^{th} grade.	To explore the relationship between shame, shame memories, and their impact on one's psychopathology in adolescence.	Adolescents were given a brief description on the purpose of the study. Adolescents completed the measures at the beginning of class at the same time and order as the rest of their classmates.	*Priming for the Shame Memory, Centrality of Event Scales* (CES), *Impact of Event Scale-Revised* (IES-R), *Other as Shamer* (OAS), *Internalized Shame Scale* (ISS), *Depression, Anxiety and Stress Scale* (DASS-21).	Shame traumatic memory and centrality of shame memory are connected to external and internal shame, depression and anxiety symptoms. Shame memories tend to exist as negative narratives tied closely to one's sense of self.

AUTHOR(S), PUBLICATION YEAR, STUDY LOCATION	STUDY POPULATION	AIM OF THE STUDY	METHODOLOGY	OUTCOME MEASURES	IMPORTANT RESULTS
De France, K., Lanteigne, D., Glozman, J., & Hollenstein, T. (2017). Southern Ontario.	149 youth between the ages of 12-17.	To assess the ability of the Shame Code to detect the amount of shame adolescents experienced during a socially stressful situation.	Filled out questionnaire on computer. Then, the experimenter asked the participants to provide a three-minute speech on any topic of their choice without preparation. Participants then completed a state-based self-report measure of the level of shame s/he experienced while participating in the speech task.	*The Shame Code.*	The Shame Code is a reliable coding scheme that is able to measure shame behaviors in real time.
De Rubeis, S., & Hollenstein, T. (2009). University of Toronto.	89 girls and 52 boys ages 11-16.	This study examined a mediation model of shame-proneness and depressive symptoms in adolescents, using avoidant coping as a mediating variable.	141 individuals filled out web-based questionnaires used to measure shame-proneness, depressive symptoms, and avoidant coping. 46 of those 141 did a one-year follow-up and filled out same questionnaire.	*Children's Depression Inventory* (CDI), *Test of Self-Conscious Affect for Adolescents* (TOSCA-A), *Children's Coping Strategies Checklist* (CCSC).	Shame proneness was a significant predictor of depressive symptoms, both concurrently and over the course of a year.
Feiring, C., & Taska, L. S. (2005). Urban and suburban populations in New Jersey.	118 sexually abused children ages 8-15.	To examine if shame is a long-lasting emotional consequence of sexual abuse.	Structured interviews.	*The Test of Self-Conscious Affect for Adolescents* (TOSCA-A), *The Children's Impact of Traumatic Events Scale–Revised, The Trauma Symptom Inventory* (TSI), *My Family and Friends* (MFF).	Children who experienced abuse-related shame were at high risk of maintaining high levels of shame throughout their lives. They were also prone to, experiencing more severe levels of PTSD symptoms.

AUTHOR(S), PUBLICATION YEAR, STUDY LOCATION	STUDY POPULATION	AIM OF THE STUDY	METHODOLOGY	OUTCOME MEASURES	IMPORTANT RESULTS
Pinto-Gouveia, J. & Matos, M. (2011). University of Coimbra, Coimbra, Portugal	811 participants from general population, consisting of 481 undergraduate students and 330 subjects from normal population.	To explore the nature of shame as a central component to a person's identity.	Filled out self-report questionnaires that measured external shame, internal shame, traumatic memory characteristics and psychopathology.	*Other As Shamer Scale* (OAS), *Experience of Shame Scale* (ESS), *Depression, Anxiety and Stress Scale* (DASS-42), *Centrality of event scale* (CES), *Impact of event scale-revised* (IES-R).	Early shame experiences show centrality of memory characteristics. Individuals who recall significant shame memories from childhood and adolescence reveal more internal and external shame in adulthood. There is a high, positive correlation between recalled shame experiences and depression, anxiety, and traumatic stress reactions.
Schoenleber, M., & Berenbaum, H. (2010). University of Illinois at Urbana–Champaign.	237 undergraduate students, ages 18-27.	To examine connections between shame and Cluster C personality disorders.	The Positive Affect Negative Affect Schedule (PANAS) was administered and audiotaped by an investigator. The Test of Self-Conscious Affect–3 (TOSCA-3) presents 16 scenarios to a participant which they rate on a scale of 1-10. The Shame-Aversive Reactions Questionnaire (ShARQ) presents 14 statements with which they rate on a 7-point Likert scale.	*The Positive Affect Negative Affect Schedule* (PANAS), *Test of Self-Conscious Affect–3* (TOSCA-3), *Shame-Aversive Reactions Questionnaire* (ShARQ).	There is a strong association with shame and Cluster C Personality Disorders. Cluster 3 PD's including avoidant, dependent, or obsessive-compulsive were prone to experience shame as aversive. Participants with Dependent personality disorder (DPD) correlated shame with pain.

AUTHOR(S), PUBLICATION YEAR, STUDY LOCATION	STUDY POPULATION	AIM OF THE STUDY	METHODOLOGY	OUTCOME MEASURES	IMPORTANT RESULTS
Tangney, J. P., Wagner, P., & Gramzow, R. (1992). George Mason University.	Study 1: 245 students ranging from ages 18-55; Study 2: 234 students ranging from ages 17-35.	To examine the links between shame, guilt and psychopathology.	Questionnaires.	*The Self-Conscious Affect and Attribution Inventory* (SCAAI), *The Test of Self-Conscious Affect* (TOSCA).	There is an association between shame-proneness and impaired empathy, an inclination to externalize blame and regulate periods of anger. Shame-prone individuals have difficulty in interpersonal relationships.
Van Vliet, K. J. (2009). University of Alberta, Edmonton, Alberta, Canada.	13 adults ranging from ages 24-70.	To examine how adults recover from experiences of shame	Face-to-face, semi-structured interviews.	N/A.	Participants recovered from experiences of shame by lessening the incongruities between their actual selves and their ideal selves, and embracing a more realistic self ideal.

Table 2: Article by Category

Articles by Category
Research Articles (N=10)
Black, R.A., Curran, D., & Dyer, K. F. W. (2013); Brown, B. (2006) Cunha, M., Matos, M., Faria, D., & Zagalo, S. (2012) De France, K., Lanteigne, D., Glozman, J., & Hollenstein, T. (2017); De Rubeis, S., & Hollenstein, T. (2009); Feiring, C., & Taska, L. S. (2005); Pinto-Gouveia, J. & Matos, M. (2011); Schoenleber, M., & Berenbaum, H. (2010); Tangney, J. P., Wagner, P., & Gramzow, R. (1992); Van Vliet, K. J. (2009)
Theoretical Articles (N=34)
Bennett, D. S., Sullivan, M. W., & Lewis, M. (2005); Arksey, H., & O'malley, L. (2005); Berzoff, J., Melano Flanagan, L., and Hertz, P. (2008); Black, R. A., Curran, D., & Dyer, K. W. (2013); Brown, B. (2008); Brown, B. (2009); Brown, B., Hernandez, V. R., & Villarreal, Y. (2011); Candea, D.-M., & Szentagotai, A. (2013); Creswell, J.W. (2013); Curtis, A. C. (2015); Dickerson S. S., Gruenewald T. L., Kemeny M. E. (2004); Erikson, E. H. (1959/1980); Gilbert, P., & Irons, C. (2005); Gilbert, P., & Procter, S. (2006); Gilbert, P. (2011); Goldberg, C. (1990); Greenberg, L. (2002); Hayes, S.C., Strosahl, K.D., & Wilson, K.G. (1999); Heller, A. (2003); Kaufman, G. (1992); Klimstra, T. A., Hale,William W., I.,II, Raaijmakers, Q. A. W., Branje, S. J. T., & Meeus, W. H. J. (2010); Levin, P. (2015); Mark, B. S., & Incorvaia, J. A. (1995); McNeece, C. A., & Thyer, B. A. (2004); Middleton-Moz, J. (1990); Morrison, A. P. (2011); Nathanson, D. (1987); Nathanson, D. (1992); Phoenix, T. L. (2001); Reimer, M. S. (1996); Rubin, A., & Bellamy, J. (2012); Steiner, J. (2015); Urdang, E. (2010); Witkin, H. A., H. B. Lewis and E. Weil. (1968); Yard, M. A. (2014)
Seminal Books (N=3)
Darwin, C. (1872); Lewis, H. B. (1971); Tangney J. P., & Dearing R. L. (2011)
Articles that Expounded on Treatment Techniques (N=6)
Brown, B. (2006; 2009); Feiring, C., & Taska, L. S. (2005); Gilbert, P., & Procter, S. (2006); Rizvi, S. L., Brown, M. Z., Bohus, M., & Linehan, M. M. (2011); Yard, M. A. (2014)

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