Abstract

Uncovering Adolescent Shame in the Therapeutic Relationship

The present study examined the role of the therapeutic relationship when an adolescent client presents with shame. While shame is a highly unpleasant emotion that is a universally experienced, it is also a neglected emotion in the therapeutic relationship. Furthermore, adolescence is a developmental stage where intense magnification of shame and mental health issues may become apparent. Estimates reveal that most mental health problems begin during the ages of 12-24 (Kinnunen, 2010). Additionally, statistics show that 20%-30% of adolescents have one major depressive episode before they reach adulthood, and 50%-75% of individuals develop anxiety disorders during adolescence (Schwarz, 2009). These numbers demonstrate rising mental health issues amongst teens. While shame has been thought of as a fundamental factor that adolescents grapple with, very little had been researched in regards to the treatment of adolescent shame, and what the role of the therapeutic relationship plays. This study used a quantitative, cross-sectional design to examine the role of the therapeutic relationship in the treatment of adolescent shame from the perspective of mental health clinicians practicing in the state of New York. The current research enriches our understanding of the treatment of adolescent shame and the importance of the therapeutic relationship. The findings also present treatment directions for social workers, providing a new way of thinking about the treatment of shame in adolescents.

Uncovering Adolescent Shame in the Therapeutic Relationship

by
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Chapter One: Dissertation Overview

The present study examined the role of the therapeutic relationship when a client presents with shame, with particular focus on adolescents. Shame is considered to be a universal part of the human condition, and it is imperative that social work practitioners and researchers understand the role it plays during the most formative years of an individual's life, while also understanding shame and its manifestations which can result in better outcomes for youth. As stated by the American Psychological Association, shame is defined as, "a highly unpleasant self-conscious emotion arising from the sense of there being something dishonorable, immodest, or indecorous in one's own conduct or circumstances" (APA Dictionary of Psychology, 2020, n.p.). The type of study conducted was a quantitative, cross-sectional design. A cross-sectional study "examines a phenomenon or relationships among variables at one point in time only…[and] does not assess changes over time" (Rubin & Bellamy, 2012, p. 228). Participants for this study were recruited through seven professional New York List Serves such as the Clinician's Collective and the Upper West Side Alliance, all of which are made up of clinicians who practice in the state of New York. Recruitment will also include the National Association of Social Workers (NASW) New York State List Serve. Data was collected through individual online surveys that will be disseminated through Google Forms. Participants were emailed a link to access the Google Form questionnaire. Email solicitation will include a consent disclosure. By clicking the link for the survey, participants gave consent to participate in the study. Once the data collection was complete, the data was analyzed by the using RStudio**.**

The National Association of Social Workers (NASW) Code of Ethics (2018) states that "professional ethics are at the core of social work. The profession has an obligation to

articulate its basic values, ethical principles, and ethical standards" (p. 2) As stated in NASW Code of Ethics (2018), social works core values include values of service, social justice, dignity and worth of a person, importance of human relationships, integrity, and competence. The following three NASW Code of Ethics are relevant to the study: competence, dignity and worth of a person, and importance of human relationships. Competence includes the responsibility of social workers to continuously strive to expand one's knowledge base and skills in order to make meaningful contributions to the field of social work. This social work value is relevant and significant to this study for the following reasons. To date, there have been very few studies that have explicitly investigated shame in adolescents and the role of the therapeutic relationship. Within the adolescent population, shame appears to be an important factor in the development of psychological problems. There is a need for greater awareness of shame in adolescents and how clinicians can be prepared to understand and treat shame in a therapeutic context. Therefore, building off of our obligation to more deeply consider shame as a powerful, universal emotion, social workers must continue to enhance their knowledge and skills in order to integrate new treatment suggestions and practice the ethical value of competence.

Social workers must also "respect the inherent dignity and worth" of all individuals (NASW, 2018, p. 5). Social workers are committed to treating all clients with respect and compassion while also striving to increase clients' capability to change. This study applies this social work value by assisting those who suffer from shame, an emotion that is often felt "as an inner torment, a sickness of the soul…[the shamed person] feels himself naked, defeated, alienated, lacking in dignity or worth" (Tomkins, 1963, p. 118). This social work

ethic is paramount in the exploration of the social worker-client relationship, one that is rooted in compassion, non-judgmental listening, and the promotion of self-determination.

The social work value "the importance of human relationships" is a grounding force for promoting healing and change (NASW, 2018, p. 6). The field of social work is grounded in understanding people and relationships. This study examined this value through the understanding of complex dynamics inherent in the client-social worker relationship. Social workers "understand that relationships between and among people are an important vehicle for change" (NASW, 2018, p. 6). Therefore, by exploring the ways in which clinicians engage with, treat, and ultimately help heal adolescent shame, this study will assist in exploring the ways in which social workers engage with adolescent shame. This quantitative study explored the ways in which social workers treat adolescent shame, and examined implications for adolescent development, adolescent psychopathology, and treatment implications.

Adolescence has been described as a "developmental epoch during which there is a rapid magnification of shame" (Kaufman, 1989, p. 43). However, shame in adolescents and the role of the therapeutic relationship has been insufficiently studied. Experiences of shame in adolescence is a ubiquitous phenomenon, so it is crucial that social workers understand implications for clinical practice. Therefore, this study will address this gap in the literature by investigating the role of the therapeutic relationship in treatment with adolescents with shame, and further understanding how shame in adolescents heals. Because few researchers have focused their studies of shame on this stage of development, this study may influence future research on shame an influence treatment of adolescents.

The method for this quantitative study was a cross-sectional survey design that is nomothetic in nature. A nomothetic approach seeks "law-like explanations for general phenomena from large sets of cross-linguistic data" and examines correlations between large-scale variables (Roberts & Winters, 2012, p. 90). This researcher's goal was to generalize the study to mental health clinicians practicing in New York State, which included social workers, mental health counselors, marriage and family therapists, creative arts therapists, psychologists, and psychiatrists. This researcher pulled out findings specific to social workers as a separate cohort for data analysis and compared to the other mental health practitioners. The study examined the role of the therapeutic relationship when a client presents with shame, with particular focus on adolescents. Online recruitment occurred via seven List Serves that were made up of a range of mental health clinicians, including social workers, mental health counselors, marriage and family therapists, creative arts therapists, psychologists, and psychiatrists. The List Serves included the Upper West Side Alliance List Serve, the Clinicians Collective List Serve, the Brooklyn and Beyond Mental Health List Serve, the Abundance Practice List Serve, the Private Practice Studio List Serve, the Smith School for Social Work Alumni New York Chapter, and the NASW New York State List Serve. The Upper West Side Alliance List Serve is made up of over 500 members. This group included a mixture of social workers, psychologists, and psychiatrists who practice in the state of New York. The Clinicians Collective List Serve is made up of 1000 clinicians with social work, psychology, and psychiatric degrees located in eight locations. This researcher utilized three out of these eight List Serve populations, which included New York City, Brooklyn, and Long Island, and excluded New Jersey, Westchester/Connecticut, Atlanta, Chicago, and Colorado. The Brooklyn and Beyond Mental Health List Serve has

1002 members; members range from LMSW's, LCSW's, LMHC's, MFT's, psychologists, and psychiatrists who practice in the state of New York. The Abundance Practice List Serve has 16,270 members all over the country, who range from LMSW's, LCSW's, psychologists, and various other mental health practitioners. 69 of these members practice in New York State. The Private Practice Studio List Serve includes 124 members. The group is a mixture of social workers, psychologists, learning specialists (Occupational Therapists, Speech Pathologists), psychiatrists, school specialists, licensed mental health counselors, and licensed marriage and family therapists. The majority of the members practiced in New York State, however some members practiced in New Jersey and Connecticut. The Smith School for Social Work Alumni New York Chapter consists of 26 members of LMSW or LCSW Smith College School for Social Work alumni who practice in New York State. Lastly, the New York State National Association of Social workers (NASW) Chapter List Serve is made up of 7,119 individuals who have a Master of Social Work (MSW) and practice in the state of New York.

This researcher was interested in reaching as many mental health clinicians in the New York State area. Inclusionary criteria included being a mental health clinician practicing in New York state, having previously or currently worked with adolescents in a clinical setting, having access to a computer with Internet, and the ability to read and write in English. Inclusionary criteria consisted of clinicians who are social workers, mental health counselors, marriage and family therapists, creative arts therapists, psychologists, and psychiatrists allowing this researcher to reach a wide sample. Information about the study was sent to the members of each of the seven List Serves, which explained the research study and inclusionary criteria. Participants who were eligible for the survey (determined by

answering yes to inclusion questions) signed an informed consent. risks and benefits of the study were clearly stated in the informed consent form and initial recruitment email so that each potential participant could determine if they felt comfortable filling out the survey. Before participants accessed the survey, they were asked to read the informed consent page and indicate that they agreed and consented to participate. The consent form stated that participation for this study is voluntary, and that responses would be collected anonymously. All of the survey data was encrypted and will be kept secured in a password protected file for three years according to Federal regulations, or kept until no longer needed at which point it will be destroyed. In the event that the data are needed beyond this point, it will be kept secured until no longer needed, and then destroyed. In order to encourage participation and engagement from participants, the researcher will share general findings from this research study with participants, including types of interventions used and the difficulties in treatment with participants.

The sampling methods were chosen as a way to reach as many mental health clinicians in New York state who treat adolescents in a clinical setting. This convenience sample was appropriate given the nature of the research. Limitations to the sampling methods included participants choosing whether or not to participate, leaving much unknown about those who do not respond to the invitations to participate. Additionally, this researcher only recruited participants in the New York State area, limiting results to a narrow geographic area.

Shame is a deeply painful affect that is threatening to the self (Lewis, 1971). One of the main tasks of adolescence is that of identity development. Erikson (1968) described how personality develops through eight life-span stages, each concerning the negotiation of a

normative, intrapsychic conflicts. Each stage builds on the last, and the stage of identity and diffusion is when an adolescent must integrate their experiences in order to form a stable sense of personal identity. In other words, they must distinguish their sense of self from their caregivers. Interestingly, there is currently very little known about the course of shame through adolescence, the main contexts associated with shame, and whether a vulnerability to shame predicts future experiences of shame as new domains become intertwined with the self-concept (Reimer, 1996). Individuals defend against the experience of shame through avoidance, suppression, aggression, anger, however major clinical consequences of this is the underlying shame that gives rise to psychopathology such as depression and anxiety. Reimer (1996) noted that many of the psychological problems that have been understood during adolescence have also been found to be associated with shame. Shame can be easily overlooked, avoided, or not attended to for a plethora of reasons. However, what remains even more so understudied is shame's insidious impact on the therapeutic relationship is critical to understand more deeply. This quantitative study will address what clinicians can tell us about the effective management and treatment of shame.

The first objective of this study was to learn more about the experience of shame in adolescents, a group that not been studied at great length. The second objective was to explore the role of the therapeutic relationship in shame treatment of adolescents. The third objective was to learn about mental health practitioners perspectives' about what they believed was most helpful in treating shame in adolescents, and therapeutic interventions with which they had utilized. The results from this study inform clinical social work about factors that can determine best practices for working with shame in adolescents in the therapy room. Additionally, including clinical social workers' perspective enriched the current

literature and provided further direction as to what might be needed to improve successful

clinical outcomes. The overall aim of this study was to understand the ways in which

clinicians treat adolescent shame. The study examined implications for adolescent

development, adolescent psychopathology, treatment implications, and direction for future

shame researchers.

In sum, this research study informs future clinically relevant research and social work

practitioners on the role of shame for adolescent clients, how this shapes the therapeutic

process, and what the impact of the therapeutic relationship and alliance is. The findings

from this study inform social workers about treating client shame in the adolescent stage of

development. Grounded in the NASW Code of Ethics, specifically competence, dignity and

worth of a person, and importance of human relationships, this study will act as direction for

future shame researchers. With respect to clinical social work practice, this study examined

the most dynamic ingredients in the therapeutic relationship, paving the way for shame

therapeutic processes and clinical interventions.

Chapter Two: The Study Problem

Shame is a universally experienced, but often neglected emotion, that has various

causes and manifestations. In adolescence, shame is a ubiquitous phenomenon, as this

developmental stage consists of several factors that can trigger feelings of shame. Therefore,

it is likely that shame is a fundamental factor in psychotherapy with adolescents, particularly

in relation to the establishment of the therapeutic relationship and healing. The

developmental period of adolescence is described in the literature as a period of "biological

explosion" of physical and physiological changes (Anastasopoulos, 2007, p. 109). According

to Kinnunen (2010), most mental health problems begin "between the ages of 12 and 24" (p.

111). In a study conducted in 1996, the U.S. Department of Health and Human Services

indicated that 20% of the adolescent population are experiencing mental health disorders at

any point in time. Accordingly, in 1996, at any given time, one in five adolescents were

experiencing mental health issues (U.S. Department of Health and Human Services, 1996).

Recent reports indicate that these numbers have increased dramatically in the general

population. According to the Substance Abuse and Mental Health Services Administration

(SAMSHA), a branch of the U.S. Department of Health and Human Services, 20%-30% of

adolescents have one major depressive episode before they reach adulthood, whereas 50%-

75% of individuals develop anxiety disorders during adolescence (Schwarz, 2009). More

recent statistics reflect that mental health issues are only rising in the United States; in 2019,

2.8% of adolescents ages 12-17 years reported having experienced a major depressive

episode in the last year; 31.5% reported feelings of sadness and hopelessness nearly every

day, and anxiety disorders which has very high rates of a 31% lifetime prevalence (Toscos et

al., 2019). These statistics demonstrate an alarmingly high rate of mental health issues in adolescents that have risen over the years.

Adolescent Development

Given that identity formation is the central developmental task that takes place in adolescence, teenagers are tasked with resolving the crisis of "identity versus role confusion" (Erikson, 1959/1980, p. 94). While Erikson's (1964) belief was that identity formation is a process that continues throughout one's life, "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). Having said that, it was essential to explore how shame uniquely interacts with the process of one's identity formation during the transition from childhood, adolescence, and young adulthood.

Historical Perspective of Shame

Shame has a long history of disparate references and theories, some which include evolutionary theories, psychoanalytic theories, cognitive theories, classical conditioning, and attachment theory. The historical precedents of shame indicate that shame is both an affective response and a defense. Affect, which is "a quantitative occurrence into the kind of qualitative experience we call feeling," is how shame is often experienced (Yard, 2014, p. 44). Carl Jung (1969) postulated that when the conscious and unconscious mind make contact with one another, an affect becomes triggered, which then generates a feeling. Defenses against shame may include projection, denial, and confabulation, as well as psychopathology (Yard, 2014). The root of the word shame can be traced back to the Indo-European word kam/kem which refers to "hiding," "concealing," and "covering up" (Karlsson & Sjoberg, 2009).

The pervasiveness of shame in premodern societies has been examined and encompasses a rich history (Stearns, 2019). Shame was presented in the Old Testament when "Adam and Eve, whilst in the Garden of Eden, noticed they were naked before God and felt shame for their actions" (Friel, 2016, p. 533). In Babylonia, shaming individuals as a way of punishing and regulating them was common. Additionally, "Babylonian law…reveals the power of the public slap, as a means of inducing shame: unwarranted slaps of high-ranking men might require payment of a fine, but in certain situations-for example, by a mother whose adult son was mistreating her—public slaps could promote better behavior" (Clark, 2019, p. 19). The role of shame in Greek and Chinese philosophy has seemingly received considerable attention. Socrates discussed shame through an educational lens; he felt that unyielding questioning could engender painful feelings, and tried to use the emotion to provoke students of his who he would have classroom debates with (Clark, 2019). Plato argued that shame could be linked to the experience a student might have after disagreeing with a figure of authority such as a teacher who induced respect. In other words, Plato "identified shame as a reaction to a gap between some individual behavior and shared ideals" (Clark, 2019, p. 20).

According to Yard (2014), the first Western definition of shame is found in Aristotle's *Nichomachean ethics* (1890). Aristotle (1890) defines shame as "a fear of disrepute. Its expression is similar to a fear of something terrifying" (p. 66). Aristotle argued that shame was fundamental to ethical behavior. Further, the Confucian idea of shame emphasizes the violation of boundaries in social relationships. Charles Darwin (1872) considered the evolution of shame in his well-known book, *The expression of the emotions in man and animals.* In his attempt to understand human emotions, Darwin (1872) explored

physical manifestations of experiencing shame such as blushing, eyes turning from side to side, and turning the entire body and head away "in some manner to hide. An ashamed person can hardly endure to meet the gaze of those present… there generally exists at the same time a strong wish to avoid the appearance of shame" (n.p.) Darwin (1872) considered the ways in which emotions are expressed in animals and found that blushing as a result of shame was uniquely linked to human beings. Having said that, the role of shame throughout human evolution was significant to understand and explore more deeply.

The physiological effects of shame have also been studied in depth. Koerner, Tsai and Simpson (2011) believe that emotion evolved as a rapid whole-body response, stating that the felt emotional experience of shame is a combination of physiology, perception, actions, and cognition that fire together. Further, they state that during evolution, "the challenges that our ancestors frequently encountered shaped neural circuits within the mammalian brain, wiring us for adaptive action to address triggering events" (Koerner et al., 2011, p. 92; Panksepp, 1998). In the work of Gilbert (2004; Gilbert & Irons, 2005; Gilbert & Procter, 2006), shame is proposed to be an emotional response that "yield[s] to the power, control, or demands of the other, inhibiting behavior that is unacceptable to them. We cast our eyes downward, our skin blushes or pales, we freeze. The felt sense of shame is one of vulnerability, of being looked at by others in a threatening manner. We typically feel contracted and small. Our action urge is to disappear, hide, or avoid notice" (Koerner et al., 2011, p. 94).

Psychoanalytic theories are generally concerned with the unconscious motivations of shame. In 1895, Sigmund Freud first wrote about shame in a letter to Wilhelm Fliess, *Draft K* (1895). In his letter, shame was suggested as a cause of repression of sexuality and was seen to function as a defense. Freud (1895) discussed how "self-reproach…transform[s] various

psychic processes into other affects such as anxiety, hypochondria, delusions of persecution, and shame" (Freud, 1895, p. 165). In another early psychoanalytic work, *Studies in Hysteria* (1895), Freud spoke about pathogenic beliefs that were at the root of neurosis. Freud (1985) suggested that "the ideas that are repressed and replaced by hysterical symptoms functioning as substitutive satisfactions…were all of a distressing nature, calculated to arouse the affects of shame, or self-reproach and a psychological pain, and the feeling of being harmed" (p. 251). Similarly, as suggested by Scheff (1994), shame is the "master emotion in that it determines whether other emotions will be felt and discharged or repressed" (p. 130). In 1896 in *Further remarks on the neuro-psychoses of defense*, Freud (1896) linked shame with self-conscientiousness. However, there remained an ambiguity in Freud's references to shame until *Three essays on sexuality* (1905), when shame was regarded as less of an affective experience and more of a defense against sexual drives. In Freud's paper *On narcissism* (1914), the concept of the ego-ideal is introduced. The concept involves ideal self-representations that existed in infancy that contained a sense of perfectionism. These self-representations are compared with what the infant ego actually has control over. According to VanDerHeid and Alexander (1995), "shame results from the failure to live up to the ideals created both through the later internalizations and identifications that compose the ego ideal as presented phenomenologically by the shape of an ideal self" (Mark & Incorvaia, 1995, p. 345). In other words, when we experience failures to live up to the expectations of our ideal self, Freud (1914) proposed that we experience shame. Freud did not continue to pursue this theory in his future work, however, ego psychologists Hartmann and Loewenstein (1962) discuss the ego ideal in further depth. They postulate that the ego ideal takes place within the

oedipal phase of development, and hypothesize that the ego ideal "becomes that toward which the ego strives" (VanDerHeide & Alexander, 1995, p. 346).

Self-psychology theorist Kohut (1966) relates shame to the frustration of one's narcissistic demands. Kohut's (1971) later work focused on "inadequately mirrored and neutralized grandiosity, which threatens the integrity of the self," as well as failed mirroring self-objects (p. 348). Morrison (1989) builds on Kohut's (1971) work, and proposes the ideal self as the internal representation of one's ideals of the self; a failure to manifest these results in the experience of shame. Morrison (1984) defined shame as "an affect reflecting a sense of failure or deficit of the self" (p. 502). Lanksy (1999) adds that:

> shame arises . . . from a vast array of psychopathological dispositions and human experience that involve awareness of failure to meet standards and ideals, from exposure as inadequate or deficient; from fantasied or actual denied or inferior status; and from awareness of oneself as dirty, inadequate, needy, empty, dependent, rageful, disappointing, shy, socially fearful or inept, humiliation prone, and the like. The spectrum of shame-related emotions and emotional situations, includes, in addition to shame itself, embarrassment, humiliation (the experience of shame as deliberately inflicted by another), inferiority, withdrawal, shyness, and social fearfulness; it also includes defenses against shame (pudeur), that is, the obverse of "shameless": modesty, humility, and related concepts. Shame can be seen as latently operative (p. 84).

Further, the interpersonal origin of shame introduced by Kaufman (1985) postulates the "fundamental human need for relationship," the mutuality of response, and the need to feel loved and wanted by another (p. 349). In summary, psychoanalytic literature posits that shame is created through early attachment relationships and interactions.

Kohut's (1977) self-psychological theory, which will be further expounded upon in this proposal, focuses on early childhood experiences of mirroring, empathy, and twinship. When a child is lacking in mirroring, empathy, twinship, and approval from their caregiver, an "internalization of sense of self as 'unattractive', worthless and with little value as a

person" may result, internal experiences which are commonly associated with shame (Gilbert & Gerlsma, 1999, p. 358). Overall, there is substantive evidence that connects early childhood attachment bonds to one's vulnerability to shame.

Lewis (1992) introduced a cognitive theory of shame called the attributional model of shame. This model suggests that in order for one to experience shame, they first must have a created set of standards and values that the individual will compare their successes and failures to. If the individual evaluates a failure of the self in meeting ones standards, they will experience shame. Lewis (1992) proposed that shame is elicited when the self-orients toward the self as a whole and involves an evaluation of the total self" (Lewis, 2003, p. 1198).

The theory of classical conditioning is prevalent to the experience of shameful behavior and thoughts as well (Johnson, 2006; Koerner et al., 2011). In classical conditioning, a conditioned response cannot be suppressed at will because it is involuntary. Therefore, a sequence becomes learned, i.e. understanding "that footsteps mean Mom is coming and comfort (being picked up, being fed) is coming. So in a few months, footsteps mean I can quit crying, quit protesting" (Johnson, 2006, p. 229-230). This same experience happens with shame. Painful responses result in shame, and through classical conditioning, the next time we are in a similar situation, we may be more likely to perceive cues of threat. Further, one's "own natural responses evoke a sense of… shame…even if there is nothing intrinsically unacceptable about our responses, and even if there are other contexts in which such responses would be acceptable. We become more likely to do what is required to reduce the threat of rejection" (Koerner et al., 2011, p. 95). When these patterns of shame become rigid and fixed, they have the ability to interfere with one's life tremendously.

Lastly, research has shown that early childhood attachment relationships significantly impact one's vulnerability to shame and psychopathology. The literature suggests that adverse experiences in childhood, including abuse, neglect, lack of affection, abandonment, rejection, and harsh parenting styles (Gilbert & Gerlsma, 1999; Matos & Pinto-Gouveia, 2014; Andrews 1998; Brown & Anderson, 1991; Bryer, Nelson, Miller & Kroll, 1987) lead to an activation of shame and affect maturation, functioning, mood, and stress in children. Lewis (1971) calls shame an "'attachment emotion' because it may be a reaction to the unexpected refusal of a parent, caretaker or important other to enter into connection (dyadic system) that would create an 'attachment bond'" (Yard, 2014, p. 44). Attachment theory (Bowlby, 1969) argues that "children have innate needs for reliable and available attachment figures" (Gilbert & Gerlsma, 1999, p. 358). This secure parent-child bond acts as a primary psychological regulator for children who are able to internalize the security of their caregiver(s) and openly engage and self-soothe. Bowlby (1969, 1973) suggested that "for normal emotional and social development to unfold, human infants need a secure relationship with their caregivers" (Matos & Pinto-Gouveia, 2014, p. 218). Further, one of the first shame theorists, Lewis (1971), suggested that "a rejection by a love[d] one…[is a] prototypic shame-inducing experience, since it is often construed as a global and uncontrollable rejection of the self" (Matos & Pinto-Gouveia, 2014, p. 222). Therefore, when a child feels loved and accepted by their attachment figures, their world feels safe and non-threatening. However, when a child does not have this secure-attachment to their caregiver, the world can be a very threatening and scary place.

Modern Day Perspectives of Shame

Research studies that have examined the correlation between shame and attachment figures discovered that "insecurely attached individuals and those with fearful and preoccupied attachment styles and attachment anxiety or avoidance reported higher shame levels, while secure attachment was found to be negatively associated with shame (Matos & Pinto-Gouveia, 2014, p. 218; Gross, & Hansen, 2000; Lopez, Gover, Leskela, Sauer, Schirmer, & Wyssmann, 1997; Wells, 1996; Wei, Shaffer, Young, & Zakalik, 2005)." Attachment relationships, then, are central to understanding shame experiences that adolescents have. The developmental pathway of shame is an understudied phenomenon as well. The theory of Object Relations, which is centered on the relationships with others, says that lifelong relationship skills are rooted to early attachments. Objects are people, parts of people, or physical objects that symbolically represent a person. Object relations as a function, involves "the ability to form and maintain coherent representations of others and of the self" (Schamess & Shilkret, 2008, p. 70-71). Therefore, a child acquires their sense of self through their interactions with significant others. Research shows that between 12 to 18 months of age, a child will be beginning to differentiate themselves from their caregiver. Lewis and Sullivan (2005) posit that shame can begin by 3 years of age, but state that the experience of shame is dependent on abilities that continue to develop well into adolescence.

Social work practice is based off of clinical theories that help us understand and explain phenomenon and practice decisions (Payne, 2014). A theory is an "organized statement of ideas about the world," and a practice theory is "seen as a device for transferring knowledge…[to] social work practice" (Payne, 2014, p. 5-7). While many social work theories build upon one another, psychodynamic ideas are historically an important source of many practices in social work; furthermore, "understanding psychodynamic theory is a

prerequisite to examining other social work theories, since its influence is pervasive" (Payne, 2014, p. 78). Specifically, self-psychology, object relations and attachment theory are leading schools of psychological thought discussed in social work pedagogy, and are applied by practitioners to a variety of social work populations. Additionally, Rasmussen and Mishna (2003) state that "psychodynamic social work usefully contributes…a focus on social context in which interpersonal relationships take place" (Payne, 2014, p. 78). Three core factors that Brearley (1991) discusses in psychodynamic social work include one's relationship between the self and significant others, between past and present, and between inner and outer reality (Payne, 2014).

The framework of social work is based on a set of values. Furthermore, the fundamental aim and mission of social work is "rooted in deep-seated beliefs…concerning the values of helping, aiding, and assisting people who experience problems in living" (Reamer, 2013, p. 11). As social work practitioners and researchers, we are committed to the six core values listed in our Code of Ethics. Specifically, social workers have an obligation to utilize sophisticated methods of intervention in order to best serve those in need, consistent with the NASW value of competence. There is limited information on ways to heal adolescent shame, and what the role of the therapeutic relationship is. Therefore, social workers have a professional and ethical commitment to more deeply understand shame in the adolescent population and the role of the therapeutic relationship, with the goal of understanding how to treat shame within the psychotherapeutic context. It is crucial that social workers inhabit deeper understanding for ways to treat adolescent shame in order to improve treatment results and better meet the needs of adolescent clients.

In attempting to develop an understanding of the etiology of shame, many researchers have described shame as the most painful of human emotions (Brown, 2006). Adolescence has been described by theorists over time as a pivotal developmental stage in which major tasks such as identity development/ formation and self-exploration take place (Erikson, 1964). Therefore, experiences of shame can occur early in life and have the potential of shaping one's sense of self and "becom[ing] central to one's identity and life story" (Pinto-Gouveia & Matos, 2011, p. 481). However, few researchers focused their studies of shame on this stage of development.

The terms therapeutic relationship and therapeutic alliance are often used interchangeably in the literature. What remained consistent in the literature is the importance of the development of a therapeutic alliance between client and therapist; many research studies suggest that the therapeutic relationship is the best predictor of outcome. The therapeutic alliance is "the trust between the patient and therapist that allows them to work together effectively. Trust is the basic ingredient" (Cabannis, 2011, p. 85). Understanding shame is clearly a relevant factor for individuals seeking mental health services. Despite its bearing, shame is not often overtly addressed during therapy (Dearing & Tangney, 2011). This study examined the role of the therapeutic relationship when treating shame in adolescents in clinical settings. "Therapeutic skills of containment, toleration, and empathy—without retaliation, contempt or retreat from the toxic shaming of regressed libidinal ego—create the safety net for successful treatment" (Yard, 2014, p. 48).

Macro Perspective of Shame

Shame is an emotion that is privately experienced; a person can feel ashamed, with all the anguish and pain discussed, even without an audience. However, it is critical that the

systems of social injustice contributing to shame be examined as well. In examining shame from a macro context, environmental factors, systemic racism, and female shame are examined.

Winnicott (1960) coined the term the "facilitating environment," which refers to a safe environment with a loving and nurturing caregiver. Such facilitating environments imply that a child can expect for their physical and emotional needs to be gratified. On the other hand, if a child does not have this dependability, confusion and doubt are likely to develop. These environmental factors may cause a child to wonder "whether one is inadequate, defective, or unlovable… contribut[ing] to a susceptibility to feeling shame" (Akhtar, 2016, p. 145). There are certain cultural and socioeconomic factors that must be considered here. Akhtar (2016) reflects on minority groups, specifically children of color in the United States, who are exposed to the social injustices of minority culture from a young age. Further, "members of racial and ethnic minority groups are forced to confront the implications of their racial identity every morning the minute they walk out the door, regarding the world with vigilance because their safety and well-being depends on it" (Akhtar, 2016, p. 141). Therefore, psychological issues arising from environmental deficits, family circumstances, and systemic racism were critical in this researcher's understanding of shame's multi-dimensionality.

Stearns (2019) reflects on slavery and lower-caste status, and states that historically, shaming has been "essential in setting boundaries" (p. 30). Teachers, for example, might "express their authority by shaming prisoners or students…in some cases, inequalities in premodern societies may have been so obvious, and well enforced, that shaming was less necessary as further discipline" (Stearns, 2019, p. 30). Further, contemporary studies of

shame frequently mention shames role in expressing and maintaining hierarchies. More broadly speaking, however, it is clear that racism is often expressed through actions and words that shame people.

When considering the specific systems of social injustice that contribute to shame, another common association of inferiority and shame proneness involves gender. Historically, women have been shamed for many reasons, some of which include the female body, sexuality, and behavior. Stearns (2019) states that "famously, women were supposed to be ashamed over some kinds of sexual transgressions that men could engage in more freely, and with far less expectation and often far less actual experience of shame" (p. 31). Furthermore, in Christianity and Islam, women were believed to be sinners more than men (Stearns, 2019). In Hinduism, a fascinating connection between gender and shame is expressed through the branch entitled Oriya Hinduism in the Orissa region (Stearns, 2019). A famous Hindu tale tells the story of the god Siva and his goddess Kali. After no man was able to subdue an evil god, Kali attempted and succeeded in killing the malevolent spirit. Siva was sent to "tame" Kali, but she was "so absorbed in her dance of destruction that she did not see him, and stepped on him. Realizing what she had done, she bit her tongue in shame…because she did something unforgivable [and] she [was feeling] shame" (Stearns, 2019, p. 31). The story concerns gender, a distinguishing physical expression of shame, and social order based on gender.

While the role of shame is well documented throughout human evolution and Western history, shame is an emotion that is rarely discussed in Western cultures outside of intellectual or academic circles (Tangney & Dearing, 2011). Brené Brown, a social work researcher, has become a public figure who speaks openly about shame in a TEDx talk that

has been viewed over 50 million times. In addition to publishing nine books and releasing her

Netflix special entitled "The Call to Courage," Brown has developed years of research on

shame, disseminating it in an accessible and relatable way. Brown explores shame's role in

current Western society; Brown explains that we live in a "culture of [perceived] scarcity,"

where we are invited to believe that we are never good enough- socially, economically,

physically, etc. Brown believes that these social forces fuel shame. Her research and analysis

of shame was relevant because for the first time in American history, shame, an emotion that

makes us feel defective and vulnerable, is meaningfully being engaged by Americans.

  In addition to this modern-day discussion of shame, Brown has written several

noteworthy scholarly works (Brown, 2007; 2009; 2010). Of these, her study of shame and

her establishment of the Shame Resilience Theory (SRT) (2006) established a new paradigm

in shame research. Through grounded theory, Brown conducted a qualitative study to explore

the components of shame in women. Within SRT, shame is defined as "an intensely painful

feeling or experience of believing we are flawed and therefore unworthy of acceptance and

belonging" (Brown, 2006, p. 45). 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. Soon

after, in 2006, Brown developed a curriculum to address shame in which she titled

Connections. Connections is a 12-session psychoeducational shame resilience curriculum

that has been facilitated around the United Stated with prevailing success. 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.

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).

Two articles utilize Brown's Shame Resilience Theory (SRT) (Hernandez &

Mendoza, 2011; Dayak, Weaver, & Domene, 2015). Hernandez & Mendoza (2011)

conducted a pilot study of Connections to assess if the use of the 12-week curriculum

anchored in shame resilience theory reduced women's shame. Participants were recruited

from residential substance abuse treatment programs in California. Six measures were

administered, including the Short Acculturation Scale for Hispanics (SASH; Marin et al.,

1987), the General Health Questionnaire–12 (GHQ–12; Vieweg & Hedlund, 1983), the

Center for Epidemiological Studies–Depression Scale (CES–D; Radloff, 1977), The

Internalized Shame Scale (ISS; Cook, 2001), The Perceived Stigma of Addiction Scale

(PSAS; Luoma et al., 2010), and the Test of Self-Conscious Affect, Version 3 (TOSCA–3S)

(Tangney & Dearing, 2002). Results showed that women had reduced levels of shame and

increased levels of self-esteem after participating in the 12-week curriculum. The researchers

believe that introducing individuals to Connections during the onset of substance abuse may be a complimentary intervention in addition to other treatment services. Furthermore, Hernandez & Mendoza (2011) believe that the curriculum "has the potential to address many of the concerns commonly observed among women in substance abuse treatment settings (e.g. appearance and body image, family, parenting, physical and mental health, surviving trauma; Brown, 2006)" (Hernandez & Mendoza, 2011, p. 388). Limitations of this study included the small sample size which limits the generalizability of the results. Secondly, the data required the use of a nonparametric test. Third, the sample was representative of Hispanic women who were considered to be highly acculturated, therefore, the findings do not represent women who are less acculturated. The study also excluded experiences of pregnant women or LBGTQ women. Lastly, the research did not include a comparison group which would have enhanced the results by discerning any disparities in types of curriculums offered to women.

Secondly, Dayal et al., (2015) conducted a narrative analysis approach to explore shame and eating disorders. Seven Canadian master's students enrolled in counseling psychology programs participated. Results were analyzed using Emden's (1998) core story creation. Participants disclosed various ways in which shame was tied to eating disorders, including issues related to "body image, control over eating, and failure in meeting professional, cultural, and societal standards" (Dayal et al., 2015, p. 162). The findings are consistent with Brown's (2006) research which describes shame as "an intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging" (Dayal et al., 2015, p. 162). Two major findings that contributed to the healing of shame in the adult participants included "connection with others (safety and belonging) and

connection with self (invalidating perfection and redefining ideas)" (Dayal et al., 2015, p. 157). These two findings suggest that Brown's Shame Resilience Theory (SRT) assists in the alleviation of shame related to eating issues. Limitations of this study include the qualitative nature and the small sample size.

Findings from both Hernandez & Mendoza (2011) and Dayal et al., (2015) support the use of Brown's Connections curriculum to help alleviate shame. However, there still remains a large hole in the research. Neither study examined the use of SRT in adolescent shame, as both studies examined adult populations. Therefore, the literature on the role of the therapeutic relationships in treating shame in adolescents is extremely limited.

This study will begin to add to the body of literature looking at shame in adolescents and the role of the therapeutic relationship in treating. Social workers are committed to a high level of professionalism as explained in our Code of Ethics. The ethical value of competence explains that social workers should frequently enhance their professional knowledge and skills. As a social worker, it is important to continue to strive to best serve clients and represent the profession. Social workers must be competent in their practices and also know when they do not have the knowledge base or skill set. The results from this study will provide support for clinicians who treat adolescents presenting with shame.

Chapter Three: Literature Review

Introduction

The general investigation of this literature review explored the psychotherapeutic treatment of shame in adolescents and the role of the therapeutic relationship in the treatment. After reviewing the systematic literature review, this section will explore five major themes from the literature. These themes included adaptive versus maladaptive shame, shame and mental health, styles of coping with shame, modalities of treating shame, and shame and the therapeutic relationship. Research relating to the role of shame in adolescents and the therapeutic relationship will be addressed. Additionally, gaps in research will be discussed. Lastly, contributions of this study to fill those gaps will be reviewed.

Methods

This researcher conducted a systematic literature review using the steps outlined by the Cochrane Collaboration on Effective Professional Practice Unit (CCEPP) (1996). A search was completed in the following four electronic databases: PsycInfo, ProQuest Central, PubMed, and Social Work Abstracts. The following search criteria for each database was used: (shame) AND (therapeutic relationship) AND (adolescence). When searching (shame) AND (therapeutic relationship) AND (adolescence), PsycInfo produced 5 results, ProQuest produced 2 results, PubMed produced 0 results, and Social Work Abstract produced 1 result. When substituting therapeutic relationship for therapeutic alliance, the search (shame) AND (therapeutic alliance) AND (adolescence) from PsycInfo produced 0 results, ProQuest produced 0 results, PubMed produced 4 results, and Social Work Abstract produced 0 results. This author also searched (shame) AND (therapeutic relationship), and found that PsycInfo produced 264 results, ProQuest results in 63 results, PubMed resulted in 178 results, and

Social Work Abstract resulted in 10 results; the researcher also substituted the word

therapeutic relationship for therapeutic alliance again, and found that when searching

(shame) AND (therapeutic alliance), PsycInfo produced 25 results, ProQuest produced 9

results, PubMed produced 9 results, and Social Work Abstract resulted in 2 results. Lastly,

this author used search terms (shame) AND (adolescence) in all three databases and found

that PsycInfo produced 185 results, ProQuest produced 78 results, PubMed produced 1326

results, and Social Work Abstract produced 15 results. Of the total articles, 44 were further

examined. Inclusion criteria included peer-reviewed articles where these key words

populated in the article's Abstract, aspects of psychopathology such as anxiety or depression,

and treatment modalities. Exclusion criteria included non-peer reviewed literature,

dissertations, articles in languages other than English, theoretical articles, and research

investigating the core differences between shame and guilt. The author identified significant

replication of articles in the four databases. Based on these exclusion criteria, only 24 peer-

reviewed articles were selected for further examination. It is noteworthy that very few

articles populated through the Social Work Abstract Database on this topic that met this

researcher's inclusion criteria. It can be hypothesized, then, that there is a significant dearth

of literature on this topic in social work databases.

Results

The following literature review will use the phrases "therapeutic relationship" or

"therapeutic alliance" as umbrella terms to refer to the relationship between client and

therapist, but will use specific terms where possible. This literature review has been

organized by themes that emerged in the literature. Of the 24 research studies analyzed in the

systematic review, 12 explored shame in adolescents where 14 examined shame in adult

populations. The majority of recent findings related to the phenomenon of shame has been studied in adult populations. Therefore, there is a gap in the literature that examines the variations of shame with respect to adolescents. The themes that will be further examined include adaptive shame versus maladaptive shame, shame and mental health, styles of coping with shame, modalities of treating shame, and shame and the therapeutic relationship.

Shame Experience in Adolescence: Adaptive and Maladaptive

Shame is typically portrayed as an excruciating human emotion that is the root of psychological disruption. However, in certain circumstances, shame has been recognized to be both adaptive and functional. While much of the literature discusses shame as a painful emotion that tends to stay concealed, shame is also essential for socio-emotional development, empathy towards others, prosocial behavior, and lower levels of aggression (Szentágotai-Tătar & Miu, 2016; De France et al., 2017). Further, Bradshaw (2005) discusses healthy shame as a way of getting one's basic needs met and states that healthy shame reminds us of our limitations, playing a role in regulation and facilitating the process of social development (Friel, 2016). Shame can also predict prosocial behavior and motivation for self-change. The research notes that "occasional short-lived states of shame are adaptive, helping to protect social relationships by eliciting an image of disapproval or rejection and motivated efforts to avoid rejection" (Mills et al., 2015, p. 195). Tangney & Dearing (2011) refer to this as primary adaptive shame, which is a "direct, initial, rapid reaction to a situation…informing us that we are too exposed" (p. 398). In group situations, feelings of shame can alert us that our behavior is offending, signaling us to correct them "in order to reduce the threat of rejection" (Tangney & Dearing, 2011, p. 398). Additionally, Auchincloss and Samberg (2012) discuss the ways in which mild shame reactions that are experienced are

self-consciousness may foster self-awareness. This may serve to regulate one's behavior,

leading to discretion and a cognizance of others. Further, Auchincloss & Samberg (2012)

state that "in this sense, shame preserves ideals and values that are specific not only for the

individual but also for the culture" (p. 245). Therefore, while much of the literature on shame

is noted as a self-conscious emotion, shame has also been linked to moral and social

transgressions (Muris, et al., 2016).

Moreover, Tangney & Dearing (2011) believe that shame is a relatively primitive

emotion that "serve[s] adaptive 'appeasement' functions in the distant past among ancestors

whose cognitive processes were less sophisticated and in the context of much simpler

societies" (p. 399). Interestingly, this theory grows out of a sociobiological approach

(Gilbert, 1997) that discusses the function of shame through an evolutionary lens. This lens

theorizes that shame decreases intragroup aggression in contexts where the possibility of

violence is high (Tangney & Dearing, 2011).

On the other hand, when shame is easily invoked and can become a dominant

emotional experience, it can lead to maladaptive behaviors and toxic shame (Carvalho, et al.,

2015; Friel, 2016). Shame has been associated with social rejection, withdrawal, low self-

esteem, and psychopathology included depression and anxiety (De France et al., 2017).

Furthermore, the continual experience of shame reinforces feelings of devaluation and

rejection of others, strengthening and exacerbating one's distress (Mills et al., 2015).

Shame is considered an emotion that is difficult to regulate. Suppression is a common

maladaptive emotion regulation strategy that for shame that may lead to both internalizing

and externalizing behaviors (Velotti et al., 2017). Internalizing psychological symptoms

include psychological distress, while externalizing psychological symptoms might include

aggression and rage. Therefore, shame is associated with maladaptive coping strategies, which also has associations to internalizing and externalizing psychological symptoms (Velotti et al., 2017). Other maladaptive emotion regulation strategies Velotti et al., (2017) explored ($n = 380$) include rumination, dissociation, anger, substance abuse, and withdrawal (Velotti et al., 2017). This study will help clinicians delineate when shame in adolescents is maladaptive.

Shame, Adolescence, and Mental Health: Depression, Anxiety, and Trauma

Consistent in the literature was the idea that shame is a central source of mental health difficulties, including depression, anxiety, trauma, low self-esteem, narcissism, post-traumatic stress disorder, personality disorders, and substance abuse (Reimer, 1996; Friel, 2016; Kinnunen, 2010; Leeming and Boyle, 2013; Matos and Pinto-Gouveia, 2010; Matos and Pinto Gouveia, 2014; Carvalho et al., 2015; Mills et al., 2015; Zhang et al., 2018; Muris et al., 2016; Muris, Meesters, and Asseldonk, 2018). During the adolescent stage of development, the literature supports a strong association between psychopathology and adolescence. Adolescence is a period of character formation and identity development, and is worthy of treatment and further study given the potential deficits in the literature around implications of adolescent shame. By enriching one's understanding of the treatment of adolescents with shame, one can better understand what helps heal in the therapeutic relationship. The articles reviewed in this systematic literature review reflected a strong association to shame and depression, anxiety, and trauma, which will be further expounded upon.

Psychopathology: Depression

Shame has been posited to play a particularly important role in the psychopathological symptoms and diagnosis of depression (Matos & Pinto-Gouveia, 2010; Matos & Pinto-Gouveia, 2014; Simonds et al., 2016; Mills et al., 2015; De Rubeis & Hollenstein, 2009). Of the five articles that focus on the correlation between depression and shame, only three included samples of adolescents (Simonds et al., 2016; Mills et al., 2015; De Rubeis & Hollenstein, 2009). Clinical samples made up of adult participants were utilized in two of the five studies (Matos & Pinto-Gouveia, 2010; Matos & Pinto-Gouevia, 2014).

The literature emphasized the key role shame plays in human functioning and its powerful impact in a wide range of psychological symptoms, intrapersonal problems, and interpersonal problems (Matos & Pinto-Gouveia, 2010). There has been a particular focus on the importance between shame and depression in adult populations, and less of a documented focus on adolescents. Using 811 participants, Matos & Pinto-Gouveia (2010) examined the role of shame as traumatic memory that results in depressive symptoms. Research has shown that shame has "trauma-like origins in early negative rearing experiences, namely experiences of shaming, abandonment, rejection, emotional negligence or emotional control, and several forms of abusive, critical…parenting" (Matos & Pinto-Gouveia, 2010, p. 301). Having said that, the correlation between shame stored as traumatic memory and psychological symptoms has been a well-documented phenomenon. Self-report questionnaires including the Experience of Shame Scale (ESS) (Andrews & Hunter, 1997), the Depression, Anxiety and Stress Scales (DASS-42) (Lovibond & Lovibond, 1995; translation and adaptation: Pais-Ribeiro, Honrado, & Leal, 2004), and the Impact of Event Scale-Revised (IES-R) (Weiss & Marmar, 1997) were utilized to understand the traumatic nature of shame and its psychological implications. The study found significant correlations

between shame and depression which was consistent with prior studies. In line with

hypotheses, results showed that individuals whose shame memories included traumatic

characteristics reported higher levels of depression. Traumatic characteristics included

"intrusions, flashbacks, strong emotional avoidance, hyper arousal, fragmented states of mind

and dissociation" (Matos & Pinto-Gouveia, 2010, p. 301; Ehlers & Clark, 2000; Gilbert,

2002; Gilbert & Irons, 2005; Gilbert & Procter, 2006; Hackmann, Ehlers, Speckens, & Clark,

2004). Having said that, results emphasized that when shame is recorded in one's memory as

a trauma, one becomes more vulnerable to experiencing a depressive disorder. Furthermore,

consistent with prior studies, results showed a correlation between both internal and external

shame and depression. This study further emphasizes the central role of early shame

experiences, which is referred to as the "shame genesis" (Matos & Pinto-Gouveia, 2010, p.

308). Clinical implications suggest that shame memories function as a central role in

understanding the psychopathology of one's depression. While this study did not examine

adolescents, Matos & Pinto-Gouveia's (2010) research was duplicated several times in the

systematic review and is thus an important study to read.

It is important to differentiate internal shame from external shame, which was a key

result in Matos & Pinto-Gouveia's (2010) study. Matos & Pinto-Gouveia (2014) state that

internal shame is "linked to complex memory systems" such as previous shame episodes,

"and to negative self-evaluations and feelings" (Matos & Pinto-Gouveia, 2014, p. 220;

Kaufman, 1989; Matos & Pinto-Gouveia, 2010; Matos, Pinto-Gouveia, & Gilbert,

2013;Tracy & Robins, 2004; Balwin, 1997). External shame is "related to how one

experiences oneself as living in the minds of others (i.e. as inferior inadequate, worthless,

bad)" (Matos & Pinto-Gouveia, 2014, p. 220). In external shame, the world is unforgiving

and risky. Shame, both externally and internally focused, has been associated with increased vulnerabilities to psychopathology, namely depressive symptoms.

Matos & Pinto-Gouveia (2014) further discuss the correlation between shame memories involving attachment figures and the internalization of shame. A convenience sample of 230 participants was collected from the general population in four cities in Portugal and six instruments were utilized. These included Shame Experiences Interview (SEI) (Matos & Pinto-Gouveia, 2006), the Impact of Event Scale-Revised (IES-R) (Weiss & Marmar, 1997), the Centrality of Event Scale (CES) (Berntsen & Rubin, 2006; Portuguese version by Matos, Pinto-Gouveia, & Gomes, 2010), Other As Shamer Scale (OAS) (Allan, Gilbert, & Goss, 1994; Goss, Gilbert, & Allan, 1994); Portuguese version by Matos et al., (2012), the Internalized Shame Scale (ISS) (Cook (1994, 2001); Portuguese version by Matos et al., (2012) and the Depression, Anxiety and Stress Scale (DASS-42) (Lovibond & Lovibond, 1995); Portuguese version by Pais-Ribeiro, Honrado & Leal, 2004). Findings form the study suggest that when individuals undergo early shame experiences from an attachment figure, "one comes to see the self the same way others have, as flawed, worthless, rejectable" (Matos & Pinto-Gouveia, 2014, p. 235). Results from this study are consistent with the biopsychosocial model of shame (Gilbert, 1998) and the literature on attachment between caregiver and child. The literature suggests that a lack of mirroring from caregiver to child can also lead to an internalization of being "bad" and "worthless," feelings that are associated with shame (Gilbert & Gerlsma, 1999). Further, "early shaming interactions with attachment figures, where one as experienced the self as undesirable, flawed, worthless in their eyes, might be internalized and become the basis for negative self-relevant beliefs and key to self-identity" (Matos & Pinto-Gouveia, 2014, p. 235).

In an attempt to expand upon previous findings (Matos & Pinto-Gouveia, 2010), Matos & Pinto-Gouveia (2014) confirmed the importance of disruptions in attachment relationships in shame dynamics. The results from both studies provide considerable evidence that there is a strong correlation between early negative experiences and depression (Matos & Pinto-Gouveia, 2010; 2014). Matos & Pinto-Gouveia (2010; 2014) enhance the understanding of shame experiences, "highlighting the importance of shame interactions with attachment figures in how shame memories come to be structured as traumatic and key memories to one's identity and life story and influence vulnerability to psychopathological symptoms" (Matos & Pinto-Gouveia, 2014, p. 238).

The results from these studies are in line with Bowlby's (1969) attachment theory, as well as Gilbert's (2009) affect regulation perspective. In light of attachment theory (Bowlby, 1969), shame memories "where the self was shamed by a loved one (father, mother), where the self was felt as flawed, worthless, unlovable in the eyes of the attachment figure," are internalized as a denunciation of the self (Matos & Pinto-Gouveia, 2014, p. 237). A "negative working model of the self (e.g. as worthless, unlovable) and others (e.g. as threatening, critical, hostile)" is developed and stored in one's memory as autobiographical knowledge of the self as "bad" (Matos & Pinto-Gouveia, 2014, p. 237). These memories can operate consciously and unconsciously and activate depressive symptoms (Matos & Pinto-Gouveia, 2010; 2014). Gilbert's (2009) affect regulation perspective suggests that experiences of shame, neglect or abuse may overstimulate brain pathways that trigger one's threat system, a physiological reaction that occurs in response to a perceived threat and activates the fight, flight, freeze response. If the threat system is more easily activated, Gilbert (2009) suggests that "negative affect and defensive behaviors (e.g. depressive symptoms)" may occur, as well

as a possible "under stimulation of the affiliative-soothing system, responsible for feelings of safeness and connectedness, with limited articulation of interpersonal schema of self, as lovable and worthy, and others, as soothing and reassuring" (Matos & Pinto-Gouveia, 2014, p. 237). Therefore, this theory suggests that the physiological response of the threat system engenders difficulty self-soothing and emotionally regulating oneself, as one's "early experiences…of shame was also the source of attachment… [which may be a] conditioned emotional memories where the need for care and soothing becomes associated with sadness, grief, yearning or threat (Gilbert, 2009b). These memories are then associated with shame and may trigger depression. Limitations to both studies include the transversal nature of the studies which limits causality between variables and the adult population studied, which is not representative of this researcher's population.

While there is strong empirical support for the link between shame and depression, exploration of these associations with an adolescent sample has been explored minimally. Three studies found in the systematic review had samples consisting of adolescents (Simonds et al., 2016; Mills et al., 2015; De Rubeis & Hollenstein, 2009). It is noteworthy that in a study that followed the trajectory of self-conscious emotions across the life span, it was reported that shame was greater in adolescence and decreased in adulthood (Orth, Robins & Soto, 2010). Furthermore, shame has been linked to poorer mental health, such as depression, in youth (Reimer, 1996; Rubeis & Hollenstein, 2009) and shaming experiences have been found to play a crucial role in adolescents' health and well-being (Äslund, Nilsson, Starrin, & Sjöberg, 2007; Reimer, 1996). Nevertheless, the research on shame in adolescence and depression is scarce.

In a study conducted by Simonds et al., (2016), adolescents ages 11-18 ($n = 12$) utilized the Adolescent Shame-Proneness Scale (ASPS) which assessed adolescents' perception of shame, the kinds of situations that provoke shame, and how they think and feel when they experience shame. Results showed that participants linked shame with feeling as though a part of the self was being exposed. Common shame-provoking situations were related to aspects of performing poorly or letting others down, negative appearance or social status, and memories of bullying experiences. Common shame-related thoughts included wanting to escape, negatively evaluating oneself, and feeling regret and disappointment. Common shame-related feelings included feeling "bad," worthless, and embarrassed, while shame-related behaviors included a desire to hide, project a "false self," crying, and getting angry (Simonds et al., 2016, p. 552). A theme in this study was a sense of personal condemnation in participants; "the experience of being negatively evaluated by others and the idea that it would be better to disappear" (Simonds et al., 2016, p. 553). Results revealed that adolescents can readily generate shame-related situations. Most situations involved becoming an undesirable person through one's own performance or conduct. The study suggested a correlation between shame and low self-esteem, depression, and a vulnerability to social criticism and rejection (Simonds et al., 2016). The limitations of this study are regarding the self-reported nature of the findings, as participants self-rated relevant shaming situations they had experienced personally. Having said that, reliability and validity should be tested, and results are not generalizable.

Another theme in the literature was the discussion of internalization as a result shame and depression (Mills et al., 2015; Matos & Pinto-Gouveia, 2014). Mills et al., (2015) states that internalizing problems and taking them in as "bad" is the most common way of coping

with emotional difficulties. Mills et al., (2015) examined the relationship between internalization and subsequent mental health disorders in adolescents (n= 174). The study examined whether negative self-beliefs and emotions predicted worsening internalization. Results showed that shame was significantly correlated to depression in adolescents. In general, the findings suggest that both shame and depression contribute to the development of children's internalizing problems. These findings are consistent with other studies which suggest that adolescents who were prone to experiencing shame were more likely to engage in depressogenic thinking.

Building off of Mills et al., (2015) discussion of internalization, Cunha et al., (2012) examines the ways in which shame memories become internalized and stored in one's memory, leading to feelings of unworthiness, sadness, and depression. The study ($n = 354$) examined shame traumatic memory and centrality of shame memory: shame traumatic memory refers to shame experiences that occurred early in one's life that result in threats to the individuals sense of themselves and their identity; centrality of shame memory refers to a central memory that an adolescent demarcates as central to their identity (Cunha, et al., 2012). Results showed that shame memories that had been internalized as "central to personal identity and life story" generated depression (Cunha, et al., 2012, p. 212). Methodological limitations of this study include the cross-sectional design of the study, which limits the study's causality. Additionally, the study utilized self-reported data to assess shame memories.

Lastly, De Rubeis & Hollenstein (2009) conducted a quantitative, cross-sectional study that sampled adolescents ($n = 46$) via an online questionnaire and measured shame, depression, and coping styles. One year later, participants completed the same questionnaire.

Shame was a significant predictor of depressive symptoms, "accounting for 30% of the variance" in depressive symptoms (De Rubeis & Hollenstein, 2009, p. 479). Results showed that shame was stable over the course of one year. Limitations of the study include the cross-sectional design, the small sample size, and the exploratory nature of the analysis which limits the conclusiveness of the results.

Overall, these three studies suggest that there is a strong correlation between shame and depression in adolescents, yet remarkably little research has been conducted in this area to more deeply strengthen this correlation (Simonds et al., 2016; Mills et al., 2015; De Rubeis & Hollenstein, 2009). The pathogenic nature of depression and shame has been mostly conducted in adult samples (Cunha, et al., 2012). Adolescence is marked by major developmental changes, such as "identity formation, establishing friendships, group identification, [and] emotional independence," but which can also be experienced as a period of vulnerability (Cunha et al., 2012, p. 212). Therefore, replication of these studies with adolescent populations would be useful.

Psychopathology: Anxiety

The developmental stage of adolescence is also marked by the significant rise of anxiety. Numerous studies account for shame's association with anxiety, but again, few are conducted in adolescent samples. Three articles explored this phenomenon, all of which were cross-sectional in nature and included a sample of adolescents (Cunha, Matos, Faria & Zagalo, 2012; Muris et al., 2016; Muris et al., 2018). Cunha et al., (2012) examined 354 adolescents via path analysis and confirmed that shame traumatic memory is associated with anxiety symptoms (Matos & Pinto-Gouveia, 2010; 2014). Findings from this study emphasize the developmental changes taking place in adolescence, marked by the formation

of an autonomous self-identity. Results postulate that the early influences of shame challenge the development of an adolescent's self-identity and thus provoke feelings of anxiety (Cunha et al., 2012).

Muris et al., (2016) examined the relationship between self-conscious emotions and psychopathology ($n = 1000$). Consistent with previous research that links psychopathology in adolescents with dysregulations in self-conscious emotions, results showed that there was a positive association found between shame, anxiety and depression. Growing off of this research, Muris et al., (2018) explored the relationship between shame, personality traits, and anxiety disorder symptoms in non-clinical adolescents ages 12-15 ($n = 118$). Results showed that shame is positively associated with a "broad range of anxiety disorders," including social anxiety disorder, generalized anxiety disorder, and phobic disorders (p. 269). These results add to the growing body of evidence indicating that high levels of shame are clearly associated with anxiety pathology (Muris et al., 2018).

These studies support the idea that shame plays a significant role in anxiety pathology. Limitations of these three studies include their cross-sectional design, limiting causality and the use of self-report data to assess shame memories. Additionally, Cunha et al., (2018) studied a fairly small sample size that lacked in racial diversity and thus, non-generalizable results (Cunha, Matos, Faria & Zagalo 2012; Muris et al., 2016; Muris et al., 2018; 2016). Additionally, further research on the exact role of shame in the etiology of anxiety disorders is necessary.

Psychopathology: Trauma

Several studies also suggest that shame memories with attachment figures function as traumatic memories, magnifying shames impact on psychopathology. Four studies examined

this phenomenon in depth (Cunha et al., 2012; Carvalho et al., 2015; Matos & Pinto-Gouveia 2010; Matos & Pinto-Gouveia 2014), however only one study examined a population made up of adolescents (Cunha et al., 2012).

In a quantitative study that examined the impact of shame memories on psychopathology in adolescents, 354 adolescents participated in self-report questionnaires that measured shame, traumatic memory, centrality of shame, depression and anxiety (Cunha et al., 2012). Consistent with prior research (Matos & Pinto-Gouveia, 2010; 2014), adolescents whose early shame memories operated as traumatic memories, "eliciting intrusions [such as] hyper arousal and avoidance symptoms, and who regard these shame events as key to personal identity…tend to develop a sense of self as exiting negatively in the eyes of others (i.e. external shame) and in their own eyes (i.e. internal shame)" (Cunha et al., 2012, p. 212). This study was correlational and cross-sectional in nature, which does not allow for generalizability (Cunha et al., 2012; Szentágotai-Tătar & Miu, 2016). Also, both studies relied on self-reports from their samples. Future studies would benefit from utilized interview measure of childhood trauma to examine its impact on shame.

Carvalho et al., (2015) examined the relationship between shame experiences and depression by examining the caregiver/attachment figures role in the self-reported shame experience ($n = 161$). The recall of shame experiences with caregiver or attachment figures has also been associated with early shaming experiences becoming a part of one's autobiographical memories. Carvalho et al., (2015) defines autobiographical memory as the remembrance of emotional experiences that are recorded as a narrative that is told to oneself, and typically involves intense, negative, or trauma-related memories. Therefore, Carvalho et al., (2015) links child-rearing and attachment between child and caregiver as being central to

the formation of beliefs about the self. It has been suggested that "persistent, criticism, shaming, and put-down experiences with caregivers might lead to an internalization of the self as flawed, inferior, rejectable, inadequate, and worthless" (Carvalho et al., 2015, p. 33). In accordance with previous studies, results showed that individuals whose shame experiences were stored as autobiographical memories central to their life story and identity experienced more depression symptoms. Further, individuals who coped with their autobiographical memories of shame by avoidance presented with more depressive symptoms. While avoidance might provide a short-term relief of unwanted emotional experiences, the attempts to control or reduce this expression is counterproductive and leads to an increase in the experience.

Matos & Pinto-Gouveia (2010) conducted a quantitative study utilizing self-report questionnaires that assessed shame and traumatic memories. Early childhood experiences of shaming included abandonment, emotional abuse, and parental styles that were chiefly critical and emotionally neglectful. The study examined early shame experiences from childhood to adolescence, and investigated the relationship between shame and trauma. Findings from the study suggest that memories of shame from childhood are stored as autobiographical traumatic memories. These memories interfere with relationships, where individuals believe that others view them as inadequate, "bad" and "undesirable" (Matos & Pinto-Gouveia, 2010, p. 307). The study also found a correlation between shame and psychopathology. While the study was interested in the relationship between shame and depression, findings also suggested a connection between "avoidance, hyperarousal, depression, anxiety, and stress" (Matos & Pinto-Gouveia, 2010, p. 307). Findings from this study emphasize the importance of assessing for the presence of shame in childhood.

Specifically, the researchers encourage therapists to be able to recognize shame in clients early on in the treatment; the researchers do not expound on this idea, leaving the reader with little guidance as to how to recognize and attune oneself to shame.

In a similar study conducted by Matos & Pinto-Gouveia (2014), individuals recalled shame experiences where the autobiographical memory of the self is shamed by a caregiver; depression tended to be higher than other individuals who reveal shame memories without the presence of a caregiver. The findings from this study expanded on previous work of Matos & Pinto-Gouveia (2010), which suggested that "early negative interactions in form of devaluation, abuse, rejection, neglect or abandonment, particularly those that unfold within the attachment bond, elevate vulnerability to psychopathology, specifically to depression" (Matos & Pinto-Gouveia, 2010; Pinto-Gouveia & Matos, 2011, p. 236).

One theme in the research amongst both adolescent and adult populations includes the reference to autobiographical memories of shame with attachment figures that operate as central identity markers, central to their life story (Carvalho et al., 2015; Cunha et al., 2012). Carvalho et al., (2015) hypothesizes that when shame experiences become so central to one's identity, they become "representative of recurrent themes in one's life story, thus serving as reference points for everyday inferences" (p. 40). Because these shame experiences that take place in childhood with attachment figures can be an "anchor to everyday inferences (Berntsen & Rubin, 2006, 2007; Pinto-Gouveia & Matos, 2010), this means that a present event unrelated to those early shame experiences can elicit the same emotional experience, leading to regular attempts of controlling the form, frequency and context in which these emotional experiences associated with shaming memories occur" (Carvalho, 2015, p. 40). It can be assumed, then, that the process of eliciting these shame reactions and experiences in

different interpersonal contexts is a consequence of avoiding shame. A common thread in the literature was autobiographical memories of shame with attachment figures operating as central to one's experience of oneself.

Styles of Coping with Shame

A key aspect of shame and psychopathology is the ability to cope with life events, which is often described in the literature as a "coping strategy" (Kinnunen et al., 2010, p. 112). Further, the term entitled "the coping self," refers to one's "self-assessed feelings of coping and success in close relationships (mastery); their subjective experience of psychology health (emotional health); and their adaptation to themselves, others, and their environment (superior adjustment)" (Kinnunen et al., 2010, p. 112). Because adolescence is a developmental period in which individuals develop coping strategies and improve their ability to manage personal conflicts, it is important to examine the ways in which adolescents cope with shame.

Seven studies examined the role of coping with shame in relationships (Szentágotai-Tătar & Miu, 2016; Yelsma, Brown & Elison, 2003; Black, Curran, & Dyer, 2013; Thomaes et al., 2008; Thomaes et al., 2011; Velotti et al., 2017; Zhang et al., 2018), however, only three of these studies examined adolescent shame and coping (Szentágotai-Tătar & Miu, 2016; Thomaes et al., 2008; Thomaes et al., 2011), while four studies analyzed adult styles of coping with shame (Yelsma, Brown & Elison, 2003; Black, Curran, & Dyer, 2013; Velotti et al., 2017; Zhang et al., 2018). The following literature outlines the various ways of coping with shame, which include both adaptive and maladaptive ways of coping. An adaptive method of coping with shame included self-compassion and resilience; common maladaptive

coping styles for dealing with shame in adolescence included withdrawal, aggression, and anger.

Szentágotai-Tătar & Miu (2016) conducted a research study ($n = 706$) that aimed to identify the ways in which adolescents ages 13-18 identify childhood trauma and emotion regulation. Strategies that were associated with shame included both adaptive and maladaptive strategies; adaptive emotion regulation strategies included refocusing on planning and positive appraisal, while maladaptive emotion regulation strategies included catastrophizing, rumination, and self-blaming. Results showed that maladaptive strategies of coping with shame were associated with higher levels of depression and anxiety symptoms, and were related to shame-proneness. The study suggests that clinicians should aim to address maladaptive emotion regulation strategies in therapy. The researchers do not go in to depth about the ways in which therapist can reduce shame in adolescents, or how to optimize therapy sessions to address maladaptive strategies.

Throughout the literature, Nathanson's (1992) Compass of Shame Theory was referenced which is made up of four distinct poles that represent how individuals react to shame (Yelsma, Brown & Elison, 2003; Black, Curran & Dyer, 2013). These four poles or coping styles include attacking the self, attacking others, withdrawing, or avoiding (Nathanson, 1992). "Attacking the self" is thought of as anger and self-blame that is turned inward and projected onto the self, where "attacking others" is the opposite- externalizing anger or blame on to others. The shame coping style, "withdrawal" is characterized by avoidance, hiding, and pulling away from others, and "avoiding" involves a rejection or denial of the shame experience as a way to distract oneself from the painful feelings they are having. The coping style that had the most negative impact on the therapeutic relationship

with the style of withdrawal. The study ($n = 50$) revealed that these individuals experience themselves as helpless, and have the tendency to hide their shameful feelings from the therapist, remaining detached from the therapeutic relationship. Interestingly, the withdrawal coping style also showed negative satisfaction in in intimate relationships (27%-29%), versus the therapeutic relationship (11%). This explains that individuals who experience shame and withdraw have negative experiences in their intimate relationships. This study suggests that individuals who experience shame are not only more likely to experience anxiety, depression, and negative core beliefs about the self, but are prone to struggle in interpersonal relationships, too. The researchers speculate about the role of shame in the therapeutic relationship by examining the ways in which shame coping styles impact the therapeutic relationship as well as intimate relationships (Black, Curran, & Dyer, 2013).

Aggression was another way of dealing with shame that was present in adolescents. Thomaes et al., (2008) describes three common ways that shame prone individuals cope ($n = 163$): withdrawing, blaming others, and behaving aggressively. Adolescents who resort to deflection as a means of coping are less motivated in the future to process and overcome them. Thus, adolescents are also less familiarized to the demands of their environment. The empirical literature points to aggression as an "appealing behavioral alternative to shamed individuals because it serves an ego-protective function" (Thomaes et al., 2008, p. 1798). Aggression is a compelling outlet for shame in the short-term, however, in the long run, does not provide any relief or resolution from the pain of shame. Aggression, while tempting, also has many consequences. Aggressive adolescents may struggle in peer groups. In summary, while "aggressive behaviors meant to discard shame in the short run may ironically increase

children's liability to be the target of victimization in the long run" (Thomaes et al., 2008, p. 1798).

In addition, Thomaes et al., (2011) explores shameful events triggering an anger response. The term "humiliated fury" (Lansky, 1987; Lewis, 1971; Lewis, 1992; Scheff & Retzinger, 1991) is introduced, which "implicates that unflattering social events that typically elicit shame may also initiate anger and fury" (Thomaes et al., 2011, p. 786). Results from this study showed that shameful events cause children and adolescents to feel anger. Consistent with Thomaes et al., (2008) conclusion that aggression may be tempting response and coping style to shame due to its ego-protectiveness, Thomaes et al., (2011) states that anger functions as a way to "downplay ego-threatening feelings of shame and to protect fragile self-esteem" (p. 791). Similarly, Kinnunen et al., (2010) reported that the avoidant coping style correlates with depressive symptoms. Both Thomaes et al., (2008; 2011) utilized the Childhood Narcissism Scale, a measurement that examines feelings of superiority and entitlement in adolescents (Thomaes et al., 2011; Stegge, et al., 2008).

In Velotti et als., (2017) review, suppression is discussed similarly to Thomaes et als., (2011) withdrawal coping strategy. Velotti et al., (2017) examined expressive suppression, which involves an attempt to "inhibit or reduce the outward expression of an ongoing emotional experience (i.e., not showing the emotion that one is feeling)" (Velotti et al., 2017, p. 173). The study found that shame was related to emotional suppression, and indicated that participants who were more prone to shame may tend to adopt maladaptive emotion regulation strategies.

Zhang et al., (2018) introduced self-compassion and resilience as adaptive ways of coping with adolescent shame ($n = 109$). Consistent with shame being a relevant predictor of

depression, Zhang et als., (2018) study hypothesized that self-compassion mediates a link between shame and depressive symptoms. Utilizing what is referred to as resilience theory, Zhang et al., (2018) argues that resilience factors are necessary for working through one's shame. Specifically, self-compassion and self-worth are associated with decreased psychopathology and a greater sense of well-being, and mediate shame that underlies depression. Given that shame is a feeling associated by feelings of inferiority and remorse, self-compassion is "compassion turned inward and the ability to hold one's feelings of suffering with a sense of warmth, connection and concern" (Zhang et al., 2018, p. 414). In particular, this model means "being connected to… one's own experience of suffering and embracing a desire or motivation to personally heal" (Zhang et al., 2018, p. 409). Therefore, the findings from this study suggest that self-compassion is a vehicle towards resilience and offers an adaptive approach in coping with shame. It is important to note that the participants recruited for this study were African American adults who had a documented history of depression. Replication of this study with adolescents is necessary.

Shame and Modalities for Treatment

A common result from the research studies reviewed was the importance of addressing, assessing, and understanding shame events in psychotherapy via a therapeutic modality. What remains missing from the literature is *how* to specifically address these shame experiences, how they impact the therapeutic relationship, what the role of the therapeutic relationship is, and if there is a specific modality that most effectively treats adolescent shame. This researcher examined the current knowledge base on shame with the goal of understanding treatment modalities that treats shame within the psychotherapeutic context. At present, there are few treatments that are specifically aimed at treating shame in

the therapy room. The literature reviewed the following modalities and the ways in which they address shame in psychotherapy: Compassion Focused Therapy (CFT) (Matos & Pinto-Gouveia, 2014; Simonds et al., 2016), Acceptance and Commitment Therapy (ACT) (Carvalho et al., 2015), and Cognitive Behavioral Therapy (CBT) (Muris, Meesters, & Asseldonk, 2018; Muris, 2015; Cohen-Filipic & Bentley, 2015). Muris, Meesters, & Asseldonk (2018), Muris (2015), and Cohen-Filipic & Bentley (2015) address treatment of adolescents specifically. Evidently, there was a significant dearth in the literature that focused specifically on adolescent shame and psychotherapy treatments. What also remained clear was that there was a dearth of randomized, experimental designed studies that detailed the efficacy of shame-focused interventions in psychotherapeutic contexts. Future studies using scientifically informed, randomized experimental designs can clarify the effectiveness of shame-based treatments in psychotherapy.

One common thread among the shame literature is the utilization of Compassion Focused Therapy (CFT) with shame-prone individuals in psychotherapy (Matos & Pinto-Gouveia, 2014; Simonds et al., 2016). CFT is a system of psychotherapy developed by Gilbert (2006), who believed that compassion could be the key to relieving intrusive feelings of shame and self-criticism (Matos & Pinto-Gouveia, 2014). It is noted in the literature as a powerful and corrective modality for those who are shame-prone. Using semi-structured interviews, Matos & Pinto-Gouveia (2014) conducted a study that explored the presence of shame with attachment figures and the ways in which shame is stored as a traumatic memory. The Shame Experiences Interview (SEI) is an interview designed to assess for shame experiences in childhood or adolescence. Results from the study revealed that the most frequent shame experiences recalled by participants were those involving attachment figures.

In a psychotherapy setting, Matos & Pinto-Gouveia (2014) underscore the importance of assessing "phenomenological characteristics of shame memories" by using the clinical interventions built in to compassion focused therapy (p. 238; Gilbert, 2006). Specifically, the researchers suggest that this modality can assist in targeting shame memories that have over time, become traumatic autobiographical memories. Additionally, the researchers suggest that therapists assist clients in "reconstructing the autobiographical meaning associated with these recollections in order to minimize their traumatic impact on current symptoms, to reevaluate their centrality to identity and to re-examine and recreate the patient's negative inner working models" (Matos & Pinto-Gouveia, 2014, p. 238). Conversely, the study revealed that clients may have a reversed, negative reaction to receiving compassion from the therapist, activating feelings of anger, and "trigger[ing] conditioned emotional responses (e.g. fight, flight, avoidance)" (Matos & Pinto-Gouveia, 2014, p. 238). These clients may have difficulty with closeness in the therapeutic relationship, as the safety and compassion developed between client and therapist is a new experience. Clients with high self-criticism and shame may respond to therapist's with anxiety, avoidance, or dissociation, making it clinically difficult to move forward and overcome shame (Matos & Pinto-Gouveia, 2014).

Simonds et al., (2016) utilized semi-structured interviews to better understand adolescents' perception of shame. The study suggested that shame-prone individuals report lower self-esteem and higher rates of depression, benefiting strongly from psychotherapy (Simonds et al., 2016). Specifically, the researchers suggest that adults may benefit from interventions that address their self-criticism, as well as interventions that increase self-compassion. These two studies recommend the use of compassion as a way to target and relieve shame in a therapy setting (Matos & Pinto-Gouveia, 2014; Simonds et al., 2016). The

extent of what is known about this modality's efficaciousness in treating adolescent shame, however, is unknown.

A similar modality that is referenced throughout the literature is Acceptance and Commitment Therapy (ACT) (Carvalho et al., 2015). Experiential avoidance is a process that contributes to "psychological inflexibility, and is characterized as the unwillingness to be in contact with one's private experiences" that leads to "rigidly and inflexibly controlling undesired internal events" (Carvalho et al., 2015, p. 34). This study reflected that individuals who recall shame experiences with attachment figures are more likely to use maladaptive coping mechanisms such as experiential avoidance. Further, the researchers found acceptance and commitment therapy interventions to be useful in assisting the shift from experiential avoidance to an accepting stance. ACT interventions "alter the way these individuals relate with their shame memories, promoting a more accepting way of experiencing them, the contact with the present moment and establishing a commitment with actions," which were also shown to be suitable in treating depression" (Carvalho et al., 2015, p. 41). A limitation of this study was that the studied sample was adults; the use of ACT to treat adolescent shame in psychotherapy remains an unknown phenomenon.

Cognitive behavioral therapy (CBT) was another modality briefly referenced in three articles identifying it as useful to the treatment of shame (Muris et al., 2018; Muris, 2015; Cohen-Filipic & Bentley, 2015). Muris et al., (2018) reflects on clinical studies of adults which note that "feelings of shame can be successfully abolished by cognitive-behavioral therapy, and so it seems worthwhile to investigate whether such a specific focus on shame can further improve of our existing prevention and early intervention programs for youths with anxiety problems" (p. 276; Hedman, Ström, Stünkel, Mörtberg, 2013; Gilbert 2009). It

is noteworthy, however, that these three articles reference cognitive behavioral therapy as a modality that assists the healing of shame in adults. These studies should be replicated with adolescents to determine if the same outcomes occur.

Another frequent theme was the reference to early intervention to treat shame (Cohen-Filipic & Bentley, 2015; Muris, Meesters & Asseldonk (2017). Muris, Meesters & Asseldonk (2017) discuss preventive measures by increasing awareness about shame to parents and other caregivers as a means to early intervention and prevention. However, no article expounds on this idea by giving specific treatment directions.

What remains clear from the literature was that interventions for shame in adolescence is critical, however, vague references that used the word "intervention" were seen throughout studies (Orth, Robins & Soto, 2010; Muris, 2015; Muris et al., 2016; Matos, Pinto-Gouveia & Costa, 2013). Orth, Robins & Soto (2010) emphasize that because adolescence is such a vital time in the development of shame, it might be of "particular importance for interventions [to be] aimed at reducing self-conscious emotions" (p. 1068). Also, Matos, Pinto-Gouveia & Costa (2013) state that therapists should use specific strategies to target rumination, thought suppression and dissociation, as proposed by prominent authors in the field (p. 161). However, these articles do not illustrate how to do so. It is evident, then, that there is a significant gap in the literature that addresses treatment modalities for shame in adolescents.

Shame and the Therapeutic Relationship

The concept of the therapeutic relationship has been thoroughly studied. Theorists have regarded the quality of the therapeutic relationship as the "quintessential integrative variable" of a therapy (Wolfe & Goldfried, 1988, p. 449). The strength and quality of the

therapeutic relationship has proven to be a consistent predictor of positive clinical outcomes independent of the psychotherapy approach and/or modality (Fenton et al., 2001; Horvath & Bedi, 2002; Norcross, 2002). Further, Wolfe & Goldfriend (1998) state that the strength of the therapeutic alliance is not contingent on the specific school of thought or theoretical framework, as "it is now commonly accepted by most orientations that the therapeutic relationship is of essential importance to the conduct of psychotherapy" (p. 449). While most theoretical orientations acknowledge the importance of the relationship between client and therapist, this is an understudied phenomenon as it relates to adolescents presenting with shame.

The therapeutic relationship, also known as the working alliance model, is one of the biggest factors of therapeutic success (Lambert, 1992). Originating from the psychoanalytic literature, three primary features must be considered when forming an alliance with a patient. First, and understanding and agreement of the patient's goals must be discussed. Secondly, a collaboration between the patient and the therapist must take place, and third, the bond and relationship between patient and therapist must be developed and grounded in trust (Bordin, 1979). Further, Bordin (1979) states, "1 propose that the working alliance between the person who seeks change and the one who offers to be a change agent is one of the keys, if not the key, to the change process" (Bordin, 1979, p. 252). Therefore, for the purposes of this study, this researcher examined the therapeutic alliance as a key aspect of the change process.

In addition, little research has been conducted on ways to treat or identify shame with adolescents in therapy. An important theme that emerged from the literature was the way in which shame permeates the treatment room, especially with adolescent patients. The literature suggests that shame is felt when something unacceptable or private about us is

discovered. A key aspect of the shame sequence is this hiding. However, a common theme

emanating from the literature is that shame is omnipresent in the treatment room (Dearing &

Tangney, 2011). What remains conclusive from the research studies presented in this

proposal is that shame is the root of multiple forms of psychopathology, including

depression, anxiety, and trauma. Having said that, little to no research has been conducted on

the insidious impact of the therapeutic alliance and adolescent shame. While social workers

have identified the importance of understanding shame, which has been seen in

psychopathology, the challenge of addressing shame in the therapy room is a complicated

and understudied phenomenon (Kohut, 1971; Morrison, 1987; 1989; Nathanson, 1987).

The therapeutic relationship has historically been known as the primary facilitator for

change. This was examined and confirmed in a qualitative study conducted by Hill et al.,

(2011), where adult shame and the therapeutic relationship were further explored. Over the

course of 21 weekly, 50-minute sessions, one adult participant met with a therapist, and

following each session, the participant completed the Working Alliance Inventory-Short

Revised (WAI-SR) self-report measure. After sessions 3, 8 and 16, the participant would

complete the Client Attachment to Therapist Scale, and before the final termination session,

the participant completed the Inventory of Interpersonal Problems. This was then followed

by a one-hour semi-structured face to face interview that assessed the participants perception

of change and healing. A major finding from the study suggested that the therapeutic

relationship was a primary facilitator of change in clients relationships. Within the context of

a secure relationship between the participant and the therapist, the client reported an ability to

"explore inhibited, painful affect associated with previously unidentified maladaptive

interpersonal patterns" (Hill et al., 2011, p. 41). At the end of therapy, the participant

reported "reduce[d] debilitating shame," and changes in her interpersonal patterns (Hill et al., 2011, p. 41). This study, however, has many limitations. First, the qualitative inquiry examined only one participant, therefore the personal nature of the data gathered was highly subjective. While this study underscores the importance of a strong therapeutic relationship as a means to healing shame, the results are not generalizable or statistically representative. Further, the study was not focused on the treatment of an adolescent.

Another study examined the two therapeutic interventions, eye movement desensitization and reprocessing (EMDR) and cognitive behavioral therapy (CBT), and sought to explore the effectiveness of these two interventions in the treatment of obsessive compulsive disorder (OCD) (Marsden, 2016). While OCD is not specifically relevant to this researchers proposed study, it is important to note that a key theme in the treatment of OCD is the role of shame, which has been a well-documented consequence of concealing one's compulsive behavior(s). This concealment inhibited participants in the study from seeking professional help, thus increasing their shame and sense of isolation. The main finding, however, concerned the therapeutic alliance. Norcross (2010) describes the therapeutic relationship as the most prominent predictor of a successful treatment, acting as "the container for the treatment model" (Marsden, 2016, p. 101). As evidenced from this study, shame and the therapeutic alliance are of paramount importance in the treatment of OCD, yet one common thread among the current shame literature was the need for more research, especially on the treatment of adolescents in therapy.

Friel (2016) used semi-structured interviews from a group of therapists ($n = 5$) to examine the healing process of adult shame in psychotherapy. Specifically, Friel (2016) was interested in integrative psychotherapy, which is defined as a "relational-developmental

approach within psychotherapy that draws upon the theoretical integration of British object

relations, self-psychology, attachment theory and humanistic psychotherapy" (Friel, 2016, p.

532). Findings from the study suggested that "healing occurs through a reparative

relationship in which trust and safety, amongst other features, are central for detoxifying

shame…The results of this study highlight the recurring need for trust and safety in the

therapeutic relationship, particularly when managing the vulnerabilities" when dealing with

shame (Friel, 2016, p. 541). Results also suggested that the first step in working with shame

in the treatment room is recognizing it. However, as Friel (2016) notes, shame "creates a

barrier to the 'interpersonal bridge'" (Kaufman, 1996, p. 155). It is through the

responsiveness, engagement, consistency and validation of the therapist that allows for the

shame to be acknowledged within the therapeutic dyad. Once the shame has been addressed

and normalized, the presence of a therapist with whom the client has a secure attachment to

brought about shame reduction. Findings indicate the need for a secure attachment within a

relational oriented therapist, including integrative therapists, and the "centrality of the

relationship in the reparative process" (Friel, 2016, p. 543). Further, he posits that "a

therapeutic relationship based on sustained affective attunement including inquiry, validation

and normalization will heal the early ruptures that gave rise to toxic shame experiences"

(Friel, 2016, p. 533). Limitations from this study included its very small sample size which is

not generalizable. Larger scale studies from a broader range of populations is required to

confirm the results.

      Leeming & Boyle (2013) also examined the therapeutic relationship's role in treating

shame through a qualitative study at a British university that investigated shame reparation (n

$= 50$). The researchers collected anonymized written narratives from 50 adult participants

with the goal of understanding how participants managed and coped with shame, repaired experiences of shame, and assessed the role that other people had in the reparation of shame. Demographic information was collected, followed by participants writing a first-person, in-depth narrative about a shaming episode. A thematic analysis was conducted to collect themes and patterns within data, and results suggested that there was a strong correlation between the process of repairing shame and the importance of connection and validation from others. These results are supported by other open-ended studies (Brown, 2006; Silfver, 2007; Van Vliet, 2008). There was a significant lack of racial diversity in the study, as most participant's identified as White, young middle-class individuals. Additionally, it is possible that some participants did not disclose the full range of their shame experiences due to these experiences being too painful to share. Therefore, results may not have captured the depth of participant's shame.

This literature review reflects a great deal of shame research, however, research on shame in adolescents is extremely limited. There is a dearth of randomized, experimental designed studies that address adolescent shame and the role of the therapeutic relationship. While there are some, albeit few, studies sharing strategies for exploring shame within the psychotherapeutic context, more exploration is needed on the role of the therapeutic relationship in the treatment of shame. Building upon what we already know about adult individuals and shame, the research on adolescent shame is scarce. Additionally, few articles weave in the role of the therapeutic relationship in treatment. Researchers must take further 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).

Furthermore, ongoing research could benefit from delineating the ways in which shame during the adolescent stage of development shows up in the therapy room, and what role the therapeutic relationship plays in treating shame. Therefore, this study aims to address the knowledge gap by examining the role of the therapeutic relationship when shame presents in adolescents.

Chapter Four: Theoretical Framework

In this section, the nature of theory will be explored. A theory is "an organized statement about the world. Fook (2002) argues that even putting names to things help to provide explanation and understanding in practice" (Payne, 2014, p. 5). As a concept, a theory explains human behavior, relationships, and social issues. This researcher selected Erikson's Psychosocial Stages of Development (1964), Kohut's (1971, 1977, 1984) theory of self-psychology, and Rogers' (1942, 1951) client-centered approach as theoretical lens' for this study, as these theories help to illustrate the role of shame in adolescents. Incorporating ideas from Erikson (1964) and Kohut (1971) will provide a framework through which to explore shame and adolescence. Both Erikson (1964) and Kohut (1971) propose a lifespan model and incorporate developmental theories into their models.

Erikson's Psychosocial Stages of Development (1964) discusses psychosocial variables that assist us in understanding the ways in which people move through development. Erikson (1964) argued that one's personality develops in a predetermined order, moving through eight psychosocial stages. From a developmental perspective, adolescence is a significant psychosocial benchmark where the task of identifying and defining one's self is taking place. This theory is relevant to this research study because shame is a common occurrence during Erikson's (1964) "identity versus role confusion" stage of development which is associated with adolescence. Specifically, the "identity versus role confusion" state of development will be referenced throughout the study. Despite the benefits and contributions of Erikson's (1964) theory, there are limitations to consider. A major criticism of his work is that the formation of one's identity is a complex process

involving more than elements described in the adolescent stage of development; arguments have been made that emphasize identity formation persisting throughout adulthood.

Kohut (1971) discusses self-psychology, where elements of narcissism and empathy are explored. These two characteristics have been identified as applicable to the understanding of shame. Of particular importance in the Kohutian theory (1971) is the concept of twinship, mirroring, the structure of the self, the idealized parent imago, and self object needs and failures. These specific terms offer unique implications to understanding adolescent shame in the therapeutic relationship and will be referenced throughout the study. The theory suggests that with consistent and secure relationships to fulfill needs in early childhood, a child can safely and gradually internalize and differentiate from self objects; when self object needs are not met, we often times see shame appear. According to Kohut, a person's orientation to self object needs is an important component of personality functioning in adulthood, therefore, it is critical to also understand one's selfobjects needs in adolescence.

Lastly, Rogers' (1942) client-centered approach is a humanistic approach that relies on three core ideas: unconditional positive regard, empathy, and genuineness. Specifically, these core ideas are central to this research study in understanding the therapeutic relationship between client and therapist, which will be expounded upon further. Rogers' (1942) believed that therapy should focus on an individual's subjective view of the world, suggesting that the therapist concentrate and understand their client as an alternative to a psychoanalytic approach which involves interpretation or analyzing the client. This approach continues to be a central theory in social work practice and contains useful implications for this study, as Rogers' approach is relevant to understanding the healing nature of the therapeutic relationship.

The Psychosocial Stages of Development

Erikson (1964) was interested in the ways in which personality developed over a series of stages. Different from his predecessors, specifically Freud's development of the five psychosexual stages, oral anal, phallic, latent, and genital stages, Erikson (1964) believed that social experiences and interpersonal relationships played an important role in the development and growth of individuals (Berzoff, 2011). Erikson (1964) developed a psychosocial timeline that looked at the developmental life stages over the course of a person's life cycle (Berzoff, 2008). It is important to note that Erikson's developmental model is framed from a North American perspective; the stages of development vary from culture to culture and do not always align. Erikson (1964) theorized that the "ego itself is shaped and transformed, not only by biological and psychological forces but also by social forces" (Berzoff, 2008, p. 99). His theory suggested that people are constantly changing and evolving over the course of their entire lives. Erikson's Epigenetic Stages include Infancy, Early Childhood, Play Stage, School Age, Adolescence, Young Adulthood, Adulthood, and Old Age (Berzoff, 2008).

Each stage of Erikson's (1964) psychosocial development grows upon the preceding stage and paves the way for subsequent stages. During the first stage of development, trust versus mistrust, infants with responsive caregivers learn that their basic needs for survival can be met; unresponsive caregivers, however, do not paint the world as a safe or predictable place. As children progress into the second stage of development, autonomy versus shame and doubt, themes around control and personal independence and autonomy begin to emerge. Webster defines autonomy as "the quality or state of being self-governing; a self-governing state; self-directing freedom and especially moral independence" (1983, p. 118, as cited in

Graves and Larkin, 2006, p. 62). Several developmental tasks take place during this stage, including toilet training and self-control around clothing, food, and play, all of which demonstrate a child's personal autonomy. Graves & Larkin (2006) discuss caregivers holding on to a child versus letting go, and state, "to hold a child too close…can become a restrictive or restraining pattern…[but] to let go too much can be destructive in the sense of neglect, or…a relaxed laissez faire approach" (Graves & Larkin, 2006, p. 64). The goal of the caregiver, then, is to find a balance between these two forces, allowing the child's expression of curiosity and independence to flourish. If the caregiver is able to provide appropriate amounts of independence in a young child's life, it is probable that the child will develop autonomy in the process of toilet training (Graves & Larkin, 2006).

As the child continues to move away from the caregiver in subsequent developmental stages, they further seek out independence and autonomy, all the while needing protection and guidance from their parents (Graves & Larkin, 2006). During these early years of development, Erikson (1964) believed that too much shame in a child's life can lead to rebelliousness, feelings of unworthiness, and a pervasive feeling of self-consciousness. Furthermore, the developmental stage of autonomy versus shame and doubt

> becomes decisive for the ratio of love and hate, cooperation and willfulness, freedom of self-expression and its suppression. From a sense of self-control without loss of self-esteem comes a lasting sense of good will and pride; from a sense of loss of self-control and of foreign over-control comes a lasting propensity for doubt and shame. (Graves & Larkin, 2006, p. 66).

While resolution of each stage is viewed on a continuum, children who feel self-conscious and ashamed will also experience similar feelings as they progress into subsequent stages (Dunkel and Harbke, 2017). A solid foundation of autonomy during the second stage of development "will prevent undue shame or doubt later in life" (Graves & Larkin, 2006, p.

66). Therefore, the second stage of development is a building block for future development. If a child learns that they can feel safe and confident in the world, they will likely prosper and develop autonomy, continuing to master subsequent tasks in socially and academically. For the purposes of this study, this researcher focused on examining what Erikson (1964) named the "adolescent" stage of development, as there is a dearth of literature regarding the psychotherapeutic treatment of shame during this developmental stage. However, there is an important link between this early stage of development, autonomy versus shame and doubt, and the fifth stage of development entitled identity versus role confusion. A key aspect of adolescence concerns the psychological task of identity development, when a teenager begins to experiment and develop their sense of self. As one transitions from childhood to adolescence, any unresolved conflicts from preceding stages will surface, interfering with the healthy development of one's identity. There is a magnification of shame during adolescence, likely regarding comparisons in peer groups, self-evaluations, physical changes, social and emotional shifts, and academic pressures. Therefore, shame's emergence in the adolescent stage of development builds off of prior stages where autonomy was not fully attained.

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. As an adolescent seeks to emerge from their roles in their families and begins to develop strong peer relations, also known as a period of separation-individuation, the loss of omnipotence makes the adolescent vulnerable to shame. Additionally, it is a period of time where personality development and a sense of identity begins to emerge. 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 adolescence, 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, and individuals who receive reinforcement and validation during this stage are more likely to 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). While adolescents navigate physical, intellectual, social and emotional changes, many of which can be empowering and liberating, they may also result in confusion, pressure, and challenge (Berzoff et al., 2011). In this light, the separation-individuation processes of adolescence is connected to the shame-related crises of Erikson's Developmental stages, specifically one's struggle for autonomy, identity, and identity diffusion.

According to Bennet, Sullivan, and Lewis (2005), shame is an experience that begins as early as toddlerhood and continues to develop well into adolescence. During the adolescent stage of development, individuals experience primary changes in three specific areas: cognition, physical appearance, and sexuality (De Rubeis & Hollenstein, 2009). Cognitively, adolescents are experiencing judgement from peers and develop increased capacity for "self-evaluation, reflection, metacognition, rumination, and social perspective taking which can lead to increased shame" (De France, Lanteigne, Glozman, & Hollenstein, 2017, p. 770). Physically, adolescents are typically concerned with their appearances and attractiveness. It is common that feelings of shame may be felt regarding one's entire identity

and outward appearance. Additionally, adolescents develop sexual interest, all the while managing social factors and the strong influence of media. Given the developmental significance of identity development and establishing intimate friendships and dating relationships during adolescence, it is important to consider the ways in which these interpersonal relationships develop. 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 of experiencing shame occurs during adolescence as a result of the maturational shifts and prominence of peer evaluation. Social workers must develop an understanding of shame that may evolve during this developmental stage and how to work with it in treatment.

Self-Psychology

Similarly, in Kohut's (1977) model of self-psychology, attachment needs across an individual's lifespan are considered. One of the most fundamental elements of Kohut's (1977) theory was that the development of the self is not only made up of drives and biological factors. Rather, Kohut (1977) believed that children required the presence of others, or what he refers to as self-objects, to provide developmentally-related needs (Wolf, 1988). Predecessors of Kohut (1977) studied emotions such as guilt and anxiety, but less consideration was given to the experience of shame. Kohut's (1977) focus of shame was grounded in an individual's sense of self. He theorized that when children's selfobjects needs were not adequately met, a sense of shame would arise.

Psychoanalyst's Helen Block Lewis (1971) and Heinz Kohut (1971) were the first to bring shame center stage in psychoanalytic theory, demonstrating the unconscious impact that shame has on our lives. Lewis (1971), author of *Shame and guilt in neurosis,* was a

highly influential shame researcher who emphasized the power of unacknowledged shame

within the therapeutic dyad. In her book, Lewis (1971) identifies shame as the central

emotion clients experience "exceeding anger, fear, grief, and anxiety" (Brown, 2006, p. 43).

The book gives a brief explanation on the differences between shame and guilt, two emotions

that share a number of common features and are thus mistakenly used interchangeably.

Tangney (1995) refers to both shame and guilt as self-conscious emotions that provoke

painful experiences. However, while guilt is often a feeling of remorse or wrongdoing arising

from our actions, shame is a painful feeling that takes over one's entire sense of self, causing

one to feel defective, weak, and flawed. While there has been extensive literature pertaining

to shame and guilt, very little evidence exists that links the two emotions to psychopathology.

Therefore, the rationale for this study was to evaluate the relationship between shame, guilt,

and psychopathology. In her study of a series of psychoanalytic case studies, Lewis (1971)

identified that shame was often bypassed or unacknowledged in treatment. She stated, "at

least in our culture, shame is probably a universal reaction to unrequited or thwarted love. By

its nature, it is a state with which it is easy to identify, and at the same time is painful, so that

both the patient and the therapist turn away from it" (Lewis, 1971, p. 16).

Heinz Kohut (1971, 1977, 1984) was known for the development of self-psychology,

and was also one of the foremost pioneers of the concept and understanding of shame. Kohut

was an Austrian-American psychoanalyst who challenged Freud's pejorative framework

embedded in traditional psychoanalytic theory and questioned its therapeutic value

(Flanagan, 2011; Kohut, 1959, 1971). Self-psychology focuses on the development of a

cohesive self and posits that all individuals are born with an inherent sense of self that

requires lifelong responses from others to facilitate optimal development (Goldstein, 2001).

In a self-psychological framework, the keys to healthy development are impingent on proper attunement of the environment and relationships therein. Developed in the United States in the 1970s and 1980s, self-psychology has been marked by its "fierce focus on individual self-definition, fulfillment, and well-being" (Flanagan, 2011, p. 161). Self-psychology was also pivotal in the rise of shame studies. In Kohut's (1971) seminal book, *Analysis of the Self*, shame was considered from a self-psychological lens.

Self-psychology, a psychodynamic framework, holds strong relations to the ethics and values of social work. In alignment with NASW's dignity and worth of all beings, as well as self-determination, self-psychology posits that it is through meaningful relationships that are psychological needs can be met (NASW Code of Ethics).

Two concepts central to individuals and interpersonal relationships according to self-psychological theory include narcissism (i.e. a self-centered view where others are viewed only as extensions of the self) (Donner, 2006) and empathy (i.e. the ability to infer and share the feeling states of others in relation to the self) (Cusi, MacQueen, Spreng & McKinnon, 2011; Decety & Moriguchi, 2007). Kohut (1971) emphasized the developmental necessity for young children to feel omnipotent, grandiose, and perfect (i.e. narcissistic) (Flanagan, 2011; Kulka, 2012) in order to form a healthy sense of self. Additionally, similar to social work, self-psychology utilizes empathy, or what Kohut (1978) defined as vicarious introspection. Vicarious introspection is "a working definition for empathy as a method for finding out about another person's inner life" (Chessick, 1998, p. 496). This cultivation of empathy by the clinician does not rely on the wisdom or interpretation of the therapist, but rather, through a position of equality and understanding of the client. Kohut's (1971) belief was that empathy is necessary for all human beings, helping a person feel heard and

understood. Flanagan (2008) states, "repeated empathic failures are the roots of disturbance and thwarted growth" (p. 169). In Kohut's (1959) paper, *Introspection, empathy, and psychoanalysis—An examination of the relationship between mode of observation and theory*, he writes:

> Only when we think ourselves into his place, only when we, by vicarious introspection,
> begin to feel his unusual size as if it were our own and thus revive inner experiences in
> which we had been unusual or conspicuous, only then begins there for us an appreciation
> of the meaning that the unusual size may have for this person and only then have we
> observed a psychological fact. (p. 461).

This therapeutic approach was momentous for its time and underscored the importance of feeling understood by another.

These two characteristics, narcissism and empathy, have also been identified as relevant to the understanding and treatment of shame. It has been argued that narcissism is central to understanding the experience of shame (Morrison, 1986; Broucek, 1991). Kohut's thinking was focused on the self and the environment and described the experience of shame as developing from a disturbed narcissistic equilibrium. He argued that shame would arise in children who had experienced repetitious failures of attunement, where their selfobjects needs were not met adequately. Kohut developed what is referred to as healthy narcissism, which refers to a child's need to experience others narcissistically in order to experience them as self-objects. In a responsive environment, caregivers provide attuned responses to a child, including mirroring and twinship, satisfying one's grandiose needs; failure to meet one's grandiose needs, however, resulting in the child feeling rejected and condemned.

When patients experience narcissism at a pathological level, a ubiquitous failure of empathy takes place (Friedman, 2004). Kohut (1984) defined empathy as the capacity to

immerse oneself into the inner life of another through vicarious introspection (Chessick, 1998). This immersion process allowed Kohut (1984) to join with the patient and understand their subjective experience from within (Flanagan, 2008). When young children do not receive empathic attunement, they will experience difficulty regulating their emotions and are prone to experience more shame and hurt.

Additionally, Kohut (1971) spoke of four descriptive categories of disorders that refer to when a person's self-psychological needs are not met. The first category is called the understimulated self, which describes those individuals whose selfobjects were not able to mirror their grandiosity, and may often feel "empty, bored, listless, or apathetic" (Flanagan, 2008, p. 181). The second category, the overstimulated self, occurs when an individual's selfobjects are too strong, which makes it difficult for the self to learn how to soothe itself on its own. The fragmenting self has "not been related to as a whole by their selfobjects" (Flanagan, 2008, p. 182), and although they have received some attention, they present as mercurial. Lastly, the overburdened self feels unsupported as a result of unreliable selfobjects (Flanagan, 2008).

Self-psychology explains the difficulties individuals experience through their ability to self-regulate and the development of a solid sense of self. According to Heinz Kohut (1978), the structure of the 'self' is made up of three distinct poles that enable the self to become cohesive. Kohut (1978) refers to these poles as aspects of development that exists within the self, each of which has their own needs (Flanagan, 2008). The three poles of the self, which comprise the tripolar self, include the pole of the grandiose self or the pole of ambition, the pole of the idealized parent imago or the pole of ideals, and the pole of twinship. Each of these poles is necessary to different extents throughout the lifetime for the

development and maintenance of a cohesive self (Flanagan, 2011; Mitchell & Black, 1995).

Embedded in these poles, Kohut (1978) specified three specific selfobject transferences:

mirroring, idealizing, and twinship.

Self-psychology proposes the importance of these selfobject transferences throughout

a lifetime, but especially in childhood. Selfobjects can be defined as "people or things outside

of the self, vitally necessary to every individual as a source of mirroring, sources of

perfection and grandeur to merge with, and as similar selves to feel at one with" (Flanagan,

2008, p. 171). According to self- psychology, selfobjects are needed to fulfill these functions

throughout the life cycle and are called selfobjects because they function to give the self what

it needs in order to become and remain cohesive. When clients who have experienced shame

begin a therapy, a self-psychological lens helps to recognize the toll that misattuned or

insufficient selfobject experiences have had on the individual. Over the course of treatment,

the client develops a selfobject transference towards the therapist, and the therapist can

become a reparative selfobject for the client by providing empathy and corrective experience

and grounding.

The Grandiose Self

The first pole is the grandiose self, which needs "mirroring selfobjects in an effort to

feel special and full of well-being," was developed from mirroring selfobjects and empathic

attunement (Flanagan, 2008, p. 172). The grandiose self includes a person's individual talents

or strengths that get mirrored back to them and help to form the core of their identity. If

appropriately attuned mirroring selfobjects are met in early development, the basis of a

healthy self-esteem is developed; if these selfobject needs are not available in early

development, however, disturbances in personality and mental health may arise. Commonly,

a depression can be traced back to a child's early unmet selfobjects needs, such as the need for twinship and mirroring.

The Idealized Parent Imago

The second selfobject need Kohut (1971) proposed, the idealized parent imago, represents a child's need to see their caregiver(s) as idealized people, sources of power and security with whom to merge and feel a part of. This pole represents the need to find admirable qualities in which one can idealize and merge with, in order to internalize these qualities within the self (Mitchell & Black, 1995; Flanagan, 2011). Kohut (1971) describes that when we merge with the qualities of "calmness and competence of the selfobject, those qualities can be established within self" (Flanagan, 2011, p. 175). When there are sufficient selfobjects in a child's life to idealize, the mature qualities of the idealized part imago begin to develop, such as "the ability to delight in and grow from qualities in others and eventually to experience pleasure and pride in one's own qualities, standards, and values" (Flanagan, 2011, p. 176). With idealizing selfobject needs are met, an ability to emotionally regulate and self-soothe offer a sense of safety for the child. However, when idealized selfobject needs are not met, a number of consequences can arise. A child may not develop a sense of safety and may experience anxiety or depression.

Twinship

Twinship is the need to feel that there are other individuals in the world who are similar to you, creating feelings of belonging and security (Flanagan, 2008). Twinship is experienced as sameness, alikeness, and being known by another (Banai, Mikulincer, & Shaver, 2005). One requires twinship in order to feel a sense of connection to others. According to Flanagan (2008), the pole of twinship refers to an individual's need to

experience and "feel that there are others in the world who are similar to oneself" (p. 176).

When a person feels this sense of sameness, they are able to facilitate the development of

empathy and social skills (Banai, Mikulincer, & Shaver, 2005).

True-Self

People possess multiple senses of self. Both Goffman (1959) and Jung (1953)

distinguished between an individual's "public self, or persona, and the individual's inner

self," which Higgins (1987) later developed into the "ideal, ought, and actual self-concepts"

(Bargh, 2002, p. 34). Other than the actual self, Carl Rogers (1951) expanded this idea into

what he called the true self. Rogers' notion of the true self was informed by Jung's (1953)

"distinction between the unconscious self and its public mask, persona" (Bargh, 2002, p. 34).

Bargh (2002) explains Roger's concept of the true self as:

> distinct from both the ideal self or possible selves on the one hand, and the
> actual self on the other, because Rogers (1951) viewed the true self of his
> clients as actually existing psychologically [i.e., a present, not a future
> version of self], but not fully expressed in social life [i.e., not the actual self]
> (p. 34).

Winnicott (1962) adopted this theory and introduced the true self and the false self.

The true self, which he sometimes called the "real self" is used to describe a sense of self that

is based on authentic experience, a "personal aliveness or feeling real" (Winnicott, 1962, p.

148). The false self was described as a "defense designed to protect the true self by hiding it"

(Blass, 2012, p. 1442), which often times presented as "polite and mannered in public"

(Winnicott, 1962, p. 148). These aspects of the self may be kept hidden out of fear of

rejection or isolation.

Overall, Kohut & Wolf (1978) understood the dangers of having inadequate

selfobjects, specifically referring to early deficits in mirroring, idealizing, and twinship lead

to disorders of the self. Failure to have one's selfobject needs met adequately can lead to a

range of psychological problems, including pathological narcissism, difficulty regulating

emotions, and deficits in interpersonal functioning (Kohut, 1984). In a clinical setting, the

therapist "serves multiple selfobject functions (Rowe & MacIsaac, 1991) and an important

aspect of treatment is identifying these selfobject transferences within the therapy process as

they develop"

(Marmarosh and Mann, 2014, p. 298). Marmarosh and Mann (2014) describe that a patient's

longing for mirroring may be expressed as a wish for validation and acceptance from the

therapist, whereas idealizing needs may be seen by the "patient admir[ing] the therapist and

look[ing] to the therapist to gain a sense of strength, emotion regulation, or protection" (p.

299). Lastly, twinship may be reflected by the patients desire to be similar to the therapist.

When conceptualizing shame from a self-psychological lens, the importance of

selfobject responsiveness is of paramount importance. According to Shapiro (1999), "Kohut

(1971) believed that shame resulted from overwhelming, unmirrored grandiosity and

simultaneous selfobject unrelatedness" (p. 56). Morrison and Stolorow (1997) suggest that

"recurring experiences of malattunement lead the child to organize his experiences according

to invariant principles that include an unconscious belief that he or she has a basic defect or

is inherently bad and shameful" (Shapiro, 1999, p. 57). In addition to selfobject needs that

are unmet, a child may feel as though their emotional reactions were not met with

acceptance, which also leads to the experience of shame (Shapiro, 1999). These emotional

misattunements give rise to shame, and a crucial aspect of a therapist must be to identify

these selfobject transferences within the therapeutic relationship. Overall, Kohut's (1971)

theory is significant to this research study, as it sheds light on the therapeutic relationship.

Client-Centered Approach

The contribution of humanistic approaches is significant when examining the therapeutic relationship, specifically the work that was developed by Abram Maslow (1950/1973) and Carl Rogers' (1942, 1951). Maslow (1950/1973) believed that a humanistic perspective accounted for the whole person, acting as somewhat of a rebellion or rejection against previous models such as behavioral or psychodynamic approaches, Maslow (1950/1973) approached the study of personality by focusing on self-actualization (Bugental, Pierson, & Schneider, 2015). Maslow's work served as a foundation for the work of Carl Rogers, who emphasizes the importance of understanding the subjective world of our client's. While examining what enables individuals to grow and change, Rogers' (1950) defined the following conditions for therapy:

> (a) two persons are in emotional contact; (b) one of them, called the client, is troubled; (c) the other, called the therapist, shows genuineness and congruence in the relationship; (d) the therapist experiences and displays unconditional positive regard for the client; (e) the therapist achieves and expresses an empathic understanding of the client; and (f) the client perceives the genuineness, positive regard, and empathy of the therapist. Create these conditions, Rogers asserted, and the client will self-actualize in his or her own self-defined directions (Moss, 1998b, p. 41–43; Rogers, 1957).

Key principles from the Rogerian approach such as unconditional positive regard, empathy, and genuineness continue to have very high-regard in the field of social work with emphasis on the therapeutic relationship. Unconditional positive regard is characterized as "warm acceptance of the client's experience without conditions, a prizing, an affirmation and a deep nonpossessive caring or love" (Bugental, Pierson, & Schenider, 2015, p. 462); empathy is the clinician's ability to understand the client from their point of view, while genuineness or congruence refers to the therapist as "mindfully genuine in the therapy relationship, underscoring present personal awareness" Bugental et al., 2015, p. 462).

In conclusion, Erikson's Psychosocial Stages of Development (1964), Kohut's (1971, 1977, 1984) theory of self-psychology, and Rogers' (1942, 1951) client-centered approach help illustrate and provide frameworks for understanding the role of shame in adolescents. Incorporating aspects from these theoretical lens' provides context of the developmental phase adolescents are underdoing (Erikson (1964). Self-psychology helps conceptualize selfobject needs; all human beings rely on some form of selfobjects throughout life in order to replenish and stimulate the self; without the fulfillment of selfobject needs, shame can be propelled and exacerbated. Lastly, the client-centered approach emphasizes the need for unconditional positive regard, empathy, and genuineness which are necessary for the therapeutic relationship. Erikson's Psychosocial Stages of Development, Rogers' client-centered approach, and self-psychology are theoretically suitable for this research study, and helped to guide the study.

Chapter Five: The Research Question

The purpose of this research study was to address the knowledge gap by examining the role of the therapeutic relationship when shame presents in adolescents. This researcher generalized the study to mental health clinicians practicing in New York State, which included social workers, mental health counselors, marriage and family therapists, creative arts therapists, psychologists, and psychiatrists. Online recruitment took place through seven online List Serves. The seven List Serves included the Upper West Side Alliance List Serve, the Clinicians Collective, the Brooklyn and Beyond Mental Health List Serve, and Abundance Practice List Serve, the Private Practice Studio List Serve, the Smith School for Social Work Alumni New York Chapter, and the NASW New York State List Serve. The Upper West Side Alliance List Serve included over 500 members and was comprised of a mixture of social workers, psychologists, psychiatrists, and other mental health practitioners, all of whom practice in the state of New York. The Clinicians Collective included 1000 clinicians with social work, psychology, and psychiatric degrees located in eight locations; for the purposes of the study, three out of these eight List Serve populations were utilized. These three List Serves included the New York City, Brooklyn, and Long Island Clinicians Collective List Serves, and excluded the New Jersey, Westchester/Connecticut, Atlanta, Chicago, and Colorado Clinicians Collective List Serves. The Brooklyn and Beyond Mental Health List Serve had 1002 members who practice in the state of New York. The Abundance Practice List Serve had 69 members who practice in the state of New York, and includes LMSW's, LCSW's, and individuals with other counseling degrees such has psychologists, mental health practitioners, etc. The Smith School for Social Work Alumni New York Chapter consisted of 26 members, all of whom were graduates of Smith College School for

Social Work practicing in the state of New York, and held an LMSW or LCSW. Lastly, this researcher utilized the New York State National Association of Social Workers (NASW) Chapter List Serve. There were 60,992 individuals in the United Stated who are on the NASW email list and hold a Master of Social Work. Out of these 60,992 individuals, 7,119 hold Master of Social Work, are members of the NASW New York State List Serve, and practice in the state of New York.

This researcher was interested in reaching as many mental health clinicians in the New York State area. Inclusionary criteria included being a clinician in New York State, having previously or currently worked with adolescents in a clinical setting, having access to a computer with Internet, and the ability to read and write in English. Inclusionary criteria included clinicians who are social workers, mental health counselors, marriage and family therapists, creative arts therapists, psychologists, and psychiatrists, which allowed this researcher to reach a wide sample. Information about the study was sent to the members of each of the seven List Serves which explained the research study and inclusionary criteria.

The study examined the role of the therapeutic relationship when an adolescent client presents with shame. The study's research question was: How much does the therapeutic relationship contribute to the treatment of adolescent shame within the context of varying treatment modalities? Sub-questions include: What intervention modality do clinicians identify as most effective in treating adolescent shame? What are the most important ingredients of the therapeutic relationship that help treat adolescent shame? What is the impact of the therapeutic relationship according to the modality chosen by the clinician?

Study Question #1:

How much does the therapeutic relationship contribute to the treatment of adolescent shame within the context of perceived most effective treatment modalities?

Hypothesis #1:

The more attention given to the quality of the therapeutic relationship, the better the client's outcome, regardless of the specific treatment modality.

Study Question #2:

What intervention modality do clinicians identify as most effective in treating adolescent shame?

Hypothesis #2:

There will be differences in effective outcomes based on intervention modalities in treating adolescent shame.

Study Question #3:

What are the most important ingredients of the therapeutic relationship that help treat adolescent shame?

Hypothesis #3:

The stronger the therapeutic relationship is, the more adolescent shame can emerge in the treatment.

Study Question #4:

What is the impact of the therapeutic relationship when working with adolescents who experience shame, according to the modality chosen by the clinician?

Hypothesis #4:

The stronger the therapeutic relationship, the more the effective treatment modality will be able to be utilized/accessed.

Chapter Six: Research Methodology

The Research Design

The present research study was quantitative in nature and completed electronically using a cross-sectional survey research design. The study was nomothetic in nature with the goal of generating explanations from a large set of data. The study was conducted in New York State, and data was collected through a survey that was disseminated online. This researcher located seven List Serves such as the Upper West Side Alliance and the Clinicians Collective that were made up mental health clinicians working in clinical settings in the state of New York. Inclusionary criteria consisted of mental health clinicians who previously worked or were currently working with adolescents in a clinical setting, had access to a computer, and were able to read and write in English. Information about the study was be sent to clinician's who met the inclusionary criteria and agreed to participate in the study.

Sampling: Data and Subjects

The source of data for the study was gathered through the use of individual online surveys which participants filled out. Online recruitment occurred via seven List Serves. This researcher was interested in reaching as many mental health practitioners in the New York State area, which included social workers, mental health counselors, marriage and family therapists, creative arts therapists, psychologists, and psychiatrists. As per an A-priori power analysis, this researcher aimed to receive 139 responses from participants (Soper, 2006). Additionally, the researcher shared general findings for types of interventions used and difficulties in treatment with participants to promote involvement in the study.

Measures

The following critical concepts were used throughout the study and operationally defined: shame, adolescents, depression, anxiety, trauma, coping, treatment modality, therapeutic relationship, therapeutic alliance, and healing. Quantifying shame is a complex, multi-layered task that has been approached from many different pathways. For the purposes of the present study, shame was operationally defined as a "self-conscious but socially shaped emotion that is linked to threats to (social) self-identity, and it plays a fundamental role in the formation of one's sense of self and self-identity as a social agent" (Matos, Pinto-Gouveia, & Duarte, 2013, p. 480; Dearing & Tangney, 2011). Shame instruments that were dominant in the literature were organized by shame proneness, internal and external shame, domain-specific shame, and physical manifestations of shame. The seven most commonly used shame instruments that populated in the literature review included the Test of Self-Conscious Affect-3 (TOSCA-3) (Tangney, Dearing, Wagner, & Gramzow, 2000), the Depression, Anxiety and Stress Scale (DASS) (Lovibond & Lovibond, 1995), the Impact of Event Scale-Revised (IES-R) (Weiss & Marmar, 1997), the Other As Shamer Scale (OAS) (Allan, Gilbert, & Goss, 1994; Goss, Gilbert, & Allan, 1994), the Experience of Shame Scale (ESS) (Andrews et al., 2002), The Rosenberg Self-Esteem Scale (RSES) (Rosenberg, 1965), and the Centrality of Event Scale (CES) (Berntsen & Rubin, 2006). None of these instruments, however, allowed for clinicians to fill out the scale.

This researcher identified ten instruments that measured the therapeutic relationship. One limitation was that these ten instruments were used for adults in psychotherapy. These instruments included the Pennsylvania (Penn) scales (Alexander and Luborsky, 1986; Luborsky et al., 1985; Luborsky et al., 1983), the Vanderbilt scales (Hartley and Strupp, 1983; O'Malley et al., 1983; Suh et al., 1986), the Toronto scales (Marziali, 1984; Marziali et

al., 1981), the Working alliance inventory (WAI) (Horvath and Greenberg 1986, 1986, 1989), the California scales (Gaston and Marmar, 1994; Marmar et al., 1989a; Marmar et al., 1989b), the Therapeutic session report (TSR) (Orlinsky and Howard (1966, 1986), the Therapeutic bond scales (TBS) (Saunders et al., 1989) (Ardito & Rabellino, 2011), the Psychotherapy status report (PSR) (Frank and Gunderson, 1990), the Agnew relationship measure (ARM) (Agnew-Davies et al., 1998), and the Kim alliance scale (KAS) (Kim et al., 2001). Out of ten instruments, seven can be completed by the therapist. For the purposes of the present study, this researcher utilized the Working Alliance Inventory – Short Revised - Therapist (WAI-SRT) (Hatcher & Gillaspy, 2006).

Working Alliance Inventory – Short Revised - Therapist (WAI-SRT)

The Working Alliance Inventory (WAI; Horvath & Greenburg, 1986, 1989) is a self-report measure designed to assess the working alliance construct proposed by Bordin (1979). Bordin (1979) suggested that the working alliance grew out of "client–therapist agreement on therapy goals, agreement on therapy tasks, and development of a strong relational bond between client and therapist" (Busseri & Tyler, 2003, p. 193). This researcher selected WAI for the present study due to the empirical attention the instrument received (Martin, Garske, & Davis, 2000). Additionally, "over 100 published research reports and several metanalytic reviews (Horvath, 1994; Horvath & Symonds, 1991; Martin et al., 2000) have explored various aspects of the WAI" (Busseri & Tyler, 2003, p. 193). The Working Alliance Inventory (WAI; Horvath & Greenburg, 1986, 1989) is a 36-item 7-point Likert type scale where 12 of which are in each of three subscales: Task, Goal, and Bond. Since 1986, several versions of the WAI have been created which many studies have adopted; it has also been translated in 18 different languages. These include the Working Alliance Inventory Short

Form (WAI-S) proposed by Tracey and Kokotovic (1989), and the Working Alliance

Inventory-Short Revised (WAI-SR; Hatcher & Gillaspy, 2006), and the Working Alliance

Inventory – Short Revised - Therapist (WAI-SRT) all of which are based on Horvath and

Greenberg's (1986, 1989) widely used Working Alliance Inventory (WAI). The WAI-SRT is

a 10-item 5-point Likert type scale to be filled out by the therapist.

      After reviewing the literature, there was a lack of consensus of an operational

definition of adolescent chronology; multiple factors must be taken in to consideration,

including the perpetual growth and development of human beings, acknowledgement of an

individual's culture, race, ethnicity, a gender variability, and fluctuating developmental

milestones. However, for the purposes of this study, the operational definition of adolescence

is a period of hormonal, biological, and sexual changes and impulses taking place between

the ages of eleven to eighteen (Berzoff et al., 2011). Depression has been operationalized to

include all depressive disorders encompassed in the Diagnostic and Statistical Manual

(DSM-5). Anxiety has also been operationalized to include all anxiety disorders

encompassed in the Diagnostic and Statistical Manual (DSM-5). Trauma was operationalized

to include all trauma and stress-related disorders encompassed in the Diagnostic and

Statistical Manual (DSM-5). Coping has been operationally defined as an individual's

"ability to manage personal problems, stress, and conflict, which is often described in terms

of coping strategies or coping behaviors (Kinnunen et al., 2010, p. 112). Treatment modality

has been operationalized to include the chosen theory and orientation in which a therapist

operates by (Dore, 1990). The therapeutic relationship and the therapeutic alliance, which are

used interchangeably throughout the present study has been operationalized to include "the

trust between the patient and therapist that allows them to work together effectively"

(Cabannis, 2011, p. 85). Lastly, the healing of shame has been operationalized through therapist's self-reports of client symptom relief which will be based on their perceptions of decreases in client's symptom distress.

Variables

  Demographic Variables. Demographic data was collected from participants to describe the sample. Demographic indicators were measured as followed: (1) age; (2) gender (0 = male; 1 = female); (3) race (1 = Caucasian/White, 2 = Hispanic, 3 = Asian, 4 = African American); (4) city of practice (0 = Brooklyn, 1 = Manhattan, 2 = Staten Island, 3 = Queens, 4 = Albany, 5 = Bronx); (5) highest degree (1 = Mental Health Counselor, 2 = Social Worker, 3 = Psychologist, 4 = Psychiatrist); (6) employment status (0 = part-time, 1 = full-time, 2 = full-time/salaried); (7) employment setting (1 = private practice, 2 = clinic, 3 = school, 4 = hospital). Ten questions asked participants to select yes or no (1 = yes, 0 = no). One question asked participants to select what impacted the treatment most (1 = the therapeutic relationship, 0 = the intervention). Participants were asked to select the length of time it took for adolescent clients to recover from shame (1 = 0-3 months, 2 = 3-6 months, 3 = 6 months-1 year, 4 = 1-2 years, 5 = 2 years or more). Two questions examined the modality of treatment for adolescents; participants were asked what their preferred modality for treatment of adolescents was, what modality they used in their current practice, as well as what modality that identified as most effective. Preferred modality will be abbreviated to PM; the modality participants used will be abbreviated to MU; the modality participants selected as most effective will be abbreviated to ME. Fourteen modalities were listed for participants to select from, which included (1) Psychodynamic/Psychoanalytic Psychotherapy, (2) Cognitive Behavioral Therapy (CBT), (3) Trauma Focused Cognitive

Behavioral Therapy, (4), A variation of a CBT approach, (5), Dialectical Behavioral Therapy

(DBT), (6) Relational Psychotherapy, (7) Attachment-based Psychotherapy, (8) Eye

Movement Desensitization and Reprocessing (EMDR), (9) Compassion Focused Therapy

(CFT), (10) Acceptance and Commitment Therapy (ACT), (11) Exposure Therapy, (12)

Supportive Psychotherapy, (13) Interpersonal Psychotherapy, and (14) Biofeedback.

Participants were to select all that applied to their clinical experience. Lastly, the Therapeutic

Relationship was measured via The Working Alliance Inventory – Short Revised - Therapist

(WAI-SRT) (Hatcher & Gillaspy, 2006), a ten question five-point Likert type scale to be

filled out by each participant (1 = Seldom, 2 = Sometimes, 3 = Fairly Often., 4 = Very Often,

5 = Always).

Procedures

In order to assess the reliability and validity of the survey, the Total Design method,

developed by Don Dillman was utilized. Over the years, the method has been refined and

expanded upon, as the development of the Total Design parallels the development in survey

methodology; the Total Design was renamed to the Tailored Design in the 2000 publication

(Zmud, 2013). Dillman et al., (2009) suggests that 'Total' "implies that attention must be

paid to all aspects of [a research] design; there is no 'silver bullet' in the design process, but

hundreds of small individual designs must receive attention, from the specific wording of the

precontact letter through to the visual design of the final questionnaire" (Zmud, 2013, p.

182). 'Tailored' implies that there is no singular method that applies universally to situations,

and that it is dependent on the topic, demographic population, location, and availability of

datasets (Zmud, 2013). Dillman's Design pays special attention to four dominant sources of

survey methodology error, which includes coverage error, sampling error, non-response error, and measurement error (Zmud, 2013).

Coverage error refers to a bias that may take place when members of a target population have a "known, non-zero chance of inclusion in the sample" (Zmud, 2013, p. 183). In order to avoid coverage error from taking place, this researcher utilized the seven List Serves and gave all potential respondents an opportunity to respond to the survey. Additionally, coverage error refers to the study population and whether the selected List Serves are an appropriate representation of one's overall study population. It is important, then, to note that some members in the selected List Serves differed from the overall study population. While all seven List Serves were made up of mental health clinicians who practice in the state of New York, five out of the seven chosen List Serves consisted not only of social workers, but of members who have professional degrees that include psychologists, mental health counselors, and psychiatrists. Specifically, the Clinicians Collective online discussion forum is made up of social workers, but also psychologists, psychiatrists, and other mental health practitioners. Similarly, the Abundance Practice List Serve included members who ranged from LMSW's, LCSW's, psychologists, and various other mental health practitioners. Participants were asked to select what their highest degree was. This researcher pulled out findings specific to social workers as a separate cohort for data analysis. It is important to note that the individuals who use the selected List Serves are connected to a large community of therapists which may impact the results. It is also possible that these individuals were more technologically savvy given that they are connected to an online community of clinicians. Therefore, this convenience sample does not represent every

mental health clinician in New York State and is therefore only representative of the participants who took part in the survey.

Sampling error takes place when the sample is too small to adequately infer survey results, therefore, this researcher attempted to reach as many mental health clinicians in the state of New York as possible. Therefore, this researcher used Dillman's recruitment efforts in order to gather a large enough sample size to provide power that could provide statistically significant results. This researcher ran an A-priori power analysis and determined that the minimum required sample size was 139 (Soper, 2006).

Non-response error refers to increasing online survey response rates. In order to do so, this researcher conducted a pilot test to identify any complications with the survey, including "question mechanics, formatting, question language, skip logic, viewing it in different browsers, and with survey length" (Monroe & Adams, 2012, p. 4). Additionally, this researcher developed a detailed plan that listed the steps participants must take during the data collection period. This researcher detailed informed consent, risks and benefits of participating, and provided general research results to individuals who participated. The researcher followed-up with participants two times to increase the likelihood of responses from participants. First, this researcher sent an email with the personalized survey link, followed by one reminder email to participants (Monroe & Adams, 2012). In order to encourage participation and engagement from participants, the researcher shared general findings from the research study with participants, such as types of interventions used and the difficulties in treatment with participants. There was no financial reward or incentive given to individuals who participated in the online survey.

Lastly, measurement error can be assessed by the reliability and validity of the questions asked in the online survey. Reliability and validity of the Working Alliance Inventory – Short Revised – Therapist (WAI-SRT) Horvath and Greenberg (1989; Horvath, 1981) have been "demonstrated through positive correlations and with other working alliance scales and therapy outcomes" (Groth & Hilsenroth, 2019, p. 4; Hatcher & Gillaspy, 2006). The questions that this researcher developed were pilot tested and further examined and assessed by experts for face validity.

Data was collected through an online survey. A link to the survey was emailed directly to a sample of clinicians who were reached through seven online List Serves, including Upper West Side Alliance List Serve, the Clinicians Collective, the Brooklyn and Beyond Mental Health List Serve, the Abundance Practice List Serve, the Private Practice Studio List Serve, the Smith School for Social Work Alumni New York Chapter, and the NASW New York State List Serve. The population used in the present study included mental health clinicians, including social workers, mental health counselors, marriage and family therapists, creative arts therapists, psychologists, and psychiatrists practicing in the state of New York. Completion of the survey by a clinician signified that informed consent was given. Additionally, all respondents were informed that their participation in the survey was voluntary and strictly confidential.

Data Analysis

The data was analyzed using RStudio. The survey collected demographic information that provided descriptive data about the population being studied. Descriptive and inferential statistics were used to analyze these measures and to look for correlations and associations between phenomena. Descriptive statistics were used to describe the demographic

characteristics of the study participants including frequency distributions, graphs, and measures of central tendency (i.e. mean, median). Descriptive statistics were also used to ensure that the data were normally distributed and that no assumptions were violated such that the inferential statistics would be invalid. A correlational matrix was conducted to ensure multicollinearity was not present. Inferential statistics were used to test associations between variables to assess whether and how strongly the variables are related to each other (Anastas, 1999).

Multiple Regression

Multiple regression analysis is a common method used by researchers when comparing multiple variables. Conducting a multiple regression analysis enabled this researcher to hold other variables constant and rule out false variables as a source of difference. According to Rubin and Bellamy (2012), a multiple regression "assess[es] the correlations between variables when the effects of the other variables are controlled for" (p. 330). Therefore, in order to test the proposed hypotheses, this researcher utilized multiple regression to examine the factors that were associated with the shame and the therapeutic relationship. To test for reliability, Cronbach's alpha was utilized. These methods told the researcher what the direction of the relationship was in, if it was statistically significant, and how powerful the relationship was.

Hypothesis	Variable Name	Definition	Level of Measurement	Variable Use	Analysis
H1: The more attention given to the quality of the therapeutic relationship, the better the client's outcome, regardless of the	Treatment modality	*Treatment modality:* the chosen theory and orientation in which a therapist	Categorical	Dependent variable: shame. Independent variable: the	Multiple regression

specific treatment modality.		operates by (Dore, 1990).		therapeutic relationship. Covariates: clinical orientation and treatment modality.	
H2: There will be differences in effective outcomes based on intervention modalities in treading adolescent shame.	Shame	*Shame*: a "self-conscious but socially shaped emotion that is linked to threats to (social) self-identity, and it plays a fundamental role in the formation of one's sense of self and self-identity as a social agent" (Matos, Pinto-Gouveia, & Duarte, 2013, p. 480; Dearing & Tangney, 2011).	Dichotomous	Dependent variable: shame Independent variable: the treatment modality.	Multiple regression
H3: The stronger the therapeutic relationship is, the more adolescent shame can emerge in the treatment.	Therapeutic relationship	*Therapeutic relationship:* "the trust between the patient and therapist that allows them to work together effectively" (Cabannis, 2011, p. 85).	Categorical	Dependent variable: safety. Independent variable: the therapeutic relationship.	Multiple regression

specific treatment modality.		operates by (Dore, 1990).		therapeutic relationship. Covariates: clinical orientation and treatment modality.	
H2: There will be differences in effective outcomes based on intervention modalities in treading adolescent shame.	Shame	*Shame*: a "self-conscious but socially shaped emotion that is linked to threats to (social) self-identity, and it plays a fundamental role in the formation of one's sense of self and self-identity as a social agent" (Matos, Pinto-Gouveia, & Duarte, 2013, p. 480; Dearing & Tangney, 2011).	Dichotomous	Dependent variable: shame Independent variable: the treatment modality.	Multiple regression
H3: The stronger the therapeutic relationship is, the more adolescent shame can emerge in the treatment.	Therapeutic relationship	*Therapeutic relationship:* "the trust between the patient and therapist that allows them to work together effectively" (Cabannis, 2011, p. 85).	Categorical	Dependent variable: safety. Independent variable: the therapeutic relationship.	Multiple regression

| H4: The stronger the therapeutic relationship, the more the effective treatment modality will be able to be utilized/accessed. | Treatment modality

Therapeutic relationship | *Treatment modality:* the chosen theory and orientation in which a therapist operates by (Dore, 1990).

Therapeutic relationship: "the trust between the patient and therapist that allows them to work together effectively" (Cabannis, 2011, p. 85). | Continuous | Dependent variable: shame.

Independent variable: the therapeutic relationship. | Linear regression with an interaction term to assess moderation of therapeutic relationship. |

Chapter Seven: Results

This chapter will present the results of the data analysis. It will begin with demographic descriptions of the sample and will be followed by the results from testing each research question and hypothesis. Additional results will be presented that relate to relevant findings from the survey. Lastly, this researcher pulled out findings specific to social workers as a separate cohort for data analysis and compared the results to the other mental health practitioners, which will be expounded upon in each research question.

Demographic Description of the Sample

A detailed demographic description of the sample is displayed in Table 1. Demographic details include means and frequencies of the participants, including age, gender, race, city of practice in New York State, highest degree, setting of practice, how long the clinician has been practicing, and how long the clinician has been working with the adolescent population. The total sample was comprised of 54 mental health practitioners. The average age of the participants was 38.28 years old ($SD = 10.95689$). The majority of the sample was female, ($n = 41$, 76%). Most of the sample identified themselves as White/Caucasian ($n = 44$, 81%). The majority of the sample identified as a social worker with either an LMSW, LCSW, or PhD ($n = 33$, 61%), while others were Mental Health Counselors ($n = 4$, 7%), Psychologists ($n = 9$, 16%), or Psychiatrists ($n = 7$, 13%).

Overall, Table 1 shows that this study population was predominantly white, female, social workers (LMSW, LCSW, PhD) practicing in a private practice in Manhattan, New York. In addition to Manhattan, participants were mainly representative of Brooklyn ($n = 7$, 13%), Staten Island ($n = 4$, 7%), Queens ($n = 4$, 7%), Albany ($n = 2$, 3%), and the Bronx ($n = 2$, 3%).

Table 1

Demographics

	N	Mean	SD	Percentage
Age	54	38.28	10.95689	--
Gender				
Female	--	41	--	76%
Male	--	12	--	22%
Race				
White/Caucasian	54	44	--	81%
Hispanic	54	4	--	7%
Asian	54	3	--	5%
African American	54	1	--	1%
City of Practice in New York State				
Manhattan	--	34	--	64%
Brooklyn	--	7	--	13%
Staten Island	--	4	--	7%
Queens	--	4	--	7%
Albany	--	2	--	3%
Bronx	--	2	--	3%
Highest Degree				
Social Work Degree: LMSW, LCSW, PhD	--	33	--	61%
Psychology Degree: Masters, PsyD, PhD	--	9	--	16%
Psychiatrist	--	7	--	13%
Mental Health Counselor	--	4	--	7%
Marriage and Family Therapist	--	0	--	0
Creative Arts Therapist	--	0	--	0
Setting of Practice				
Private Practice	--	22	--	41%
Clinic	--	15	--	28%
School	--	9	--	17%

Hospital	--	7	--	13%
Length of Time Working with Adolescents (years)	--	9.141	8.049271	--
Length of Time Practicing in the Field (years)	--	9.17	9.1	--

Research Question and Hypothesis Testing

Four hypotheses were tested to answer four overall research questions. These research

questions are detailed below.

Research Question #1: How much does the therapeutic relationship contribute to the

treatment of adolescent shame within the context of perceived most effective (ME) treatment

modalities?

Hypothesis #1: The more attention given to the quality of the therapeutic relationship, the

better the client's outcome, regardless of the specific treatment modality.

A multiple regression was conducted to test the therapeutic relationship and how it

predicted the treatment outcome when addressing shame within the context of perceived

most effective treatment modalities. The time estimated for adolescent recovery of shame

was used as the dependent variable, and all 54 participants reported having seen a reduction

in shame throughout their treatment of adolescents. The fourteen modalities included (1)

Psychodynamic/Psychoanalytic Psychotherapy, (2) Cognitive Behavioral Therapy (CBT), (3)

Trauma Focused Cognitive Behavioral Therapy, (4), A variation of a CBT approach, (5),

Dialectical Behavioral Therapy (DBT), (6) Relational Psychotherapy, (7) Attachment-based

Psychotherapy, (8) Eye Movement Desensitization and Reprocessing (EMDR), (9)

Compassion Focused Therapy (CFT), (10) Acceptance and Commitment Therapy (ACT),

(11) Exposure Therapy, (12) Supportive Psychotherapy, (13) Interpersonal Psychotherapy,

and (14) Biofeedback. The therapeutic relationship and each of the fourteen modalities were treated as independent variables and covariates in a multiple regression analysis to determine the contribution of each individual independent variable while controlling for the others. This allowed the researcher to determine to what degree the therapeutic relationship affected the reduction of shame in adolescents when controlling for all of the intervention modalities. A continuous dependent variable, the amount of time an adolescent took to recover from shame while in psychotherapy, and the independent variable, the therapeutic relationship, were inputted to evaluate what was most effective. Results showed that the therapeutic relationship contributed significantly to the reduction time of shame in adolescents when controlling for all of the other intervention modalities. Specifically, the stronger the therapeutic relationship was, the shorter the amount of time it took to recover and heal from adolescent shame while controlling for all fourteen treatment modalities (B = -0.08262, t = -2.519, p = 0.0164). Only one intervention emerged as significant when controlling for each therapeutic modality and the therapeutic relationship, Attachment-based Psychotherapy. However, the direction of the treatment affect was in the opposite expected direction, showing that the use of Attachment-based Psychotherapy increased the recovery time in treating adolescents with shame (B = 1.10591, t = 3.183, p = 0.003). In other words, participants who utilized Attachment-based Psychotherapy took longer to see a reduction of shame in their adolescent clients. See Table 2 for detailed results.

This researcher condensed the fourteen intervention modalities into five categories and utilized a multiple regression. The five condensed intervention groups appear in Table 2a. A continuous dependent variable, the amount of time an adolescent took to recover from shame while in psychotherapy, and the independent variable, the condensed individual

intervention modalities, were inputted to evaluate what was most effective. When controlling for relationship-based modalities, the therapeutic relationship approaches significance and has an appropriate estimate, meaning that it shows a reduction in recovery time as the strength of the therapeutic relationship increases (B = -0.06161, t = -1.936, p = 0.058481). When controlling for behavioral modalities, the therapeutic relationship was statistically significant, meaning that the true contributor was the therapeutic relationship in terms of reducing shame (B = -0.07326, t = -2.328, p = 0.024). With regard to psychodynamic modalities and the therapeutic relationship shows statistical significance (B = -0.06768, t = -2.142 , p = 0.0369). Similarly, when controlling for trauma-based modalities, as the therapeutic alliance strengthens, the recovery time for shame decreases (B = -0.06513, t = -2.065, p = 0.044). Lastly, with regard to compassion-based modalities and the therapeutic relationship, results showed statistical significance (B = -0.07021 , t = -2.060, p = 0.0446).

This researcher also conducted a regression with the five condensed intervention modalities; specifically, the continuous dependent variable remained the amount of time an adolescent took to recover from shame while in psychotherapy, and the independent variable included the five condensed modalities, (1) relationship-based modalities, (2) behavioral modalities, (3) psychodynamic modalities, (4) trauma modalities, and (5) compassion focused modalities. Results showed that the therapeutic relationship was statistically significant and none of the interventions were. Table 2b shows detailed results.

This researcher also considered multicollinearity of the independent variables. The highest variance inflation factor was 2.03, well below the standard cutoff of 10 for variables of concern. Therefore, it was concluded that the independent variables were indeed

measuring different constructs and appropriate to analyze within the same multiple regression model.

This researcher assessed the normality of shame. Results showed a mean of 3.26, a standard deviation of 1.1, a skew of -0.18, and kurtosis of -0.2, indicating that the skew and the kurtosis are within the normal range and that the researcher's dependent variable is considered normal. See Histogram in Figure 3.

This researcher also tested the reliability of the Working Alliance Inventory – Short Revised - Therapist (WAI-SRT) (Hatcher & Gillaspy, 2006) measure within this study sample. The WAI-SRT measure performed good reliably within this cohort ($a = 0.789$). See Table 4 and Table 5 for detailed results.

Lastly, this researcher pulled findings specific to social workers as a separate cohort for data analysis and compared them to the other mental health practitioners. Other mental health clinicians were made up of mental health counselors, psychologists, and psychiatrists. When examining reported adolescent shame recovery time, the results showed that there was not a statistically significant difference between social workers and the other practitioners. Social workers reported a slightly shorter recovery time but it was not statistically significant ($B = -0.1212$, $t = -0.391$, $p = 0.69$). See Table 6 and 7 for more detailed results.

This researcher also compared the recovery time for adolescent shame and the perceived most effective intervention modality between social workers and other mental health practitioners. When examining what participants perceived to be the most effective intervention modality in relation to the recovery time, social workers did not show statistical significance (*Therapeutic Relationship Score* = 0.09481). When examining what other clinicians perceived to be the most effective intervention modality in relation to the recovery

time for adolescent shame, the therapeutic relationship did show statistical significance (p = 0.0403, b = -0.16104, t = -2.990).

Similar to aforementioned results, social workers who utilized Attachment-based Psychotherapy showed a slower recovery time in shame for adolescent clients (B = 1.28056, t = 3.121, p = 0.00659). These results indicate that social workers who used Attachment-based Psychotherapy take longer see a reduction of shame in their adolescent clients.

Overall, these findings suggest that the therapeutic relationship showed statistical significance in the grouping of other clinicians, however, this was not the case within social workers. This variance in recovery time between groups may be due to a group phenomenon or a loss in statistical power due to the smaller sample sizes in the subset groups. Results, however, show, that the therapeutic relationship has a great predictor for outcomes for other mental health clinicians when compared to social workers. Limitations will be further expounded upon in the discussion section. See Table 8 for further details.

Table 2

Therapeutic Relationship, Intervention Modalities, and Shame Recovery Time

	B	t	p
Therapeutic Relationship Score	-0.08262	-2.519	0.0164*
Psychodynamic/Psychoanalytic Psychotherapy	-0.04413	-0.138	0.8909
Cognitive Behavioral Therapy (CBT)	-0.24805	-0.748	0.4591
Trauma Focused Cognitive Behavioral Therapy	0.3265	0.825	0.4149
A variation of a CBT approach	-0.22525	-0.693	0.4928
Dialectical Behavioral Therapy (DBT)	0.35285	1.113	0.2731
Relational Psychotherapy	-0.46576	-1.354	0.1842
Attachment-based Psychotherapy	1.10591	3.183	0.003**
EMDR	-0.0364	-0.057	0.9548
Compassion Focused Therapy (CFT)	0.65525	1.275	0.2106
Acceptance and Commitment Therapy (ACT)	-0.41356	-0.995	0.3264
Exposure Therapy	-0.48925	-0.742	0.4626
Supportive Psychotherapy	-0.09015	-0.26	0.796
Interpersonal Psychotherapy	0.08059	0.257	0.7986
Biofeedback	-0.923	-1.278	0.2095

Footnote: *<.05, **<.01

Table 2a

Relationship-Based Modalities	Behavioral Modalities	Psychodynamic Modalities	Trauma Modalities	Compassion Focused Modalities
Relational Psychotherapy	Cognitive Behavioral Therapy (CBT)	Psychodynamic/ Psychoanalytic Psychotherapy	Trauma Focused Cognitive Behavioral Therapy	Compassion Focused Therapy (CFT)
Attachment-Based Psychotherapy	Dialectical Behavioral Therapy (DBT)			Acceptance and Commitment Therapy (ACT)
Interpersonal Psychotherapy	A variation of a CBT approach			Biofeedback
Supportive Psychotherapy	Exposure Therapy			Eye Movement Desensitization and Reprocessing (EMDR)

Table 2b

	B	t	p
Therapeutic Relationship	-0.07639	-2.196	0.033282
Relationship-Based Modalities	0.18225	1.075	0.288252
Behavioral Modalities	-0.01668	-0.109	0.914001
Psychodynamic Modalities	0.07183	0.224	0.823705
Trauma Modalities	0.43228	1.161	0.251781
Compassion Focused Modalities	-0.26688	-1.092	0.280547

Figure 3

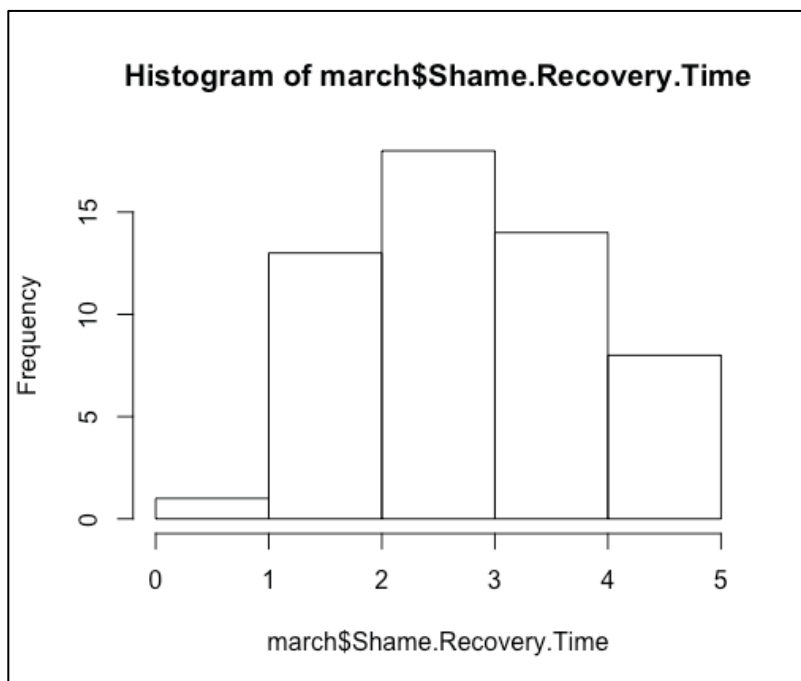

Histogram of march$Shame.Recovery.Time

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Table 4

Inter-Item Correlation Matrix

	_ and I agree about the steps to be taken to improve his/her situation.	I am genuinely concerned for _'s welfare.	We are working towards mutually agreed upon goals.	_ and I both feel confident about the usefulness of our current activity in therapy.	I appreciate _ as a person.	We have established a good understanding of the kind of changes that would be good for _.	_ and I respect eachother.	_ and I have a common perception of his/her goals.	I respect _ even when he/she does things that I do not approve of.	We agree on what is important for _ to work on.
_ and I agree about the steps to be taken to improve his/her situation.	1	0.125	0.416	0.33	0.168	0.524	0.183	0.247	0.103	0.447
I am genuinely concerned for _'s welfare.	0.125	1	0.023	-0.032	0.28	0.21	0.04	0.059	0.013	-0.02
We are working towards mutually agreed upon goals.	0.416	0.023	1	0.511	0.372	0.517	0.428	0.497	0.413	0.464
_ and I both feel confident about the usefulness of our current activity in therapy.	0.33	-0.032	0.511	1	0.14	0.479	0.461	0.302	0.216	0.431
I appreciate _ as a person.	0.168	0.28	0.372	0.14	1	0.3	0.515	0.287	0.575	0.16
We have established a good understanding of the kind of changes that would be good for _.	0.524	0.21	0.517	0.479	0.3	1	0.207	0.329	0.216	0.423
_ and I respect eachother.	0.183	0.04	0.428	0.461	0.515	0.207	1	0.306	0.377	0.235
_ and I have a common perception of his/her goals.	0.247	0.059	0.497	0.302	0.287	0.329	0.306	1	0.199	0.419
I respect _ even when he/she does things that I do not approve of.	0.103	0.013	0.413	0.216	0.575	0.216	0.377	0.199	1	0.068
We agree on what is important for _ to work on.	0.447	-0.02	0.464	0.431	0.16	0.423	0.235	0.419	0.068	1

Table 5

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
_ and I agree about the steps to be taken to improve his/her situation.	35.358	18.388	0.473	0.353	0.77
I am genuinely concerned for _'s welfare.	34.528	20.1	0.116	0.168	0.824
We are working towards mutually agreed upon goals.	34.83	16.336	0.678	0.54	0.74
_ and I both feel confident about the usefulness of our current activity in therapy.	35.226	17.717	0.518	0.474	0.764
I appreciate _ as a person.	34.151	18.784	0.518	0.549	0.766
We have established a good understanding of the kind of changes that would be good for _.	35.057	17.247	0.612	0.487	0.751
_ and I respect eachother.	34.396	18.705	0.498	0.458	0.768
_ and I have a common perception of his/her goals.	34.811	19.118	0.481	0.312	0.771
I respect _ even when he/she does things that I do not approve of.	34.396	19.013	0.383	0.419	0.78
We agree on what is important for _ to work on.	35.019	18.903	0.48	0.39	0.77

Table 6

Perceived Most Effective Treatment Modality: Social Workers

Modality	n	Percentage
Relational Psychotherapy	17	31%
A variation of a CBT approach	17	31%
Psychodynamic/Psychoanalytic Psychotherapy	16	30%
CBT	16	30%
Supportive Psychotherapy	16	30%
DBT	14	26%
Interpersonal Psychotherapy	13	24%
Attachment-based Psychotherapy	13	24%
Trauma Focused Cognitive Behavioral Therapy	11	20%
Acceptance and Commitment Therapy (ACT)	10	18%
Compassion Focused Therapy (CFT)	6	11%
Exposure Therapy	4	7%
Biofeedback	1	1%
EMDR	1	1%

Table 7

Perceived Most Effective Treatment Modality: Other Mental Health Practitioners

Modality	n	Percentage
Interpersonal Psychotherapy	13	24%
Psychodynamic/Psychoanalytic Psychotherapy	10	18%
CBT	9	16%
A variation of a CBT approach	9	16%
Supportive Psychotherapy	8	15%
DBT	6	11%
Relational Psychotherapy	6	11%
Trauma Focused Cognitive Behavioral Therapy	4	7%
Attachment-based Psychotherapy	3	5%
Compassion Focused Therapy (CFT)	3	5%
Acceptance and Commitment Therapy (ACT)	3	5%
EMDR	2	4%
Biofeedback	2	4%
Exposure Therapy	1	1%

Table 8

Perceived Most Effective Intervention Modality: Recovery Time for Adolescent Shame

Type of Clinician	B	t	p
Social Worker	-0.09743	-1.776	0.09481
Other (Mental Health Counselor, Psychologist, Psychiatrist)	-0.16104	-2.99	0.0403*

Footnote: *<.05, **<.01

Research Question #2: What intervention modality do clinicians identify as most effective in treating adolescent shame?

Hypothesis #2: There will be differences in effective outcomes based on intervention modalities in treading adolescent shame.

This researcher ran descriptive frequencies of the data to determine if a specific intervention modality was identified by clinicians as most effective in the treatment adolescent shame. These findings are detailed in Table 9. The three prominent modalities included Psychodynamic/Psychoanalytic Psychotherapy (48%), a variation of a CBT approach (48%), and Interpersonal Psychotherapy (48%). Cognitive Behavioral Therapy (CBT) was second modality that 46% of participants selected as effective in the treatment of adolescent shame. These results are representative of the clinician's perspective as the most effective intervention used to heal adolescent shame.

Specifically amongst social workers, Relational Psychotherapy (31%) and a variation of a CBT approach (31%) were utilized most frequently, followed by 30% of social work participants utilized a Psychodynamic/Psychoanalytic Psychotherapeutic approach. When compared to other practitioners, the most common intervention modality used was

Interpersonal Psychotherapy (24%), followed by Psychodynamic/Psychoanalytic

Psychotherapy (18%). See Table 10 for detailed results.

Secondly, a regression was also conducted to identify if certain therapeutic

intervention modalities facilitated a faster recovery of shame. The reduction model suggested

that when not controlling for the therapeutic relationship, only one modality, Attachment-

Based Psychotherapy was significant and in the opposite of the expected direction ($B =$

1.03277, $t = 2.788$, $p = 0.00832$). When using Attachment-based Psychotherapy, results

showed that there was a delayed recovery for shame, taking approximately three months to

one year. See Table 11 and Table 12 for full results.

Table 9

Intervention Modality that is Most Effective: All Clinicians

	N	Percent
Psychodynamic/Psychoanalytic Psychotherapy	26	48%
A variation of a CBT approach	26	48%
Interpersonal Psychotherapy	26	48%
Cognitive Behavioral Therapy (CBT)	25	46%
Supportive Psychotherapy	24	44%
Relational Psychotherapy	23	43%
Dialectical Behavioral Therapy (DBT)	20	37%
Attachment-based Psychotherapy	16	30%
Trauma Focused Cognitive Behavioral Therapy	15	28%
Acceptance and Commitment Therapy (ACT)	13	24%
Compassion Focused Therapy (CFT)	9	17%
Exposure Therapy	5	9%
Eye Movement Desensitization and Reprocessing (EMDR)	3	6%
Biofeedback	3	5%

Table 10

**Intervention
Modalities Clinicians
Identified as Most
Effective in Treating
Adolescent Shame**

Type of Clinician	Most Common Intervention Modality	Second Most Common Intervention Modality
All 54 Clinicians	Psychodynamic/Psychoanalytic Psychotherapy (48%)	CBT (46%)
	A variation of a CBT approach (48%)	
	Interpersonal Psychotherapy (48%)	
Social Workers	Relational Psychotherapy (31%)	Psychodynamic/ Psychoanalytic Psychotherapy (30%)
Other Mental Health Practitioners (Mental Health Counselors, Psychologists, Psychiatrists)	Interpersonal Psychotherapy(24%)	Psychodynamic/ Psychoanalytic Psychotherapy (18%)

Table 11

Therapeutic Modalities and Shame Regression: All Clinicians

	B	t	p
Psychodynamic/Psychoanalytic Psychotherapy	-0.08945	-0.262	0.79468
Cognitive Behavioral Therapy (CBT)	-0.27669	-0.781	0.43986
Trauma Focused Cognitive Behavioral Therapy	0.27696	0.655	0.5166
A variation of a CBT approach	-0.21223	-0.61	0.54538
Dialectical Behavioral Therapy (DBT)	0.25718	0.764	0.44983
Relational Psychotherapy	-0.40846	-1.112	0.27314
Attachment-based Psychotherapy	1.03277	2.788	0.00832**
Eye Movement Desensitization and Reprocessing	0.03507	0.051	0.95924
Compassion Focused Therapy (CFT)	0.89989	1.666	0.10411
Acceptance and Commitment Therapy (ACT)	-0.17106	-0.395	0.6948
Exposure Therapy	-0.53623	-0.761	0.45148
Supportive Psychotherapy	-0.20294	-0.553	0.58386
Interpersonal Psychotherapy	0.21902	0.663	0.51117
Biofeedback	-0.69899	-0.912	0.36792

Footnote: *<.05, **<.01

Table 12
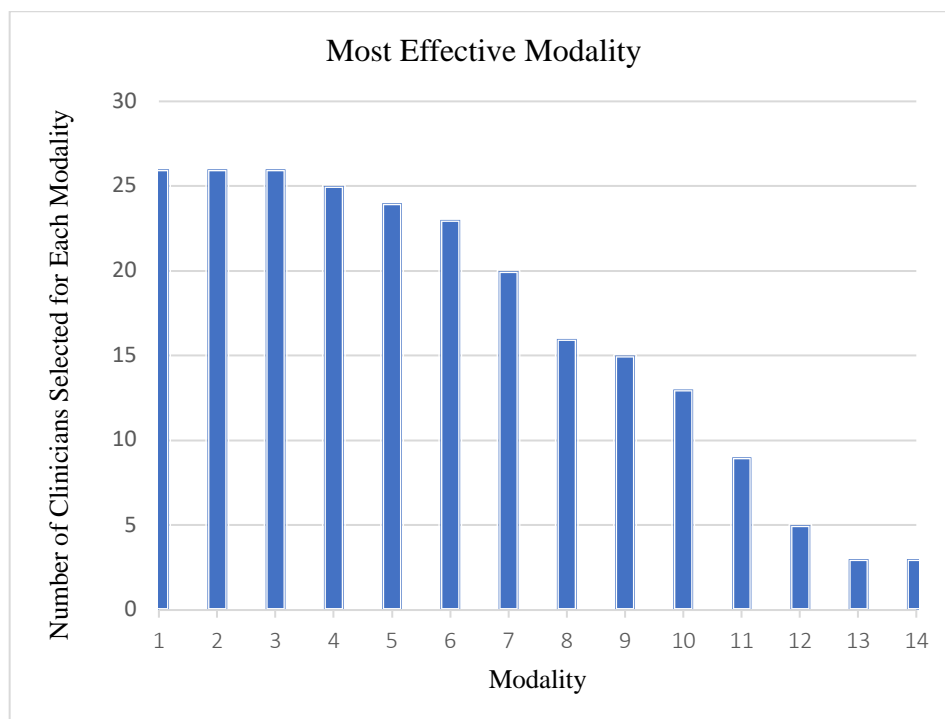
Footnote: 1 = Psychodynamic/Psychoanalytic Psychotherapy, 2 = Cognitive Behavioral Therapy (CBT), 3 = Trauma Focused Cognitive Behavioral Therapy, 4 = A variation of a CBT approach, 5 = Dialectical Behavioral Therapy (DBT), 6 = Relational Psychotherapy, 7 = Attachment-based Psychotherapy, 8 = Eye Movement Desensitization and Reprocessing (EMDR), 9 = Compassion Focused Therapy (CFT), 10 = Acceptance and Commitment Therapy (ACT), 11 = Exposure Therapy, 12 = Supportive Psychotherapy, 13 = Interpersonal Psychotherapy, 14 = Biofeedback

Research Question #3: What are the most important ingredients of the therapeutic

relationship that help treat adolescent shame?

Hypothesis #3: The stronger the therapeutic relationship is, the more adolescent shame can

emerge in the treatment.

A multiple regression was conducted to determine what clinicians identified as the

most important components of the therapeutic relationship. Based on clinician's perspectives,

results showed a variation in the outcomes of shame. Nine options were listed for participants

to select from, and participants were given the option to select all that applied. These nine options included (1) Rapport, (2) Trust, (3) Safety, (4) Emotional Attunement, (5) Respect, (6) Consistency, (7) Acceptance, (8) Patience, (9) Commitment, (10) None. The majority of participants reported that rapport was one of the most important components to healing shame. Two out of the nine options, emotional attunement and trust, showed significance when compared to the other seven options. Results indicated that clinicians who selected emotional attunement as an important component to the therapeutic relationship had an increase in the time it took to recover from shame ($B = 0.974$, $t = 2.388$, $p = 0.02131$). This could be anywhere from 3 months to 1 year. Results showed that clinicians who selected trust as an important ingredient to the therapeutic relationship showed a reduction in the time it took to recover from shame ($B = -1.0435$, $t = -2.143$, $p = 0.03768$). This could be anywhere from 3 to 6 months. See Table 13 for detailed results.

When looking at what component of the therapeutic relationship predicted a reduction time in shame specifically amongst social work participants, there was no statistical significance ($p = 0.6567$). Similarly, when comparing social work participants to the other mental health practitioners, there was also no statistical significance ($p = 0.7977$). This was likely due to the reduction in power due to the smaller sample size in subset groups.

Table 13

Therapeutic Relationship Components and Shame

	B	*t*	*p*
Rapport	-0.2286	-0.339	0.73653
Trust	-1.0435	-2.143	0.03768*
Safety	0.7884	1.891	0.06527
Emotional Attunement	0.9736	2.388	0.02131*
Respect	0.2839	0.757	0.45281
Consistency	0.1757	0.432	0.66797
Acceptance	0.6671	1.512	0.13771
Patience	-0.408	-0.945	0.34986
Commitment	-0.3429	-1.008	0.31902

Footnote: *<.05, **<.01

Research Question #4: What is the impact of the therapeutic relationship according to the modality chosen by the clinician?

Hypothesis #4: The stronger the therapeutic relationship, the more the effective treatment modality will be able to be utilized/accessed.

A simultaneous multiple regression analysis was used to determine the magnitude of effect on the recovery time for shame according to the fourteen intervention modalities, and the therapeutic relationship. This model varies from the first analysis by using the intervention modalities that participants selected as used. The modality independent variable had significant overlap in responses given that participants were asked to select all modalities used and did not specify in relation to the treatment of shame. Results indicated that the therapeutic relationship was not statistically significant when controlling for all of the used intervention modalities, but it did approach significance ($B = -.07$, $t = -1.84$, $p = .07$). All but one intervention used were also not statistically significant ($p > .05$). Attachment-based Psychotherapy still showed the opposite direction of effect ($B = 0.50385$, $t = 1.538$, $p =$

0.132447) indicating a longer time to recover from shame for adolescents. See Table 14 and

Table 15 for detailed results.

Table 14

Modality Effective Versus Modality Used

	Most Effective (ME) Treatment Modality			Most Used (MU) Treatment Modality		
	B	t	p	B	t	p
Psychodynamic/Psychoanalytic Psychotherapy	-0.02452	2.333	0.0283	-0.05414	-1.419	0.16523
Cognitive Behavioral Therapy (CBT)	0.04589	-1.02	0.31818	0.04596	-0.999	0.3282
Trauma Focused Cognitive Behavioral Therapy	-0.01524	-0.303	0.7667	-0.03029	-0.908	0.37571
A variation of a CBT approach	-0.0575	-1.015	0.32	-0.07017	-2.08	0.0459
Dialectical Behavioral Therapy (DBT)	-0.14589	-2.388	0.02809	-0.12081	-1.962	0.07341
Relational Psychotherapy	-0.02887	-0.636	0.5317	-0.02044	-0.421	0.6772
Attachment-based Psychotherapy	-0.03044	-0.502	0.6233	-0.06674	-1.196	0.2457
Eye Movement Desensitization and Reprocessing (EMDR)	-0.2903	-2.598	0.234	-1	N/A	N/A
Compassion Focused Therapy (CFT)	0.01513	0.283	0.785	0.01786	0.128	0.905
Acceptance and Commitment Therapy (ACT)	-0.03635	-0.669	0.5175	-0.008363	-0.116	0.91
Exposure Therapy	-0.23913	-2.4	0.0958	-0.05769	-0.947	0.3971
Supportive Psychotherapy	-0.05601	-1.099	0.2835	-0.05824	-1.447	0.15953
Interpersonal Psychotherapy	-0.09895	-1.937	0.06464	-0.10164	-2.014	0.054874
Biofeedback	-0.3571	-2.887	0.212	0.0625	0.577	0.667

Table 15

Most Used Modality: All Clinicians

	B	t	p
Therapeutic Relationship Score	-0.0704	-1.839	0.073794
Psychodynamic/Psychoanalytic Psychotherapy	-0.59226	-1.61	0.115706
Cognitive Behavioral Therapy (CBT)	-0.44211	-1.118	0.270789
Trauma Focused Cognitive Behavioral Therapy	0.29125	0.679	0.501115
A variation of a CBT approach	-0.22821	-0.623	0.537005
Dialectical Behavioral Therapy (DBT)	0.47319	1.171	0.248887
Relational Psychotherapy	-0.33508	-0.993	0.326969
Attachment-based Psychotherapy	0.50385	1.538	0.132447
Eye Movement Desensitization and Reprocessing (EMDR)	-1.04564	-1.13	0.26559
Compassion Focused Therapy (CFT)	0.55442	0.874	0.387791
Acceptance and Commitment Therapy (ACT)	0.21896	0.511	0.612262
Exposure Therapy	-0.31896	-0.614	0.543076
Supportive Psychotherapy	-0.36851	-0.999	0.324029
Interpersonal Psychotherapy	0.45213	1.284	0.206754
Biofeedback	-0.96527	-1.283	0.207296

Chapter Eight: Discussion

This chapter summarizes and interprets the findings, outlines the study's strengths and limitations, recommendations for future research, and implications for social work practice, policy and education.

Summary and Discussion of Major Findings

This study sampled a group of 54 mental health practitioners practicing in the State of New York. Participants completed an online survey comprised of closed and open-ended questions designed to investigate four research questions: (1) How much does the therapeutic relationship contribute to the treatment of adolescent shame within the context of varying treatment modalities? (2) What intervention modality do clinicians identify as most effective in treating adolescent shame? (3) What are the most important ingredients of the therapeutic relationship that help treat adolescent shame? (4) What is the impact of the therapeutic relationship according to the modality used by the clinician? The following section presents a discussion of the findings for each hypothesis.

Participants were asked how much they believed the therapeutic relationship contributed to the treatment of adolescent shame within the context of perceived most effective treatment modalities (ME). Overall, the therapeutic relationship emerged as the strongest contributor to shame recovery time when compared to specific modalities. Further, the data showed that the stronger the therapeutic relationship was, the shorter the amount of time it took to recover and heal from adolescent shame while controlling for the treatment modalities.

Participants were also asked to select the impact of the therapeutic relationship according to the modality used by the clinician (MU). Results indicated that the therapeutic

relationship, while approaching significance, was not significant when controlling for the modalities used. This researcher anticipated that these results would mirror one another, however, this was not the case. Therefore, this researcher will compare these two questions side by side.

The question that is prompted in the online survey that reflects research question 1 is, "What modality do you think is most effective for the treatment of adolescents? Select all that apply." Fourteen options are listed for participants to select from, which include (1) Psychodynamic/Psychoanalytic Psychotherapy, (2) Cognitive Behavioral Therapy (CBT), (3) Trauma Focused Cognitive Behavioral Therapy, (4), A variation of a CBT approach, (5), Dialectical Behavioral Therapy (DBT), (6) Relational Psychotherapy, (7) Attachment-based Psychotherapy, (8) Eye Movement Desensitization and Reprocessing (EMDR), (9) Compassion Focused Therapy (CFT), (10) Acceptance and Commitment Therapy (ACT), (11) Exposure Therapy, (12) Supportive Psychotherapy, (13) Interpersonal Psychotherapy, (14) Biofeedback. Quantitative analyses for research question 1 focused on participant scores of the independent variables, the therapeutic relationship and the clinician perceived most effective (ME) fourteen intervention modalities. These variables were analyzed to explore the degree to which the therapeutic relationship impacted the reduction of shame in the treatment of adolescents when controlling for the perceived most effective (ME) fourteen intervention modalities. Modalities included (1) Psychodynamic/Psychoanalytic Psychotherapy, (2) Cognitive Behavioral Therapy (CBT), (3) Trauma Focused Cognitive Behavioral Therapy, (4), A variation of a CBT approach, (5), Dialectical Behavioral Therapy (DBT), (6) Relational Psychotherapy, (7) Attachment-based Psychotherapy, (8) Eye Movement Desensitization and Reprocessing (EMDR), (9) Compassion Focused Therapy (CFT), (10)

Acceptance and Commitment Therapy (ACT), (11) Exposure Therapy, (12) Supportive

Psychotherapy, (13) Interpersonal Psychotherapy, (14) Biofeedback. When controlling for

the perceived most effective (ME) fourteen intervention modalities, results indicated that the

therapeutic relationship was the primary contributor to healing shame in adolescents, which

aligns with the evolving and aforementioned research on the therapeutic relationship.

Previous theorists state that the strength of the therapeutic relationship is a consistent

predictor of positive clinical outcomes, despite the psychotherapy approach or intervention

modality the therapist utilizes in the therapy (Wolfe & Goldfried, 1988; Fenton et al., 2001;

Horvath & Bedi, 2002; Norcross, 2002). This question suggested that overall, the therapeutic

relationship was the true contributor in improvement to recovery of shame when compared to

all of the other fourteen modalities.

  The research question that is prompted in the online survey that reflects research

question 4 is, "What modality do you use for the treatment of adolescents? Select all that

apply." The same fourteen options from Question 1 are listed for participants to select from,

which include (1) Psychodynamic/Psychoanalytic Psychotherapy, (2) Cognitive Behavioral

Therapy (CBT), (3) Trauma Focused Cognitive Behavioral Therapy, (4), A variation of a

CBT approach, (5), Dialectical Behavioral Therapy (DBT), (6) Relational Psychotherapy, (7)

Attachment-based Psychotherapy, (8) Eye Movement Desensitization and Reprocessing

(EMDR), (9) Compassion Focused Therapy (CFT), (10) Acceptance and Commitment

Therapy (ACT), (11) Exposure Therapy, (12) Supportive Psychotherapy, (13) Interpersonal

Psychotherapy, (14) Biofeedback. Quantitative analyses for research question 4 also focused

on participant scores of the independent variables, but instead of examining the therapeutic

relationship and the clinician perceived most effective (ME) fourteen intervention modalities,

it examined the intervention modality used by the clinician (MU). Results showed that there was no statistical significance for the therapeutic relationship when controlling for the intervention modalities participants used (MU), however, similar to aforementioned results, Attachment-based Psychotherapy had a negative effect. In other words, results showed participants who utilized that Attachment-based Psychotherapy took longer to see a recovery from shame than any of the other intervention modalities.

When this researcher looked at the time it took to recover from shame in relation to the intervention modalities participants believed were most effective (ME) in treating shame, the therapeutic relationship was statistically significant. Moreover, the therapeutic relationship was the main contributor to the recovery of shame. However, when this researcher looked at the time it took to recover from shame in relation to the intervention modalities participants used (MU), this relationship was no longer statistically significant. The therapeutic relationship was not significant, however, it was closer than other modalities and still showed a similar relationship. This lack of consistency in the findings is likely due to two reasons: lack of specification in the questions being asked and little variation in the modalities. First, the way in which the question was asked was potentially unclear to the reader. The research question did not specify that participants were to select the modality used in relation to adolescent shame. Therefore, there was saturation in the results, which likely skewed the findings when controlling for the intervention modalities. This ultimately showed very little variation in the selection of the modalities that participants used, reducing the statistical power to identify an association between the therapeutic relationship and the healing of shame. Secondly, when this researcher compared the modality used to the perceived most effective modality, data showed that the modalities participants used to treat

adolescent shame were not intervention modalities that they felt were most effective in treating shame. This suggests that participants may have misunderstood the question, treating the question as a more generalized inquiry about clinicians treatment approaches. These two reasons can account for the differences in the results.

It is important to note that there are commonalities between clinician's perception of what intervention modality was most effective (ME) versus the modality the clinician used (MU). First, intervention modalities that are most effective imply that the participant has used this modality at some point in their lives. It is not uncommon for a mental health practitioner to be employed in a setting where a specific intervention modality is recommended. Further, in the "age of accountability" and evidence-based practice eras, research-based evidence is a growing phenomenon, and many employment settings mandate certain treatment approaches based on this (Rubin & Bellamy, 2012, p. 5). Therefore, because the modalities that were most effective were, at some point, modalities the practitioner used, this researcher believes that participants perception of what is most effective is likely indicative of what participants use.

The overall intention of this research study began by exploring the therapeutic relationship and specific treatment modalities that treat shame in adolescents. Practically every research article about the treatment of shame called for more research on this topic (Matos & Pinto-Gouveia, 2014; Simonds et al., 2016; Carvalho et al., 2015; Muris, Meesters, & Asseldonk, 2018; Muris, 2015; Cohen-Filipic & Bentley, 2015). One result from the literature review was the importance of addressing shame events in psychotherapy through a particular therapeutic modality. Three specific modalities appeared in the literature as useful in the treatment of shame, Compassion Focused Therapy (CFT) (Matos & Pinto-Gouveia,

2014; Simonds et al., 2016), Acceptance and Commitment Therapy (ACT) (Carvalho et al., 2015), and Cognitive Behavioral Therapy (CBT) (Muris, Meesters, & Asseldonk, 2018; Muris, 2015; Cohen-Filipic & Bentley, 2015), however none of these modalities were tested on adolescent participants who experienced shame. An opposing result from the literature review was role of the therapeutic relationship in the treatment of shame. The literature suggests that the therapeutic relationship was a primary facilitator of change and reduction of shame (Hill et al., 2011; Marsden, 2016; Friel, 2016; Leeming & Boyle, 2013).

Furthermore, in this study, the results indicate that none of the modalities considered most effective in treating shame remained statistically significant when controlling for the therapeutic relationship. While little is known about how these modalities impact the treatment of adolescent shame, this study provides preliminary evidence to address this gap. The responses to this data reflect opposing results from what has previously been reported.

In assessing how much the therapeutic relationship contributed to the treatment of adolescent shame within the context of perceived most effective treatment modalities, this researcher was thoughtful about the role that shame plays in psychopathology as well. Participants were asked about their thoughts on what specific DSM-5 diagnosis was present in the treatment of shame in adolescents. Consistent in the literature was the idea that shame plays an important role in the psychopathological diagnosis of depression, anxiety, trauma, post-traumatic stress disorder, personality disorders, and substance abuse (Reimer, 1996; Friel, 2016; Kinnunen, 2010; Leeming and Boyle, 2013; Matos and Pinto-Gouveia, 2010; Matos and Pinto Gouveia, 2014; Carvalho et al., 2015; Mills et al., 2015; Zhang et al., 2018; Muris et al., 2016; Muris, Meesters, and Asseldonk, 2018). Participants reported most commonly seeing anxiety disorders in adolescents with shame, including Generalized

Anxiety Disorder (GAD), Unspecified Anxiety Disorder and Social Anxiety Disorder ($n =$ 24, 44%). Additionally, Major Depressive Disorder (MDD) was reportedly present in the psychotherapy of adolescents presenting with shame ($n = 13$, 24%) as well as Post-traumatic stress disorder (PTSD) ($n = 10$, 18%).

Anxiety, depression, and trauma were commonly cited across literature with regard to adolescent shame (Reimer, 1996; Friel, 2016; Kinnunen, 2010; Leeming and Boyle, 2013; Matos and Pinto-Gouveia, 2010; Matos and Pinto Gouveia, 2014; Carvalho et al., 2015; Mills et al., 2015; Zhang et al., 2018; Muris et al., 2016; Muris, Meesters, and Asseldonk, 2018). This study data is consistent with the literature in that 66% of participants believed that their adolescent clients have a pre-morbid or post-morbid diagnosis alongside shame ($n = 36$, 66%). Due to the data being written responses to an open-ended question, there was no opportunity to expand responses by asking further questions to gain more depth. Additionally, there were several participants who left these questions blank. Additional diagnoses presented in the data included Adjustment Disorder: $n = 4$, 7%, Attention deficit hyperactivity disorder: $n = 3$, 5%, and Substance Use: $n = 3$, 5%.

Further, this researcher requested for mental health clinicians to draw on experiences of treating adolescents with shame. Results were met with slightly mixed results. First, results showed that all 54 participants noted that during their experiences treating adolescents, they saw a reduction in the client's shame. 53 participants believed that the therapeutic relationship has an effect the treatment of shame in adolescents. Interestingly, the majority of participants also noted that the therapeutic relationship impacts treatment more than the therapeutic intervention ($n = 51$, 94%). These results suggest that the therapeutic relationship outweighed the importance of a specific intervention or modality in the treatment

of adolescent shame. Additionally, this research study indicated that the stronger the

therapeutic relationship, the shorter the amount of time it took to heal from adolescent shame.

There was one intervention modality that showed statistical significance, Attachment-based

Psychotherapy. The results, however, were in an unexpected direction, indicating that the use

of this intervention in the psychotherapeutic of adolescent shame increased the duration of

time it took for adolescents to recover from shame.

The significance and utilization of Attachment-based Psychotherapy was a surprising

finding. Previous literature on intervention modalities that help treat shame in psychotherapy,

while limited, indicated that Compassion Focused Therapy (CFT) (Matos & Pinto-Gouveia,

2014; Simonds et al., 2016), Acceptance and Commitment Therapy (ACT) (Carvalho et al.,

2015), and Cognitive Behavioral Therapy (CBT) (Muris, Meesters, & Asseldonk, 2018;

Muris, 2015; Cohen-Filipic & Bentley, 2015) are beneficial to the treatment of adult shame;

none of the studies that this researcher examined in the literature review were tested on

adolescent participants. In examining Attachment-based Psychotherapy, Bowlby (1969,

1980, 1988) believed that "human beings are biologically driven to pursue relationships that

create certainty" (Shumaker, Deutsch, & Brenninkmeyer, 2009, p. 92). Further, Ainsworth

and colleagues' (1978) methodology for examining attachments, now known as the Strange

Situation, examined an infant and their mother being separated for brief periods of time.

Emerging from this study were four distinct attachment styles, Secure Attachment, Insecure/

Avoidant Attachment, Insecure/ Ambivalent Attachment, Insecure. Disorganized

Attachment, or Non-attachments (Shumaker, et al., 2009). A securely attached child would

experience anxiety upon their mothers leaving the room, but would be able to calm down and

welcome their mother back. An insecure/avoidant child would not protest the mothers

leaving the room, but would have a minimal response to the mothers return, while an insecure/ambivalent child would show distress even before the mother's departure and are either clingy or have a difficult time being soothed upon the mothers return. Disorganized children have no consistent way of regulating themselves from anxiety and separation and may experience their caregivers as frightening (Payne, 2014).

The emergence of attachment security in the first year allows children to become more tolerant of separation from the caregiver and to use the caregiver as a secure base from which to explore the external environment (Bowlby, 1973). Children learn new strategies that enrich their competency and regulatory abilities and eventually begin to function autonomously, without being completely dependent on the caregiver. During middle childhood, secure attachment patterns allow the child to tolerate and regulate feelings of distress while engaging with others. Interestingly, during adolescence, secure individuals allows the adolescent to form reciprocal relationships with peers and become a source of comfort to others (Milkulincer & Shaver, 2004). These adolescents will continue to build healthy self-esteem and self-regulation skills to handle distress.

Relevant to this study is an adolescent's attachment style, which is associated with an array of cognitive, emotional, and behavioral outcomes (Shumaker, 2009). Adolescence is a period of enormous transition and transformation around "emotional, cognitive, and behavioral systems surround attachment relationships as the adolescent evolves from being a receiver of care to becoming a self-sufficient adult" (Allen & Land, 1999, p. 419). These attachment relationships extend to client-therapist relationships, and can be observed in Attachment-based Psychotherapy. Attachment-based Psychotherapy increasingly represents a comprehensive continuum of various models and techniques that are guided by an

overarching set of principles grounded in attachment theory (Payne, 2014). Bowlby (1988) suggests that the therapist functions as a secure base for clients, implying that therapists are often inadvertently engaging in attachment therapy (Allen & Land, 1999). Further, evolving research suggests that "engagement with an understanding and sympathetic adult triggers a basic set of human capacities for relatedness and generates an alliance that appears therapeutic—apparently almost regardless of the content—and that the quality of the alliance is one of the best predictors of outcome" (Allen & Land, 1999, p. 785). Therefore, while this research study showed that the use of Attachment-based Psychotherapy showed a negative effect on the treatment, future researchers must further explore this finding to better understand why this is so.

Cronbach's Alpha ($\alpha = 0.789$) suggested a relatively high internal consistency. The use of the Working Alliance Inventory – Short Revised - Therapist (WAI-SRT) (Hatcher & Gillaspy, 2006), which asked participants to answer a ten question, five-point Likert type questionnaire, suggested a negative correlation in one out of the ten questions. WAI-SRT's (Hatcher & Gillaspy, 2006), second question, "I am genuinely concerned for _'s welfare," suggests a negative correlations and therefore detracted from the value of the overall measure from the scale. This suggests that the overall measure would be more accurate if this question was excluded from the ten questions. Therefore, while the reliability was strong, this researcher's analyses output suggested that that the value from question number two in the WAI-SRT Questionnaire (Hatcher & Gillaspy, 2006) had a negative correlation. A Differential Item Functional Analysis could assess whether specific items in the measure might function differently in a varying population, which this researcher will extrapolate on in recommendations for future studies.

This researcher pulled findings specific to social workers and compared them to the other grouping of mental health clinicians, which included mental health counselors, psychologists, and psychiatrists. There was no statistical significance between social workers and the other practitioners when examining reported adolescent shame recovery time, however, there was a negative affect, meaning that social workers reported a slightly shorter recovery time of adolescent shame when compared to the other group of mental health clinicians. In other words, the results show that social workers working with adolescents experiencing shame see a decrease in shame faster than mental health counselors, psychologists, and psychiatrists do.

Secondly, social workers did not show statistical significance when examining the recovery time for adolescent shame and the perceived most effective intervention modality utilized. Results did indicate statistical significance for social workers who practiced using Attachment-based Psychotherapy, however, the results were in the opposite direction, meaning that it took longer see a reduction of shame in their adolescent clients. When examining recovery time for adolescent shame and the perceived most effective intervention modality utilized in the other group of mental health clinicians, interestingly, the therapeutic relationship did show statistical significance.

These results reflect a variance in recovery time between social workers and other mental health clinicians, which was an unexpected finding. Two explanations can explain this variance. First, this researcher subset the sample; social workers were made up of 33 participants (61%), while the other grouping of mental health clinicians was made up of 20 participants (37%); as the sample size got smaller within the grouping of social work participants, power in the sample was lost. Both groups are very small, impacting the results.

Secondly, this is largely due to a group phenomenon. Overall, the results show that the therapeutic relationship has a great predictor for outcomes for other mental health clinicians when compared to social workers. Limitations and recommendations for future research will be further expounded upon in the discussion section.

Results for research question two were examined by looking at the fourteen intervention modalities and shame while not controlling for the therapeutic relationship. Amongst the 54 clinicians, results showed that three out of fourteen intervention modalities facilitate a greater therapeutic alliance. These three modalities included Psychodynamic/Psychoanalytic Psychotherapy (48%), a variation of a CBT approach (48%), and Interpersonal Psychotherapy (48%), and Cognitive Behavioral Therapy (CBT) ranking as the next most commonly utilized modality (46%). Specifically amongst social workers, Relational Psychotherapy (31%) and a variation of a CBT approach (31%) were utilized most frequently, while Interpersonal Psychotherapy (24%) and Psychodynamic/Psychoanalytic Psychotherapy (18%) were utilized most amongst the other group of practitioners. These results tell us that the intervention modality used across groups varies tremendously**.** It is important to note that participants self-reported perception-based responses. Therefore, it is difficult to determine how this might generalize to a sample similar to the one in this study where participants rate themselves from another perspective. Perception-based questions require participants to have a level of self-awareness and insight which will impact their responses (Lukowitsky & Pincus, 2013).

In additional analyses, this researcher assessed whether certain intervention modalities facilitated greater strength in the recovery time of shame. The regression model showed that the fourteen intervention modalities were still not statistically significant when

removing the therapeutic relationship from the model. However, similar to the results from Research Question 1, results showed that Attachment-Based Psychotherapy was significant but opposite of the expected direction, suggesting that there is a delayed recovery for shame for adolescents working with a clinician utilizing this intervention modality.

The literature contains numerous components that make up the therapeutic relationship. Lambert (1992) infers three central components that make up the alliance. First, goal consensus and a thorough understanding and agreement of the patient's objectives must be discussed between patient and therapist. Secondly, a collaborative relationship that allows room for feedback, and third, a bond or positive regard between therapist and patient must be established (Bordin, 1979). However, results from question three suggest that the current research has not exhausted the behaviors that are associated with therapy success. There is insufficient controlled research at this time to draw any conclusion. This is evident in the participants written short-answer responses when asked to share what they believe are two helpful factors. Authenticity ($n = 11, 20\%$), acceptance ($n = 10, 18\%$), and safety/trust ($n = 9$, 16%) were among some of the commonly reported responses to the most central components to the therapeutic alliance. However, six participants wrote that having a sense of humor and levity was important and four participants felt that self-disclosure was a central ingredient. One participant eloquently stated, "Some very careful and thoughtful self-disclosure can humanize [the] therapist. Adolescents have a lot of authority figures in their lives and a lot of power struggles, that's why giving them personal power within the therapeutic frame is important." The results are varied, suggesting that what works for some clinicians and clients may not work for others. However, decades of research suggest that the therapeutic relationship is the most substantial contributor for change and success (Lambert, 1992).

Clinicians are constantly adapting and tailoring their specific treatment to meet the needs of an individual patient and individual context. Customizing a therapy for a patient helps to tailor to the particulars of a patient's needs, individualizing the therapy for that client. Having said that, while there may not be a prescriptive list of specific components that must be present in the therapeutic relationship for therapeutic success, the literature does point to several effective means of creating an effective therapy relationship, including empathy, goal consensus, collaboration, positive regard, containment, and tolerance (Elliot et al., 2011; Lambert, 2010; Lambert, 1992; Yard, 2014).

Results from this study suggested that rapport was a central component in their therapeutic with adolescents experiencing shame. Participants who selected trust and emotional attunement showed statistically significant results. This finding provides insight into how clinicians beliefs have the ability to impact client impacts. Data results showed that if clinicians put emphasis on emotional attunement in the therapeutic relationship with an adolescent, the process of healing shame actually led to derogatory outcomes for the client, taking longer to heal from shame than any other therapeutic component. Alternatively, clinicians who selected trust as an important ingredient to the therapeutic relationship showed a reduction in the time it took to recover from shame. This finding aligns with the literature. Cannabis (2011) refers to the therapeutic alliance as "the trust between the patient and therapist that allows them to work together effectively. Trust is the basic ingredient" (p. 85). Therefore, the findings from this study provide further evidence for the importance of trust as an essential component to the therapeutic relationship when treating adolescent shame.

When comparing this finding to the social workers versus other mental health clinicians, results showed an overlap in results. All clinicians believe that rapport is the most

important ingredient in the therapeutic relationship when working with adolescents

experiencing shame (Social Workers: $n = 32$, 59%; Other Mental Health Clinicians: $n = 19$,

35%. Both groupings identified that acceptance was the second most important component in

the therapeutic relationship (Social Workers: $n = 30$; 55%; Other Mental Health Clinicians: n

$= 18$, 33%). This finding provides insight into what mental health practitioners prioritize and

value in their therapeutic relationships with clients.

Participants were asked to write in a short-answer response what they believed were

protective factors and/or resources in ameliorating shame in psychotherapy with adolescents.

Nineteen participants wrote that normalization, validation, and acceptance allowed for clients

to share more about their shame. One participant stated, "with the therapist's time, patience,

and the innate structure of the treatment session, the patient will grow more comfortable and

feel more safe, and the therapeutic relationship will eventually become stronger and more

stable." Additionally, sixteen participants shared that having a reliable network of support

through friends and/or family ameliorated shame in the therapy. Other results included

involvement in activities ($n = 8$), psychoeducation ($n = 8$), positive childhood experiences,

including attunement and modeling from family ($n = 5$), and unconditional positive regard (n

$= 4$).

Participants were also asked to write in a short-answer response what they believed

were obstacles in developing a strong therapeutic relationship with an adolescent

experiencing shame in therapy. Interestingly, 29 participants wrote about fears and

difficulties with trustworthiness, identifying the therapist as an authority figure. One

participant noted the transitional stage of development adolescents face, stating that they are

at a "complex age where [the] client is trying to separate from parental figures and become

more independent/more attached to friends…[they may] rather spend time with friends or socializing than with an adult discussing feelings. Family dynamics and family involvement in the adolescent's therapy was another commonly reported obstacle therapist identified in forming a strong therapeutic relationship with adolescents ($n = 16$). Other responses included mandated treatment ($n = 11$), trauma ($n = 5$), negative past therapist experiences or relationships ($n = 4$), primitive defense mechanisms ($n = 3$), and countertransferential issues ($n = 2$).

These findings suggest that a clinician's perspective on what is important in the therapeutic relationship impacts outcomes. In other words, the specific components that therapists emphasize in their therapeutic relationship with adolescents can influence clinical results which are possibly driving a clinician's decisions and behaviors in the therapy, impeding clinical outcomes. Overall, there was variation according to what clinicians believed to be important and the recovery time in shame.

Strengths of the Study

The study explored the therapeutic relationship and varying treatment modalities to determine if shame decreased based on the utilization of a specific treatment modality, an assumption that was prevalent throughout the literature on the treatment of shame. One of the strengths of this study was the examination of the therapeutic relationship as it contributes to the treatment and healing of adolescent shame. At present, there is scarce literature on adolescent shame and the role of the relationship between client and therapist. This study examined a topic that is clearly missing in the literature and began to address this knowledge gap by examining the role of the therapeutic relationship when shame presents in adolescents. Additionally, recruiting mental health practitioners and learning about

adolescent shame from their perspective allowed for an examination of the role of the therapeutic relationship in the treatment of shame in adolescents. Building upon what we already know about adult individuals and shame, the research on adolescent shame is scarce. Lastly, a strength of this study was the method of an online, anonymous survey, as it allowed for participants to partake in the survey and respond to the questions in an anonymous manner.

Methodological Limitations of the Study

The sample for this study presented many limitations. The sample size consisted of 54 participants which was smaller than this researcher had initially projected. Due to a global and regional health emergency that resulted in a state-wide mandate for social isolation, this researcher cancelled data collection once the collection had slowed to a stop. This researcher determined that there were enough participants to identify a moderate relationship.

The online survey was sent to seven List Serves using a web-based survey. This researcher sent emails to the seven List Serves, however, it is important to note that a number of the email addressed were undeliverable as some email addresses were not up to date and thus bounced back. Therefore, this researcher is unable to know how many individuals this on-line survey reached. There are additional limitations to consider when utilizing web-based surveys. First, online surveys require participants to have access to the Internet and be computer literate (Baron et al., 2002). The online nature of the survey along with the various online recruitment attempts through List Servs may limit the sample to those with Internet access and those who speak English. An additional limitation is the concern of missing data, as participants may be unlikely to fill out lengthy surveys online (Krug, 2005 as cited in Hoerger, Quirk & Weed, 2011). Furthermore, participants will self-select to be in the study

which may impact the findings. Therefore, the researcher will not know about those who chose not to participate in the research or their reasons for not participating.

A similar limitation may have been the survey design itself. The survey was piloted and reported to take approximately 10-15 minutes to complete. However, various surveys submitted were incomplete with missing data. Many participants did not complete the open-ended questions that this researcher included in the survey, such as, "In your work with adolescents, do you find that there is a pre-morbid or co-morbid DSM-5 diagnosis present? If so, what is the DSM-5 diagnosis?" One participant stated that this was "This [was] a poorly written question, hard to know what you mean." Perhaps this reflects that some questions could have been wording more clearly to promote participants to completely fill it out. Another limitation of the survey design relates to the data analysis of the results to the open-ended questions. Not all participants answered every open-ended question and some had very short answers. Lastly, some modality independent variables had significant overlap in responses, as participants were given the option to "select all that apply" in several questions. Future studies would benefit from asking participants to rank their responses in order of importance instead of selecting as many as they want.

For the question, "On average, what is your observation of how long it has taken for adolescent clients to recover from shame?", it would have been better for the researcher to provide equal increments of time for participants to select from instead of 0-3 months, 3-6 months, 6 months-1 year, 1-2 years, or 2 years or more. However, the finding from Research Question #2, which examined what intervention modality clinicians identified as most effective in treating adolescent shame, was surprising to this researcher. This researcher learned that Attachment-based Psychotherapy did more harm than good.

Due to the survey being online and anonymous, there was no opportunity to follow up with participants and ask for further elaboration to draw out more analytical themes. Finally, the survey was designed to measure responses at only one point in time and therefore the results rely on cross-sectional data, which may not fully speak to whether the results would remain stable over time or change based on other factors (i.e. timing, stress, mood, etc.).

A final limitation was the lack of diversity in the sample. 81% percent of the sample was Caucasian/White, 63% of the sample lived in Manhattan, New York as opposed to other areas of New York State, and 76% of participants identified themselves as female. This leaves much unknown about clinicians who are people of color, individuals who live in other areas of New York state, and clinicians who identify as male or other gender identities and expressions. It is possible that participants in any of these categories may have vastly different experiences than the current sample. Alternatively, they may be excluded from the present study based on access to the online survey which was exclusively disseminated to online List Serve groups that therapist had to be connected to.

The majority of participants, 61%, were social workers (LMSW, LCSW, PhD). 16% of participants identified themselves as an individual with a psychology degree (Masters, PsyD, PhD), 13% of participants were psychiatrists, and 7% of participants were mental health counselors. Zero participants identified themselves as Marriage and Family therapists or Creative Arts therapists. This limited the diversity of participants in this study and excluded their perspectives from the results. It is possible that had the present online survey reached a more diverse group of participants, the results would be more heterogeneous.

Implications and Contributions to the Knowledge Base

The contributions of this research study will provide significant input regarding the role of the therapeutic relationship when treating shame in adolescents. The implications for the study are categorized below and include implications for practice, policy, and research. Also, the researcher will discuss implications for future research.

Implications for Practice

Much of the literature points towards the importance of reducing shame by way of therapeutic intervention(s). The literature on shame is widespread and varied, and it is clear that the impact of shame on mental health is exorbitant. What remains clear is that it is difficult to create and undertake empirical research on shame. However, there is more research needed that explores the issue of adolescent shame in psychotherapy. This includes more deeply understanding the role of the therapeutic alliance in healing and treating adolescent shame. By increasing knowledge about the role of the therapeutic relationship in treating shame in adolescents, social workers can understand relevant information that can be used in future treatment directions. The results from this study will inform clinical social workers about factors that can determine best practices for working with shame in adolescents in the therapy room. Additionally, the utilization and inclusion of clinical social workers' perspective will enhance and deepen the current literature by providing direction as to what might be needed to improve successful clinical outcomes.

A major finding from this study suggested the importance of trust as an essential component to the therapeutic relationship. These results indicated that clinicians who believed trust to be a fundamental aspect of the alliance showed that adolescents healed from shame more quickly. This finding aligns with the literature which regards trust as the "basic ingredient" to the therapeutic alliance (Cannabis, 2011, p. 85). Overall, this finding suggests

that clinicians focus on the development and maintenance of a trusting relationship with their clients.

Implications for Policy

When examining the implications of shame from a societal and institutional lens, there are several factors to bear in mind that contribute to one's experience of shame, specifically environmental factors and systemic racism. Steams (2019) suggests that in addition to psychopathology and coping with shame, there are ways in which systems of social injustice also play a role in one's experience of shame. Potential implications for social work policy can be gleaned from this research study when examining shame from a macro lens, a perspective that is not expounded upon in many research articles found in this systematic review. Utilizing social works person in environment (PIE) model, clinicians must consider the social identities of their clients, the multi-dimensional nature of shame, and how forms of injustice continue to marginalize individuals (Payne, 2014). Therefore, this study has policy implications in seeking to assess the impact of the therapeutic relationship and shame in adolescents from this perspective. This study may inform future research that could potentially influence development of new policy.

Implications for Research

Research across the knowledge base of shame is limited. In reviewing the literature, this researcher became aware of the lack of specific instruments intended to measure shame. Having said that, there is a dearth of randomized, experimental designed research studies that examine the psychotherapeutic treatment of shame. Seeing that shame is made up of a cluster of affects, behaviors, defenses, cognitions, and sensations, most shame instruments are measured by self-report questionnaires that are scenario-based measures and lack internal

consistency. Out of the seven most commonly used shame instruments populated in the systematic review, zero allowed for clinicians to fill out the scales themselves. However, ten instruments that measure the therapeutic relationship include the Pennsylvania (Penn) scales (Alexander and Luborsky, 1986; Luborsky et al., 1985; Luborsky et al., 1983), the Vanderbilt scales (Hartley and Strupp, 1983; O'Malley et al., 1983; Suh et al., 1986), the Toronto scales (Marziali, 1984; Marziali et al., 1981), the Working alliance inventory (WAI) (Horvath and Greenberg 1986, 1986, 1989), the California scales (Gaston and Marmar, 1994; Marmar et al., 1989a; Marmar et al., 1989b), the Therapeutic session report (TSR) (Orlinsky and Howard (1966, 1986), the Therapeutic bond scales (TBS) (Saunders et al., 1989) (Ardito & Rabellino, 2011), the Psychotherapy status report (PSR) (Frank and Gunderson, 1990), the Agnew relationship measure (ARM) (Agnew-Davies et al., 1998), and the Kim alliance scale (KAS) (Kim et al., 2001). This researcher will utilize the Working Alliance Inventory – Short Revised - Therapist (WAI-SRT) (Horvath & Greenberg, 1989; Horvath, 1981).

Areas for Future Research

This study examined the role of the therapeutic relationship when an adolescent client presents with shame in psychotherapy. Future research would benefit from recruitment of a larger sample size to assess if results are consistent and generalizable. Given that this study specifically examines shame in adolescents, future research would also benefit from writing survey questions that are more specific to shame in this developmental stage. This study explored the intervention modality that participants use when working with adolescents. These research questions require further study to explicitly substantiate how participants work with adolescents who experience shame, and what modalities that feel are most effective/ used in their current practices. Specifically, in future research, questions should be

specifically geared towards the treatment of adolescent shame. This researcher suggests that research question 1 and research question 4 being combined and re-worded to, "In your practice with adolescents, what intervention have you found to be the most effective in treating shame?" Secondly, instead of having participants select all that apply, it would be beneficial for participants to rank the interventions based on effectiveness.

Secondly, it would also be useful to replicate this study in a manner that would allow the researcher to triangulate the data. Across the two independent variables in this research study, the findings were not consistent. While this lack of consistency is likely based on two reasons, the wording of the question and little variation in the modalities, this researcher suggests that future data collection include mental health practitioners as well as adolescent clients who experience shame. This would further help in determining if the results show a consistent association between the therapeutic relationship and the healing of shame. Additionally, it may also be useful to further explore some of the findings from the open-ended questions. The data from this study yielded valuable information and a follow-up study using a qualitative design, such as clinician interviews, would help probe further into their experiences of the therapeutic relationship and what specifically occurred that led to the healing of shame in adolescents. Hearing more in depth experiences from mental health practitioners would contribute to best practices and common elements across experiences the therapy relationship between therapist and client.

Findings suggested that not all components of the therapeutic relationship had positive contributing factors. Therefore, future research would benefit from exploring the components of the therapeutic relationship from the perspective of the clinician and the client to see if these relationships continue to minister, or if there are variations.

Future research should also conduct a Differential Item Functional Analysis using a more diverse population. In this study, question two in the Working Alliance Inventory – Short Revised - Therapist (WAI-SRT) (Hatcher & Gillaspy, 2006), "I am genuinely concerned for _'s welfare," suggested negative correlations and detracted from the overall measure of the scale. A Differential Item Functional Analysis would assess whether specific items in a measure functioned differently among different groups.

Conclusion

In sum, the primary objective of this study was to learn more about the experience of shame in adolescents and to explore the role of the therapeutic relationship in psychotherapy. This researcher was interested in the perspective of mental health practitioners' who treat adolescents who experience shame with the hope of better understanding what they believed was most helpful in treating shame in adolescents. To date, most research in the area of shame has concentrated on adults, and few articles have examined the role of the therapeutic relationship.

Results suggest three intervention modalities that participants identified as most effective in treating adolescent shame. These included Psychodynamic/Psychoanalytic Psychotherapy (48%), a variation of a CBT approach (48%), and Interpersonal Psychotherapy (48%). Secondly, in summary, the therapeutic relationship contributed significantly to the reduction time of shame in adolescents when controlling for the most effective intervention modalities. However, the therapeutic relationship was not statistically significant when controlling for the intervention modalities participants used. However, this is likely due to potential errors in the way the questions were asked. Lastly, given the evidence to suggest that the therapeutic relationship is the most significant contributor to

treating shame in adolescents, it is important to consider what components of the therapeutic relationship are most important. Almost every participant reported that rapport was an essential component to the healing of shame. Additionally, the utilization of trust showed a reduction in the time it took to recover from shame. On the contrary, clinicians who believed that emotional attunement was an essential component to the therapeutic relationship showed derogatory results for reduction time in shame, taking longer to recover from shame.

Overall, this study adds to the literature that examines shame and the role of the therapeutic relationship with a focus on the adolescent population, a demographic that has been minimally studied. The results of this study provide strong support for future researchers, offering a unique clinical perspective on the treatment and healing process of shame in adolescents. These findings contribute relevant information that can be used for further social work research, and provide rich future directions for social work practitioners.

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APPENDIX A: QUESTIONNAIRE

Have you ever had shame interfere with the therapeutic relationship?
☐ Yes
☐ No

Have you experienced difficulty establishing a therapeutic relationship with adolescents who experience shame?
☐ Yes
☐ No

If so, select all that apply:
☐ Difficulty with developing trust in the therapeutic relationship.
☐ Difficulty establishing safety in the therapeutic relationship.
☐ Difficulty establishing relational intimacy.
☐ Difficulty with vulnerability.
☐ Difficulty with expectations of the treatment i.e. wanting a 'quick fix.'

Have you worked with clients who present with symptoms of anxiety and depression?
☐ Yes
☐ No

Percentage of clients with shame: each number represents the percentage of your clients
If so, what percentage of your adolescent clients with shame show symptoms of anxiety and depression?

	1	2	3	4	5	6	7	8	9	10
10 %	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
100%										

Do you find that shame in adolescents delays the development of the therapeutic relationship?
☐ Yes
☐ No

In what proportion of clients did shame impact the therapeutic relationship?

	1	2	3	4	5	6	7	8	9	10
10 %	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
100%										

How would you rate your therapeutic relationship with adolescent clients who present with shame?

	1	2	3	4	5	6	7	8	9	10
10 %	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
100%										

What interventions have you found to be effective in treating shame in adolescents? Select all that apply.
☐ Validation
☐ Normalization
☐ Acknowledgement
☐ Affirmation
☐ Challenging
☐ De-escalating
☐ Psychoeducation
☐ Encouragement
☐ Empathic responses
☐ Modeling
☐ None

Do you think that the therapeutic relationship effects the treatment?
☐ Yes
☐ No

What are the most important ingredients of the therapeutic relationship that help treat adolescent shame? Select all that apply.
☐ Rapport
☐ Trust
☐ Safety
☐ Emotional attunement
☐ Respect
☐ Consistency
☐ Acceptance
☐ Patience
☐ Commitment
☐ None

Do you think an intervention would work without the therapeutic relationship?
☐ Yes
☐ No

Do you think the therapeutic relationship would work without the therapeutic intervention?
☐ Yes
☐ No

How much do you think the therapeutic relationship contributes to the clients healing in treatment?

	1	2	3	4	5	6	7	8	9	10
10 %	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
100%										

Do you think the choice of treatment effects outcomes?
☐ Yes
☐ No

Have you seen a reduction in the shame?
☐ Yes
☐ No

On average, what is your observation of how long it has taken for adolescent clients to recover from shame?
☐ 0-3 months
☐ 3-6 months
☐ 6 months-1 year
☐ 1-2 years
☐ 2 years or more

What do you think impacts treatment most?
☐ The therapeutic relationship
☐ The intervention

What do you think contributes to shame?
Fill in

In your work with adolescents, do you find that there is a pre-morbid or co-morbid DSM-5 diagnosis present?
☐ Yes
☐ No

If so, what is the DSM-5 diagnosis?
Short answer text

What is your preferred modality for treatment of adolescents? Select all that apply.
☐ Psychodynamic/Psychoanalytic Psychotherapy
☐ Cognitive Behavioral Therapy (CBT)
☐ Trauma Focused Cognitive Behavioral Therapy
☐ A variation of a CBT approach
☐ Dialectical Behavioral Therapy (DBT)
☐ Relational Psychotherapy
☐ Attachment-based Psychotherapy

☐ Eye Movement Desensitization and Reprocessing (EMDR)
☐ Compassion Focused Therapy (CFT)
☐ Acceptance and Commitment Therapy (ACT)
☐ Exposure Therapy
☐ Supportive Psychotherapy
☐ Interpersonal Psychotherapy
☐ Biofeedback

What modality do you use for treatment of adolescents? Select all that apply.
☐ Psychodynamic/Psychoanalytic Psychotherapy
☐ Cognitive Behavioral Therapy (CBT)
☐ Trauma Focused Cognitive Behavioral Therapy
☐ A variation of a CBT approach
☐ Dialectical Behavioral Therapy (DBT)
☐ Relational Psychotherapy
☐ Attachment-based Psychotherapy
☐ Eye Movement Desensitization and Reprocessing (EMDR)
☐ Compassion Focused Therapy (CFT)
☐ Acceptance and Commitment Therapy (ACT)
☐ Exposure Therapy
☐ Supportive Psychotherapy
☐ Interpersonal Psychotherapy
☐ Biofeedback

What modality do you think is most effective for the treatment of adolescents? Select all that apply.
☐ Psychodynamic/Psychoanalytic Psychotherapy
☐ Cognitive Behavioral Therapy (CBT)
☐ Trauma Focused Cognitive Behavioral Therapy
☐ A variation of a CBT approach
☐ Dialectical Behavioral Therapy (DBT)
☐ Relational Psychotherapy
☐ Attachment-based Psychotherapy
☐ Eye Movement Desensitization and Reprocessing (EMDR)
☐ Compassion Focused Therapy (CFT)
☐ Acceptance and Commitment Therapy (ACT)
☐ Exposure Therapy
☐ Supportive Psychotherapy
☐ Interpersonal Psychotherapy
☐ Biofeedback

What are two helpful factors in developing a strong therapeutic relationship with an adolescent in therapy?
Short answer text

What are two obstacles in developing a strong therapeutic relationship with an adolescent in therapy?
Short answer text

What are protective factors or resources you are aware of in ameliorating shame in therapy with an adolescent?
Short answer text

Working Alliance Inventory (WAI-SRT)
Below is a list of statements about experiences people might have with their clients. As you read the sentences, mentally think generally about your adolescent clients.

___ and I agree about the steps to be taken to improve his/her situation.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

I am genuinely concerned for ___'s welfare.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

We are working towards mutually agreed upon goals.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

___ and I both feel confident about the usefulness of our current activity in therapy.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

I appreciate ___ as a person.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

We have established a good understanding of the kind of changes that would be good for ___.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

___ and I respect each other.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

___ and I have a common perception of his/her goals.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

I respect ___ even when he/she does things that I do not approve of.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

We agree on what is important for ___ to work on.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

What is your age?
Short answer text

What is your gender?
Short answer text

What is your race?
Short answer text

In what city of New York do you practice in?
Short answer text

Indicate your highest earned degree(s):
☐ Social Work Degree: LMSW, LCSW, PhD
☐ Mental Health Counselor
☐ Marriage and Family Therapist
☐ Creative Arts Therapist
☐ Psychology Degree: Masters, PsyD, PhD
☐ Psychiatrist

What is your employment status?
Short answer text

What sort of setting are you employed in?
Short answer text

Approximately how many adolescents do you/did you see each week?
Short answer text

How long have you been practicing?
Short answer text

How long have you been working with the adolescent population?
Short answer text