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WOMEN'S SHAME RESILIENCE: EXAMINING VARIOUS THEORETICAL ASSUMPTIONS OF SHAME RESILIENCE THEORY

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For Sophia Marie

May you always know your worth. May you endeavor to challenge the messages that would threaten to tame your wild heart, stifle your bold creativity, and silence your authentic voice. May you never be afraid to fly on your own wings. And when you grow weary from the struggle, may you always know that your father and I are nearby to lighten your load, champion your cause, and celebrate your imperfections.

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Table of Contents

List of Tables

Abstract

Shame has been identified as a self-conscious emotion (i.e., emotions evoked by self-reflection and self-evaluation) that negatively impacts interpersonal relationships, mental health, and psychological adjustment (Tangney & Dearing, 2002). Shame Resilience Theory (Brown, 2006; SRT) proposes that women can decrease and manage the effects of shame by learning and practicing the four elements of shame resilience: acknowledging personal vulnerability to shame, critical awareness, reaching out, and speaking shame. SRT emerged from a grounded theory study; however, to date, there have been no quantitative research studies to examine the theoretical assumptions of SRT. Thus, the purpose of this study was to examine the theoretical relationships among shame and three elements of shame resilience: critical awareness, self-compassion, and reaching out. A fourth predictor was added to control for troubling family experiences, which have been shown to contribute to shame levels in adulthood (Gilbert, 2003). Results of a hierarchical multiple regression analysis indicated that critical awareness, self-compassion, and reaching out explained 39% of the variance in shame scores beyond that predicted by income, education, and number of troubling family experiences. Critical awareness and self-compassion, but not reaching out, were significant individual predictors of shame scores. Findings provide empirical support for various theoretical assumptions of SRT and encourage the fostering of critical awareness and self-compassion in the treatment of shame and shame-related disorders.

Women's Shame Resilience:

Examining Various Theoretical Assumptions of Shame Resilience Theory

Shame has been the focus of clinical, developmental, and social psychologists for decades. Historically, this self-conscious emotion (i.e., any emotion evoked by self-reflection and self-evaluation) was viewed as necessary to human moral and psychological development (Scheff, 2003). Recently, however, researchers have recognized shame's negative impact on psychological adjustment, interpersonal relationships, and overall general mental health (Tracy & Robins, 2004; Tangney & Tracy, 2012). Consequently, shame has been described as the dominant emotion experienced by clients seeking mental health services (Dearing & Tangney, 2011; Lewis, 1971), as well as the "master emotion of everyday life" (Scheff, 2003, p. 239).

The terms shame and guilt often are used interchangeably, however research supports the conclusion that these are two distinct emotional experiences with unique outcomes (Tangney & Dearing, 2002). Researchers have examined various ways to distinguish between shame and guilt, including identifying antecedents and situational triggers, and exploring the public as compared to private aspects. The evidence seems to favor the most salient distinction as being between evaluations of the self vs. one's behavior (Tangney, Stuewig, & Mashek, 2007). Utilizing Lewis' (1971) seminal description of shame as a negative evaluation of the self and guilt as a negative evaluation of an action, Tracy and Robins (2006) found that participants reported feeling shame when they attributed failure to global, stable, and uncontrollable aspects of self. However, when participants attributed failure to a behavior influenced by transient and controllable aspects of self, they reported feeling guilt. Subsequently, an

abundance of research (e.g., Brown, 2006; Lewis, 1971; Lindsay-Hartz, 1984; Tangney & Dearing, 2002) has shown that participants consistently described shame as feeling flawed, unworthy, powerless, inferior, and exposed, feelings that prompted a desire to hide, withdraw, or escape. In contrast, guilt elicited feelings of remorse, empathy, and compassion, feelings that elicited a desire to confess, apologize, and right the wrong.

Despite the evidence that shame is the more debilitating emotion, it continues to be a taboo and misunderstood concept in our society (Scheff, 2003). However, the burgeoning field of shame research has proven that understanding the nature and influence of shame has great clinical utility. Shame has been acknowledged as both a contributor and predictor of psychopathology (Cândea & Szentagotai, 2013). Moreover, it has been suggested that shame-proneness and shame regulation may act as diagnostic criteria, as well as outcome variables, for depression (Kim, Thibodeau, & Jorgensen, 2011), anxiety-related disorders (Fergus, Valentiner, McGrath, & Jencius, 2010), eating disorders (Murray, Waller, and Legg, 2000), and personality disorders (Schoenleber & Berenbaum, 2012). Shame has also been found to be prevalent among individuals, couples, and families seeking therapy (Dearing & Tangney, 2011). In fact, Black, Curran, and Dyer (2013) found that internalized shame coping styles (i.e., withdrawal and attacking of self) significantly impeded the development of a therapeutic alliance.

In an effort to understand the nature of shame and its impact on women, Brown (2006) conducted a grounded theory study "to determine why and how women experience shame and to identify the various processes and strategies women use to develop shame resilience" (p. 43). What emerged was the Shame Resilience Theory

(SRT), currently the only comprehensive theory of shame and shame resilience. Shame resilience, as defined by Brown (2007), is the "ability to recognize shame when we experience it, and move through it in a constructive way that allows us to maintain our authenticity and grow from our experiences" (p. 31).

For the participants in Brown's 2006 study, shame was the intersection of feeling trapped, powerless, and isolated, and the intricate weaving together of these concepts was what made shame so powerful and ubiquitous. SRT conceptualizes shame as a "psycho-social-cultural" (p. 45) construct that is supported by a web of competing expectations defined and enforced by self, family, friends, partners, community, society, and the media (Brown, 2006). Failing to meet social and cultural expectations for what a woman should be often results in shame, which Brown defined as believing one is unworthy of authentic relationship due to a flawed self (Brown, 2006).

The conceptual model for SRT is depicted as a continuum that extends from a state of shame characterized by fear, blame, and disconnection to a state of empathy characterized by courage, compassion, and connection with others (Brown, 2007). The women participating in Brown's (2006) study specifically described the receiving and giving of empathy as an antidote to shame. Likewise, the ability to generate self-empathy or self-compassion was seen as a protective factor in the absence of empathy from others (Brown, 2010). Neff (2003b) described self-compassion as the ability to treat oneself with kindness and understanding during moments of pain or failure, to see one's experiences as common to all humans, and to keep painful emotions in perspective.

The SRT model proposes that the effects of shame can be decreased and managed by learning and practicing the four elements of shame resilience: (a) recognition of personal vulnerability to shame and shame triggers; (b) practicing critical awareness (i.e., connecting personal experiences to sociocultural expectations); (c) reaching out to supportive others to give and receive empathy; and (d) learning to speak shame (i.e., the accurate and honest communication of one's shaming experience; Brown, 2006).

Brown (2009) developed a 12-week psychoeduational group curriculum based on SRT, which focused on teaching the four elements of shame resilience. In a pilot study of 19 women in residential substance abuse treatment programs, participation in the group led to improved general health, decreased depressive symptoms and internalized shame, and increased shame resilience (Hernandez & Mendoza, 2011). However, to date, there has been no quantitative examination of the assumptions of the SRT model and the relationships among shame, empathy (including self-compassion), and the elements of shame resilience (i.e., personal vulnerability, critical awareness, reaching out, and speaking shame). The purpose of this study was to examine the relationships among shame, self-compassion, critical awareness, and reaching out in women.

It is essential that the theories guiding research and clinical practice be empirically examined in order to facilitate evidence-based practice and the use of best available research evidence (APA, 2006). Exploring the potential roles of self-compassion, critical awareness, and reaching out in facilitating shame resilience has important implications for future theory development, research, and practice.

Understanding these relationships will not only lead to a more complete understanding of the construct of shame, but also may provide meaningful guidance for clinicians in helping clients cultivate resiliency against the potentially debilitating impact of shame.

As noted previously, shame, along with emotions such as guilt, pride, and embarrassment, is considered a self-conscious emotion that involves self-evaluative processes regarding important standards of behavior (Kim et al., 2011). As such, self-conscious emotions, including shame, have been viewed as important to the maintenance of status, prevention of group rejection, fostering of moral behavior, and negotiation of complex social structures (Scheff, 2003; Tracy & Robins, 2004; Tangney & Dearing, 2002). However, mounting research has suggested that shame may not serve the same adaptive function as guilt, pride, or embarrassment (Tracy & Robins, 2004). Shame has emerged as a maladaptive emotion with negative consequences for long-term psychological adjustment, interpersonal relationships, and overall general mental health (Lewis, 1971; Tangney & Dearing, 2002).

Shame vs. Guilt

The last 20 years of research examining self-conscious emotions has yielded considerable work in distinguishing the conceptual and critical differences between shame and guilt (Tracy & Robins, 2004). Although these terms are often used interchangeably, research has supported the conclusion that shame and guilt are distinct emotional experiences with vastly different outcomes (Lewis, 1971; Lindsay-Hartz, 1984; Tangney & Dearing, 2002). As noted previously, though researchers have examined various ways to distinguish between these two emotions (e.g., situational and behavioral antecedents, public vs. private nature), the evidence seems to favor a

distinction between shame and guilt that examines focus on the self vs. focus on a behavior (Tangney et al., 2007). Developed by Lewis (1971), this theoretical conceptualization delineates the distinct nonverbal expressions, action urges, and behaviors prompted by shame and guilt. The key distinction is whether a person attributes the real or perceived transgression to a problem with the self or to a problem with a behavior (Lewis, 1971). A growing body of research has supported this conceptualization (e.g., Niedenthal, Tangney, & Gavanski, 1994; Tangney, Miller, Flicker, & Barlow, 1996; Tangney & Dearing, 2002). For example, Tracy and Robins (2006) found that participants reported feeling shame when failure was attributed to global, stable, and uncontrollable aspects of self. In contrast, guilt was felt when failure was attributed to a behavior influenced by transient and controllable aspects of self.

Contrasting Consequences

The attributional differences between shame and guilt result in distinct internal experiences and reactions. Research participants have consistently identified shame as a more painful and paralyzing emotion that routinely elicited the desire to hide, self-silence, deny, or escape the shame-inducing situation (Tangney & Dearing, 2002; Van Vliet, 2008). Experiences of shame were described as resulting in feeling flawed, unworthy, powerless, exposed, and inferior (Lewis, 1971; Lindsay-Hartz, 1984). In contrast, participants reported that feeling guilt caused them to reflect on their actions and make personal changes, engendered feelings of remorse, caused a desire to confess or apologize, and resulted in reparative actions as they sought to make things right (Brown, 2007; Tangney & Dearing, 2002).

The impact of shame versus guilt on interpersonal relationships is similarly divergent. Researchers (Joireman, 2004; Tangney & Dearing, 2002) have found a strong correlation between guilt and other-oriented empathy through increased perspective taking and concern. In contrast, shame correlated with a decreased capacity for empathy due to an increased focus on the self, which resulted from personal distress and self-rumination (Tangney & Dearing, 2002). Cooperation with others followed a similar pattern. For instance, Ketelaar and Au (2003) and de Hooge, Zeelenberg, and Breugelmans (2007) found that feelings of guilt increased cooperation between participants engaged in a social bargaining game, whereas feelings of shame led to a decrease in cooperation.

When considering these findings, it is not surprising that researchers have found positive correlations among shame, anger, self-blame, and other-blame (Bennett, Sullivan, & Lewis, 2005; Harper & Arias, 2004; Paulhus, Robins, Trzesniewski, & Tracy, 2004; Tangney & Dearing, 2002; Thomaes, Bushman, Stegge, & Olthof, 2008). Externalizing blame may help the shame-prone individual escape the painful focus on self and regain a sense of agency and control through self-righteous anger (Tangney & Dearing, 2002). Described as "humiliated fury" (Lewis, 1971, p. 41), shame-based anger can induce aggressive behaviors (Thomaes, Bushman, Stegg, Olthof, & Nezlek, 2011). In fact, the act of externalizing blame has been found to mediate the link between shame and physical aggression (Stuewig, Tangney, Heigel, Harty, & McCloskey, 2010). Moreover, Tangney, Stuewig, and Martinez (2014) found that shame, mediated by externalized blame, predicted recidivism in offenders. Guilt, however, was shown to inhibit criminal re-offense within the first year.

In contrast, characterized by an increased capacity for empathy and a focus on one's effect on others, individuals experiencing guilt are less motivated to externalize blame and are more apt to acknowledge their transgression and take responsibility for their actions (Tangney et al., 2007). Consequently, researchers have found a negative correlation between guilt and externalization of blame (Stuewig et al., 2010), guilt and destructive anger (Tangney & Dearing, 2002), and guilt and aggression (Paulhus et al., 2004).

Shame, Guilt, and Gender

Historically, research consistently indicated that women report greater levels of shame and guilt than men (Ortho, Robins, & Soto, 2010; Tangney & Dearing, 2002). Recent findings, however, have suggested that women experience greater shame related to food, eating, and their bodies; greater shame and guilt regarding sex and sexuality; and greater guilt about expressing grief (Else-Quest, Higgins, Allison, & Morton, 2012; Grabe, Hyde, & Lindberg, 2007). Men, on the other hand, reported greater shame in the area of emotional expression through crying and when faced with situations that threatened traditionally masculine identities (e.g., situations depicting physical weakness, lack of mechanical skill, and failed heroism; Ferguson, Eyre, & Ashbaker, 2000). Harper and Arias (2004) also found that women were more likely to react to shame by experiencing internalized responses (i.e., rumination and depression), whereas men were more likely to react with externalized responses (i.e., anger and aggression). SRT, however, was based on Brown's (2006) conceptualization of shame in women. Consequently, this study examined the process of shame resilience in women only.

Shame, Guilt, and Age

In examining the life span trajectory of shame and guilt, Ortho et al. (2010) found that guilt increased from adolescence into old age, while shame decreased from adolescence into middle adulthood but increased again in old age. They attributed these patterns, with the exception of increased shame in old age, to the "maturity principal of personality development" (p. 1061), which posits that as people age they become more prone to experiencing adaptive self-conscious emotions. They suggested that shame increased in old age due to changing social roles and relationships as well as decreased independence. Moreover, their results suggested that across the lifespan shame continued to be maladaptive, while guilt remained adaptive.

Long-term Consequences

As discussed previously, evidence supports the conclusion that shame is psychologically and interpersonally more painful and detrimental than guilt. Shame has been examined for its role in a wide range of mental health issues, including anger and aggression (Stuewig, et al., 2010), depression (Cheung, Gilbert, & Irons, 2004; Grabe, et al., 2007), addiction (Potter-Efron, 2011), eating disorders (Troop, Allan, Serpell, & Treasure, 2008), bullying (Ahmed & Braithwaite, 2004), post-traumatic stress disorder (Herman, 2011), suicide (Tangney & Dearing, 2002), family violence (Harper & Arias, 2004), academic difficulties (Turner & Husman, 2008), and sexual assault (Weiss, 2010).

According to Gilbert (2003), troubling family experiences in childhood (e.g., poor attachment to parental figures, neglect, poverty, abuse) strengthen the long-term influence of shame and have been shown to significantly contribute to shame-proneness

in adulthood (Tangney & Dearing, 2002). For example, Matos and Pinto-Gouveia (2010) found that early shame experiences elicited traumatic memory characteristics (e.g., intrusion, flashbacks, emotional avoidance, hyperarousal, fragmented states of mind, and dissociation), continued to impact shame and psychopathology in adulthood, and moderated the relationship between shame and depression in adults. In a more recent study examining the impact of shame and shame memories, Matos, Pinto-Gouveia, and Gilbert (2013) found that external shame (i.e., negative evaluation from others) was associated with adult paranoid ideation, whereas internal shame (i.e., negative evaluation of self) correlated with adult social anxiety.

Shame Resilience Theory (SRT)

The focus of the current study was to examine certain assumptions of SRT. Developed by Brown (2006), SRT emerged from a grounded theory study in which a diverse group of 215 women were interviewed to understand the unique influence of shame on women and the strategies employed to deal with the consequences. As previously noted, shame resilience is the "ability to recognize shame when we experience it, and move through it in a constructive way that allows us to maintain our authenticity and grow from our experiences" (Brown, 2007, p. 31). SRT proposes that women who experience shame can reduce its negative impact by implementing specific strategies and processes that increase awareness and understanding about shame and the sociocultural expectations that trigger it (Hernandez & Mendoza, 2011).

SRT defines shame as the painful feeling of believing one is unworthy of acceptance and belonging due to a flawed self (Brown, 2006). Echoing the findings of previous researchers (e.g., Lewis, 1971; Tangney & Dearing, 2002), participants in

Brown's (2006) study distinguished between shame and guilt by describing guilt as a negative feeling about a flawed or bad behavior rather than a flawed or bad self, which they experienced as shame. In SRT, shame is described as a "psycho-social-cultural construct" (p. 45), a combination of the personal, interpersonal, and cultural contexts in which shame is felt (Brown, 2006). In other words, shame taints the emotions, thoughts, and behaviors of one's self; erodes relationship and connection to others; and is born out of the inability to meet competing expectations.

SRT and the Nature of Shame

The participants in Brown's (2006) study described the experience of shame as the intersection of feeling trapped, powerless, and isolated. In SRT, the concept of feeling trapped combines the experience of unrealistic expectations with limited options in which to meet those expectations. Similar to Frye's (1983) concept of the double bind, – "situations in which options are reduced to a very few and all of them expose one to penalty, censure, or deprivation" (p. 2) – feeling trapped creates the proverbial 'damned if you do and damned if you don't' scenario. Brown (2006) explained that "the concept of trapped expands the double bind concept by combining limited and punitive options with layers of competing expectations to form a complex web that traps women" (p. 46). Take, for example, the gender norm expectation for women to smile and be cheerful. Although there are positive repercussions, complying with this gendered expectation can signal submission and acquiescence to one's situation, which serves to silence, disempower, and make invisible. However, the alternative is for a woman to be labeled as mean, bitter, angry, and difficult to work with. Regardless of

the choice, the individual is likely to experience financial, personal, relational, and professional peril (Frye, 1983).

SRT proposes that powerlessness occurs as a function of minimized consciousness, choice, and change. Participants in Brown's (2006) study reported that shaming experiences often produced overwhelming feelings of fear, confusion, judgment, and the desire to escape. Consequently, participants found it difficult to process what they were experiencing, resulting in decreased awareness, with a sense of little or no ability to influence the situation. Even when shame was accurately identified, change was made more difficult by the silencing and secret nature of shame (Brown, 2006).

According to the SRT model, isolation is the ultimate result of feeling trapped and powerless. Brown's (2006) participants reportedly felt increasingly disconnected vis-à-vis decreased awareness and a sense of loss regarding the possibility of change coupled with increased powerlessness. Relational-cultural theorists Miller and Stiver (1997) poignantly captured this concept:

> We believe that the most terrifying and destructive feeling that a person can experience is psychological isolation. This is not the same as being alone. It is feeling that one is locked out of the possibility of human connection and of being powerless to change the situation. In the extreme, psychological isolation can lead to a sense of hopelessness and desperation. People will do almost anything to escape this combination of condemned isolation and powerlessness. (p. 72)

SRT utilizes the metaphor of a shame web to highlight the experience of feeling trapped, powerless, and isolated in a web of layered, competing, and conflicting sociocultural expectations. Narrowly defined, these expectations occur within the context of one's identity (e.g., gender, race, class, sexual orientation, age, religious

identity) and/or role (e.g., mother, employee, partner, group member) and attempt to dictate how women represent themselves and perform in society (Brown, 2006). Expectations are then expressed and/or enforced by various individuals and groups (e.g., self, family, friends, partner, children, coworkers and membership groups) and are rigidly reinforced by media culture, including television, advertising, marketing, film, music, and print (Brown, 2006; Ferguson et al., 2000). More often than not, survival in the shame web requires one to choose some connections over others (Brown, 2006; Frye, 1983; Stiver & Miller, 1997). That is, in order to escape or protect against the shame of not meeting another's perceived or actual expectations, disconnection is employed and certain relationships are forfeited (Jordan, 1989; Miller & Stiver, 1997).

SRT proposes that there are no universal shame triggers for women; however, there is a shared experience of how social and cultural expectations are enforced by peers, family, community, and the media. Multiple categories emerged in Brown's (2006) qualitative study as common areas of shame for women: appearance and body image, sexuality, family, motherhood, parenting, professional identity and work, mental and physical health, aging, religion, speaking out, and surviving trauma. It is the unwanted identities associated with these categories that make women vulnerable to shame. For example, Brown explained that many participants identified terms like "loud-mouth" and "pushy" as unwanted identities associated with speaking out (Brown, 2006, p. 46). As previously defined, unwanted identities are experienced when self- or other-attributed labels undermine one's self-ideals (Ferguson et al., 2000). Indeed, unwanted identities were found to be causal antecedents of shameful reactions in children, adolescents, and adults (Ferguson et al., 2000).

The conceptual model for SRT is represented as a continuum that extends from a state of shame characterized by fear, blame, and disconnection to a state of empathy characterized by courage, compassion, and connection with others (Brown, 2007; see Appendix A). Brown defined empathy utilizing Wiseman's (1996) four attributes of empathy: (a) to be able to see the world as others see it; (b) to be nonjudgmental; (c) to understand another person's feelings; and (d) to communicate your understanding of that person's feelings (p. 1165). It involves the ability to tap into one's own experience in order to relate to another's experience. Participants in Brown's (2006) study identified experiencing empathy as the opposite of experiencing shame. That is, the ability to share their shaming experience with someone who could say, "I understand, I've been there, too" or "It's okay, you're normal" helped to alleviate the judgment, secrecy, and silence needed to perpetuate shame. When giving or receiving empathy, participants experienced an increase in connection and power that strengthened shame resilience (Brown, 2006; Miller & Stiver, 1997).

Shame Resilience

The SRT model proposes that the effects of shame can be decreased and managed by learning and practicing the four elements of shame resilience. As such, shame resilience is conceptualized as the sum of: (a) the ability to acknowledge, and have self-compassion regarding, personal vulnerability to shame; (b) the level of critical awareness regarding sociocultural expectations of the shame web; (c) the ability to form mutually empathic relationships that facilitate reaching out to others; and (d) the ability to discuss and deconstruct shame, described as the ability to "speak shame" (Brown,

2006, p. 49). Each of these elements is conceptualized as lying on a continuum between maladaptive and adaptive ways of navigating through shame (see Appendix A).

The vulnerability continuum. The vulnerability continuum represents the ability to recognize and accept personal vulnerabilities in general and one's shame triggers in particular. This is experienced as confusion, judgment, fear, anger, and blame versus recognition, awareness, protection, and support. The participants in Brown's (2006) grounded theory study described shame as being experienced in areas of vulnerability characterized by unmet self-ideals or sociocultural ideals. When shame was experienced in an unacknowledged area of vulnerability or in an area thought to be invulnerable, more intense shame was experienced (Brown, 2007). However, when some level of awareness was present regarding personal vulnerability, participants were more likely to respond in adaptive ways (e.g., with self-compassion and reaching out for support; Brown, 2006). Self-compassion was particularly effective at alleviating the anger, judgment, and self-blame that accompanied an exposed area of vulnerability to shame and fostered the awareness of shame triggers (Brown, 2010).

The consequences of ignoring one's personal vulnerability have been examined in health psychology and social psychology research. Sagarin, Cialdini, Rice, and Serna (2002) reported the link between the perception of invulnerability and the reluctance to acknowledge at-risk status and participate in preventative health behaviors. Similarly, in a study examining the susceptibility to deceptive, persuasive advertising and marketing, the level of acknowledged personal vulnerability determined the resistance to such appeals. In both studies, it was the "illusion of invulnerability" (p. 539) that kept participants from responding in protective and adaptive ways (Sagarin et al., 2002).

The critical awareness continuum. The critical awareness continuum ranges from the reinforcing, individualizing (i.e., feeling alone and isolated within an experience), and pathologizing of shaming experiences to the deconstructing, contextualizing, and normalizing of such experiences (Brown, 2006). Deconstructing and contextualizing involves the ability to link one's personal experiences to larger social issues in order to understand the universal influence of sociocultural expectations (Brown, 2006; Frye, 1983). Doing so increases one's resilience and personal power to connect to supportive others and create meaningful environmental change (Johnson, Worrell, & Chandler, 2005). Feminist theorists have suggested that the result of critical awareness is empowerment, which can increase resilience for current and future stressors (Worell, 2001).

The reaching out continuum. The reaching out continuum emphasizes the powerful influence of mutually empathic relationships to identify shared experiences and protect against the isolating properties of shame (Brown, 2006). SRT both supports and is supported by the concepts of relational-cultural theory, which expands the notion of shame from a self-conscious emotion to a relationally-conscious emotion (Hartling, Rosen, Walker, & Jordan, 2000). In other words, shame happens between people during the painful moment of feeling cut off from acceptance and belonging (Miller & Stiver, 1997).

Jordan (1989) suggested that the relational aspect of shame creates the need for *strategies of disconnection* in order to minimize the vulnerability to further exposure, criticism, and humiliation. Hartling (2000), a relational-cultural theorist, utilized the work of Karen Horney to describe strategies of disconnection as moving away by

withdrawing, hiding, and self-silencing; moving toward by seeking to appease and please; and moving against by trying to gain power over others, being aggressive, and using shame to fight shame. These strategies thwart authentic relationship in favor of a shallow, perfunctory relationship that saves face and helps to maintain at least some semblance of connection (Miller & Stiver, 1997).

In contrast, reaching out to supportive others creates a safe environment in which to find acceptance, validation, and empowerment (Brown, 2007). Acceptance and validation come as shared experiences are realized, shame is normalized, and mutual empathy is felt (Hartling et al., 2000). Empowerment begins as women work together to increase critical awareness and redefine the expectations for how they relate to and move through the world. In this way shame resilience occurs through connection with others (Brown, 2006; Johnson et al., 2005; Miller & Stiver, 1997).

The speaking shame continuum. This continuum advocates for education in the nature and influence of shame in order to accurately identify, label, and externalize shaming experiences (Brown, 2006; Tangney & Dearing, 2002). Developing a shared language for the influence of shame allows women to engage in meaningful dialogue to develop strategies of resilience (Brown, 2007; Lewis, 1971). This element of shame resilience combines several elements, as it requires one to acknowledge personal vulnerability to shame, be able to connect the shaming experience to sociocultural systems, and reach out for support.

SRT, Vulnerability, and Self-compassion

When empathy from others was not readily available, the participants in Brown's (2006) study reported that engagement in self-compassion (i.e., self-empathy),

protected against the self-critical, isolating, and emotionally overwhelming nature of shame. According to Neff (2003a), self-compassion "involves being touched by and open to one's own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one's suffering and to heal oneself with kindness" (p. 87). Self-compassion has three components: self-kindness (i.e., being kind and understanding toward oneself in instances of pain or failure rather than being harshly self-critical), common humanity (i.e., perceiving one's experiences as part of the larger human experience rather than seeing them as separating and isolating), and mindfulness (i.e., holding painful thoughts and feelings in balanced awareness rather than over-identifying with them; Neff, 2003b). In other words, self-compassion is compassion turned inward and, in relation to the vulnerability continuum, reduces personal vulnerability to shame.

Studies have shown that people high in self-compassion experience less negative psychological outcomes and exhibit greater emotional resilience (Neff, 2011). Self-compassionate individuals are less likely to experience anxiety and depression and enjoy greater life satisfaction and feelings of well-being (Neff, 2011), experience decreased eating guilt (Adams & Leary, 2007), and are more motivated to correct interpersonal mistakes (Baker & McNulty, 2011). Wasylkiw, MacKinnon, and MacLellan (2012) found that higher self-compassion in female undergraduates predicted fewer body concerns and less body preoccupation and eating guilt, and partially mediated the link between body preoccupation and depressive symptoms. For individuals with obsessive-compulsive, avoidant, and dependent personality disorders, therapy that increased self-compassion led to a decrease in psychiatric symptoms,

interpersonal problems, and personality pathology (Schanche, McCullough, Stiles, Svartberg, & Nielsen, 2011). Likewise, self-compassion was found to have a negative correlation with avoidance strategies in individuals who reported post-traumatic symptoms (Thompson & Waltz, 2008). Neff and Germer (2013) found that up to one year after an eight-week mindful self-compassion program, participants maintained the positive psychological outcomes, including increased self-compassion, compassion for others, mindfulness, life satisfaction, and happiness. Decreased depression, anxiety, stress, and emotional avoidance were also experienced.

Self-compassion has also been shown to mitigate the maladaptive reactivity toward negative events (Leary, Tate, Batts Allen, Adams, & Hancock, 2007). For example, first-year college students higher in self-compassion reported lower levels of homesickness and depression, as well as higher college life satisfaction, and were better able to manage social difficulties (Terry, Leary, & Mehta, 2013). Moreover, self-compassion moderated students' response to academic failure (Neff, Hsieh, & Dejitterat, 2005). Sbarra, Smith, and Mehl (2012) found that people higher in self-compassion during the beginning of a marital separation experienced less distress about their divorce during the following year. Similarly, clergy higher in self-compassion experienced higher ministry satisfaction and lower emotional exhaustion, leading to the conclusion that self-compassion may protect against clergy burn-out (Barnard & Curry, 2011).

Last, self-compassion was shown to be related to better management of health threats, improved health-related affect, and greater health-related self-care (Terry, Leary, Mehta, & Henderson, 2013). Similarly, self-compassion has been associated

with well-being later in life and, for some older adults, increased their willingness to use supportive medical devices (Allen, Goldwasser, & Leary, 2012). In patients with persistent musculoskeletal pain, self-compassion predicted lower levels of negative affect, pain catastrophizing, and pain disability, as well as higher levels of positive affect and pain self-efficacy (Wren et al., 2012).

Self-Compassion vs. Self-Esteem

Self-esteem and self-compassion are related but distinct constructs (Barnard & Curry, 2011). Self-esteem stems from self-evaluations of worth that are dependent on external indicators of success and social appropriateness. Often these self-evaluations are based on comparisons with others, as well as on another's evaluation of self (Crocker, Luhtanen, Cooper, & Bouvrette, 2003). Consequently, self-esteem may fluctuate with day-to-day feelings of self-worth, leading to high reactivity to negative feedback and outcomes (Neff & Vonk, 2009). Unlike self-compassion, self-esteem has been linked to self-aggrandizement, narcissism, and a lack of empathy (Leary et al., 2007; Neff & Vonk, 2009).

In contrast, self-compassion is not dependent on self-evaluation, social acceptability, or positive evaluation from others. Instead, self-compassion focuses on valuing the self while still acknowledging self-perceived imperfections (Neff, 2003a). Self-compassion was also found to be a stronger predictor of positive relationship behaviors than trait self-esteem (Neff & Beretvas, 2013).

Self-compassion and Shame

In a study testing a program designed to teach self-compassion to a group of participants high in shame and self-criticism, Gilbert and Procter (2006) found

significant reductions in depression, anxiety, self-criticism, shame, inferiority, and submissive behavior at the conclusion of the group. In addition, participants increased their ability to self-soothe and generate feelings of warmth and self-reassurance. Similarly, Johnson and O'Brien (2013) found that shame was a significant mediator of the relationship between self-compassion and depression; interestingly, guilt was not. Further, using self-compassion to process shameful experiences reduced negative affect, depression, and overall shame-proneness. These results, coupled with the research related to self-compassion and psychological health, suggest that self-compassion may serve as a strong preventive measure against personal vulnerability to shame.

SRT, Shame, and Critical Awareness

SRT proposes that shame resilience can be increased through the element of critical awareness (Brown, 2006). Defined as the ability to interpret personal experiences within the context of sociopolitical influences, critical awareness is integral to the feminist theoretical framework (Gutierrez, 1995). Over the last four decades, feminist and women-centered psychologists have been at the forefront in developing interventions that address unique issues related to women (Worell, 2001). A hallmark of these interventions has been a focus on increasing critical awareness, which in turn engenders empowerment, personal agency, and resilience in the face of hardship (Gutierrez, 1995; Worell, 2001). An important component of critical awareness is the belief that one has the ability to effect the desired changes in one's life, while also seeing oneself as a participant in social processes and a contributor to social change (Freire, 1973). The corollary of proactive critical awareness is empowerment (Gutierrez, 1995).

Empowerment has been defined as a process by which individuals, groups, and communities regain an actual or a perceived sense of control over their resources and affairs, leading to social and political change (Kasturirangan, 2008). Worell and Remer (2003) developed a model of empowerment that outlined four broad critical awareness principles. The first principle, personal and social identities are interdependent, addresses the interrelation between personal and social identity development. The second principle, the personal is political, assumes that pathology emerges within a social and political context and encourages interventions to address gender-role stereotyping, institutionalized sexism, and oppression. The third principle, relationships are egalitarian, addresses the unequal power status between men and women, as well as between majority and minority groups. Last, the fourth principle, women's perspectives are valued, proposes that women's experiences and ways of relating should be more greatly valued, therefore enabling women to trust themselves and other women (Worell & Remer, 2003). Judith Worell (2001) wrote:

> Empowerment encourages women and minority groups to identify and challenge the external conditions of their lives that devalue and subordinate them, and that deny them equality opportunity. Empowerment thus incorporates both internal and external contributions to distress and well-being and assists people in distinguishing between them. (p. 336)

The majority of research examining Worell and Remer's (2003) model of empowerment has focused on its influence on trauma. Johnson et al. (2005) found that empowered White women who had suffered intimate partner violence (IPV) showed greater resilience in the face of stress and trauma and fewer psychological symptoms. In a study to examine the role of empowerment for African American women who had experienced IPV, Wright, Perez, and Johnson (2010) found that empowerment mediated

the relationship between race and posttraumatic stress disorder (PTSD), and race and depression. Moreover, in comparison to resource acquisition, empowerment was found to attenuate PTSD symptoms for low to moderate levels of IPV severity (Perez, Johnson, & Wright, 2012).

In sum, critical awareness, made evident through the process of empowerment, is an important component to shame resilience. When the experience of shame is understood through the lens of sociopolitical processes that negatively impact the identity development of women, the etiology of shame is shifted from a flawed self to a flawed sociopolitical paradigm (Brown, 2006). This opens the possibility of increased agency for personal and environmental change, connection to supportive others, and resilience against psychological stress and trauma.

SRT, Shame, and Reaching Out

SRT proposes that shame resilience is increased when women experience mutually empathic relationships (Brown, 2006). Participants in Brown's (2006) qualitative study reported that reaching out to supportive others following a shame experience led to increased shame resilience. Additionally, critical awareness was evoked through the acknowledgement of shared experiences and the ongoing deconstruction of shame. SRT utilizes the relational-cultural model of relational development to support and interpret these experiences.

Developed as a feminist approach to counseling, relational-cultural theory (RCT) challenges the dominant psychological theories that stress separation-individuation as the primary indicator of development and growth (Frey, 2013; Liang et al., 2002b). In contrast, RCT proposes that women are empowered through the

engagement in growth-fostering, mutually empathic, and empowering relationships characterized by mutual engagement (i.e., mutual involvement and attunement), authenticity (i.e., full expression of self and the other), empowerment/zest (i.e., feeling strengthened and inspired toward action), and the ability to handle difference or conflict (i.e., the expression and acceptance of differences; Miller & Stiver, 1997). As such, psychological distress is conceptualized as the chronic absence of these qualities in relationships, which results in a sense of isolation and aloneness (Comstock et al., 2008; Frey, 2013).

RCT proposes that relational movement across the lifespan happens in the context of the one's racial, cultural, and other social identities (Comstock et al., 2008). Consequently, experiences of isolation, shame, humiliation, oppression, and marginalization are relational violations and traumas (Birrell & Freyd, 2006). Relationships strong in engagement, authenticity, empowerment, and empathy serve as protective factors against and healing processes for such experiences (Birrell & Freyd, 2006; Miller & Stiver, 1997).

Liang, Tracy, Taylor, and Williams (2002a) found that mentoring relationships high in engagement, authenticity, and empowerment were associated with higher self-esteem and less loneliness in female college students. Frey, Tobin, and Beesley (2004) found that higher peer and community relational health quality (i.e., engagement, empowerment, authenticity) in women and higher community relational health quality in men predicted lower psychological distress beyond the distress predicted by troubling family experiences. The same gender differences were observed in a similar study that found relational health was a significant predictor of psychological distress beyond the

quality of parental attachment (Frey, Beesley, & Miller, 2006). These studies lend support for the RCT assumption that relational development is a dynamic process that integrates peer, mentor, and community relationships. Moreover, perhaps consequent to gender norms, women and men seem to utilize and benefit from quality relationships in different ways (Frey, 2013).

SRT proposes that reaching out to supportive others helps to normalize and demystify the experience of shame. This occurs through mutually empathic relationships, where empathy is both given and received (Brown, 2006; Jordan, 1989). As previously discussed, shame can be an isolating and self-silencing experience (Lewis, 1971; Tangney & Dearing, 2002). Moreover, the relational aspect of shame may cause some to engage in strategies of disconnection that serve to protect against further harm to self (Hartling et al., 2000). Often this requires hiding the parts of one's self that elicit shame. By hiding, some minimal level of connection is maintained, which protects against psychological isolation but at the cost of true authentic relationship (Jordan, 1989). Miller and Stiver (1997) described this process as the *relational paradox.* Fedele (2004) explained, "Simply put, the paradox is that in order to stay in connection, we keep parts of ourselves out of connection" (p.196).

RCT suggests that growth-fostering connections result in *the five good things,* which include: (a) zest (i.e., a sense of vitality and aliveness), (b) action (i.e., constructive dialogue and behaviors), (c) clarity (i.e., increased knowledge and understanding), (d) sense of worth (i.e., feeling acceptance and belonging), and (e) a desire for further connection (i.e., commitment to connection; West, 2005). The absence of these good things in relationships can result in diminished energy, feeling

stuck, confusion, low self-worth, isolation, and fear of relationships. In other words, many of the same negative outcomes as shame. Moreover, as shame happens in the context of relationship, those experiences may be internalized and result in *relational images* (i.e., internal images based on past relational experiences) that negatively influence expectations for future relationships (Liang & West, 2011). In this way, the relational paradox is perpetuated, as the dialectic of both wanting connection but fearing connection is present (Miller & Stiver, 1997).

As previously discussed, shame may have the toxic effect of damaging current relationships and thwarting the possibility of future relationships. Research examining the principles of RCT and the importance of growth-fostering, mutually empathic and empowering relationships supports the hypothesis that reaching out to supportive others may serve as a protective factor against the negative interpersonal effects of shame (Brown, 2006; Jordan, 1989; Miller & Stiver, 1997).

Research Questions

SRT identifies self-compassion regarding personal vulnerability, critical awareness, and reaching out to facilitate mutually empathic relationships as key elements of shame resilience (Brown, 2006, 2010). As such, SRT acknowledges that shame resilience is comprised of both intrapersonal (i.e., self-compassion and critical awareness) and interpersonal (i.e., reaching out) processes. Further, SRT illuminates the radiating influence of both shame and shame resilience from the personal (i.e., self-compassion) to the communal (i.e., reaching out) and sociopolitical (i.e., critical awareness) arenas (Brown, 2006). Supported by the relational-cultural model, SRT interprets shame as a relationally-conscious emotion that is best ameliorated through

mutually empathic and empowering relationships, self-compassion, increased critical awareness, and the ability to accurately label and describe shame (i.e., speak shame; Brown, 2006; Jordan, 1989; Miller & Stiver, 1997).

The purpose of this study was to examine the theoretical relationships among shame and several elements of shame resilience: self-compassion (identified by SRT as crucial to the decreased vulnerability to shame), critical awareness, and reaching out. Additionally, a fourth predictor to control for troubling family experiences was added in view of the previously discussed research suggesting a relationship between early family experiences and shame in adulthood (Gilbert, 2003; Tangney & Dearing, 2002). The research questions for the proposed study were: (a) Do the predictors as a group account for significant variance in shame? and (b) What individual predictors emerge as significant predictors of shame scores?

Method

Participants

A total of 363 participants consented to participate in the study; however, 80 cases were excluded due to incomplete data. The remaining 283 participants were included in the final analysis. The mean age of the sample was 40 (*SD* = 11.94) years and participants ranged in age from 21-73 years old. Eighty percent (*n* = 227) of the participants identified as Caucasian, 5% (*n* = 15) as American Indian, 5% (*n* = 15) as Hispanic/Latina, 5% (*n* = 13) as Biracial/Multiracial, with the remaining 4% (*n* = 12) as African or African American, Asian or Asian American, or Alaskan Native. One participant did not report ethnicity. Sixteen percent (*n* = 43) of the participants identified as lesbian, bisexual, or "other" designation (e.g., pansexual, queer,

questioning, and transgendered). Four participants (1%) did not report sexual orientation or gender identity.

The sample was relatively well-educated with 35% (n = 100) of the participants reporting a bachelor's degree, 27% (n = 75) a master's degree, 16% (n = 47) some college, 13% (n = 36) a doctoral/professional degree, 5% (n = 13) an associate's degree, and 4% (n = 12) a high school diploma. Education was received in a variety of areas: social sciences (42%, n = 120), arts and humanities (18%, n = 50), life sciences and medicine (11%, n = 30), and business and management (10%, n = 29). Four percent (n = 10) received education in natural sciences and 2% (n = 5) were educated in engineering and technology. Thirty-nine participants (13%) did not report an area of study.

Twenty-five percent (n = 72) of the participants reported an annual income of $25,000-50,000, 21% ($n$ = 59) reported $50,000-75,000, 17% ($n$ = 48) reported $75,000-100,000, 13% ($n$ = 38) reported $100,000-125,000, 13% ($n$ = 36) reported less than $25,000, and 10% ($n$ = 28) reported more than $125,000. Two participants (1%) did not report income. The majority of participants (53%, n = 150) identified as Christian. Of the remainder, 11% (n = 30) identified as agnostic, 10% (n = 28) as Roman Catholic, 9% (n = 26) as atheist, 8% (n = 23) as non-religious, and 4% (n = 11) as either Buddhist or Muslim (Islamic). Five percent (n = 15) identified as "other" (e.g., deist, humanist, pagan, spiritual, mystical).

Participants were from five different geographic regions: South (81%, n = 228), Midwest (12%, n = 33), and West (4%, n = 10), with an additional 4% (n = 10) from the Northeast and Pacific regions. Two participants did not report geographic location.

Fifteen percent (n = 43) of the participants were part-time or full-time students and 81% (n = 229) reported working at least part-time. Fifty-six percent (n = 158) reported having no children, 34% (n = 96) reported 1-2 children, and 10% (n = 27) reported 3-4 children, and 1% (n = 2) reported five or more children.

Instruments

Instruments included the Shame Inventory (Rizvi, 2009; Appendix B), Personal Progress Scale – Revised (Johnson et al., 2005; Appendix C), Self-Compassion Scale – Short Form (Neff, 2003b; Raes, Pommier, Neff, & Van Gucht, 2010; Appendix D), Relational Health Indices (Liang et al., 2002b; Appendix E), Family Experiences Questionnaire (Draper, Jennings, Baron, Erdur, & Shankar, 2002; Appendix F), and a brief demographic questionnaire (see Appendix E). The demographic questionnaire collected basic information, as well as student and work status, religious orientation, and number of children.

The Shame Inventory. The Shame Inventory (SI; Rizvi, 2009) was designed as a self-report measure to assess an individual's propensity to experience shame both globally and in response to specific life events and utilizes a definition of shame that is congruent with Brown's (2006) definition. The instructions include a general definition of shame for the participant. In Part I, three questions inquire about general feelings of shame in terms of frequency and intensity (e.g., "To what extent does shame negatively affect the quality of your life"). Item responses are rated on a 5-point scale ranging from 0 (*Never*) to 4 (*Always*), with higher scores indicating higher levels of shame. Part II, is comprised of individual shame cues (e.g., "A time when I was … laughed at by others, lost something important, was sexually harassed") that participants are asked to

rate according to their level of shame regarding those cues. These item responses are also rated on a 5-point scale, ranging from 0 (*No Shame*) to 4 (*Extreme Shame*). In this section, there is also an additional option to mark an "X" (*Didn't Happen/Does Not Apply to Me*). Endorsed items from Part I and II are summed and the average calculated to obtain a total score, which ranges from 0 to 4, with 4 indicating a higher degree of shame.

For the initial validation study (Rizvi, 2009), the SI was administered to a sample of undergraduate students (N = 379), which yielded good overall internal consistency, with a Cronbach's alpha of .84, as well as good internal consistency in Part I (Cronbach's alpha = .80) and Part II (Cronbach's alpha = .83). Likewise, test-retest reliability was high with a correlation coefficient of .85 (Rizvi, 2009). The measure was significantly correlated with well-known measures of shame (i.e., TOSCA-3 shame subscale, PFQ-2 shame subscale scales) and showed discriminant validity with well-known measures of guilt (i.e., TOSCA-3 guilt subscale, PFQ-2 guilt subscale). Last, the measure showed predictive validity through the significant differences between the high shame scores of participants diagnosed with borderline personality disorder, moderate shame scores of participants diagnosed with obsessive-compulsive personality disorder, and low shame scores of the norm group (Rizvi, 2009). For this study, the Cronbach's alpha was .93 for the total score.

The Self-Compassion Scale-Short Form. The Self-Compassion Scale – Short Form (SCS-SF; Neff, 2003b; Raes et al., 2010) is a short form of the original 26-item self-report Self-Compassion Scale designed by Neff (2003b) to assess the six theorized components of self-compassion, including self-kindness vs. self-judgment, common

humanity vs. isolation, and mindfulness vs. over-identification. The original scale included six subscales. The short form of the scale (i.e., SCS-SF) is a 12-item self-report measure of self-compassion and was used as a measure of personal vulnerability. The brevity of the scale and low internal consistencies of the subscales did not allow for the original six-subscale model and suggested the scale is best used as an overall measure of self-compassion; however, items continued to reflect a good fit with the original hypothesized higher-order model (*CFI* = .97 and *NNFI* = .96). The measure yielded good internal consistency (.86) as measured by Cronbach's alpha (Raes et al., 2010).

Item responses for the SCS-SF are rated on a 5-point scale ranging from 1 (*Almost Never*) to 5 (*Almost Always*). The mean of the total score reflects overall level of self-compassion, with a higher score reflecting higher self-compassion. Items include statements such as, "I try to be understanding and patient towards those aspects of my personality I don't like," "When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people," and "When something upsets me I try to keep my emotions in balance." Initial validation of the SCS-SF was conducted with a diverse sample of 415 university students. The SCS-SF total score was found to have near-perfect correlation with the long form total score (r = .98). Correlations between the long and short form subscales were also good (ranging from .89 - .93). For this study, the Cronbach's alpha was .89.

The Personal Progress Scale-Revised. The Personal Progress Scale - Revised (PPS-R; Johnson et al., 2005) is a 28-item self-report measure of empowerment and was used as a measure indicating critical awareness (Brown, 2006). The revised scale is an

updated and improved version of Worell and Remer's (2003) Personal Progress Scale. Like its predecessor, the PPS-R is derived from the four previously discussed principles of Worell and Remer's (2003) empowerment model (i.e., personal and social identities are interdependent, the personal is political, relationships are egalitarian, and women's perspectives are valued). In addition the measure is designed to assess the outcomes associated with empowerment: (a) positive self-evaluation and self-esteem, (b) a favorable comfort distress ratio (i.e., the ability to regulate emotional distress), (c) gender-role and cultural identity awareness, (d) a sense of personal control/self-efficacy, (e) self-nurturance and self-care, (f) effective problem-solving skills, (g) competent use of assertiveness skills, (h) effective access to multiple economic, social, and community resources, (i) gender and cultural flexibility, and (j) socially constructive activism (Worell & Remer, 2003). Due to the complexity of this model and brevity of the measure, the factor analysis did not yield reliable subscales. Consequently, the PPS-R has been found to be best used as a single overall measure of empowerment (Johnson et al., 2005).

Respondents are asked to answer items based on important personal identities, such as gender, sexual orientation, race, and family background. Examples of items include: "I now understand how my cultural heritage has shaped who I am today," "I give in to others so as not to displease or anger them," and "I am aware of my own strengths as a woman." Item responses are rated on a 7-point scale ranging from 1 (*Almost Never*) to 7 (*Almost Always*). The total score reflects overall empowerment, with higher scores reflecting a higher sense of empowerment.

Johnson et al., (2005) administered the PPS-R to a diverse sample of women (*N* = 222), including a subgroup of women who had experienced intimate partner violence (*N* = 86). Overall internal consistency was high, with a Cronbach's alpha of .88. Convergent validity was established through positive significant correlations with measures of autonomy, self-evaluation, and overall well-being. Likewise, discriminant validity was good, as the measure showed a negative significant correlation with measures of symptomatic distress that indicated low empowerment. For this study the Cronbach's alpha was .90.

The Relational Health Indices. The Relational Health Indices (RHI; Liang et al., 2002b) is a 37-item self-report measure that assesses the growth-fostering qualities of engagement, authenticity, and empowerment in the separate domains of peer (12 items), mentor (11 items), and community (14 items) relationships. The measure is based on the relational-cultural model that proposes healthy psychological growth is achieved through the development and maintenance of mutually empathic and empowering relationships (Miller & Stiver, 1997). The mentor component was not relevant to the current study; therefore, the peer and community components were used as a measure of reaching out (Brown, 2006).

RHI item responses are rated on a 5-point scale ranging from 1 (*Never*) to 5 (*Always*). Peer and community relationships are defined for the participant before instructing them to rate the quality of their relationships by responding to items such as, "My friendship inspires me to seek other friendships like this one" (peer item), and "If members of this community know something is bothering me, they ask me about it" (community item). The peer and community composite scores were averaged to obtain

a total score with a range of 0-5. Higher scores indicated higher relational health (i.e., higher engagement, authenticity, and empowerment).

The initial validation study with a group of 450 undergraduate students yielded RHI peer, mentor, and community composite scores with adequate internal consistency (.85 - .92) as measured by Cronbach's alpha (Liang et al., 2002b). Subsequent studies have yielded similar internal consistencies ranging from .88 - .92 (Frey et al., 2004; Frey et al., 2006). In addition, the RHI has shown good convergent and concurrent validity through correlations with related instruments (e.g., The Mutual Psychological Development Questionnaire, The Quality of Relationships Questionnaire, Rosenberg's Self-Esteem Scale, and Perceived Stress Scale; Liang et al., 2002b). For this study, the Cronbach's alpha was .91.

The Family Experiences Questionnaire. The Family Experiences Questionnaire (FEQ; Draper et al., 2002) is an 18-item questionnaire used by the Research Consortium of Counseling and Psychological Services in Higher Education to measure troubling or concerning family experiences (e.g., parent with a drug problem, parental divorce, experiences of abuse) that may have an impact on psychological adjustment. The FEQ was used to control for troubling family experiences that may impact shame level in participants. The FEQ response format is a 3-point Likert scale (1 = *no,* 2 = *unsure,* 3 = *yes*). The range of total scores is 0 to 54, with higher scores indicating a higher level of troubling family experiences. A limitation of the FEQ is the restricted variability in response choices. For this study, the Cronbach's alpha was .79.

Procedure

After obtaining IRB approval, snowball sampling (Noy, 2008) was used to recruit women, ages 18-80. Initial participants were recruited from the professional (e.g., listservs, colleagues) and personal (e.g., family, friends, and students) contacts of the researcher, as well as social media. Participation in the study was voluntary and eligible participants were directed to the online survey through a link provided in the recruitment email or online posting. Data was collected anonymously through Qualtrics software. Prior to presentation of the questionnaires, participants were asked to review an information sheet explaining the purpose of the study. After agreeing to participate, participants completed the SI, PPS-R, SCS-SF, RHI, FEQ, and a brief demographic questionnaire.

Upon completion of the survey, participants were given the opportunity to provide an email address to enter a raffle for one of four Amazon gift certificates. The email database was not connected to survey responses and was destroyed following winner notification. The online survey and raw data were securely stored and maintained digitally in an individual password-protected user file for the principal investigator through the University of Oklahoma Center for Educational Development and Research. Upon completion of the instruments, participants were asked to forward the online survey to at least four additional women.

Data Analysis

A hierarchical regression model was used to explore the relationship of the predictor variables to the criterion variable, total shame score. The relevant demographic variables of income and education, along with the FEQ total score were

entered into block one to control for their effects, followed by SCS-SF total score, PPS-R total score, and RHI total score in block two.

Results

Preliminary analyses indicated no violation of the assumptions of normality, linearity, multicollinearity, and homoscedasticity. Correlational analyses were conducted to determine the relationships among the predictor and criterion variables (see Table 1 for means, standard deviations, and intercorrelations). Income (r = -.23, $p \leq 001$) and education (r = -.21, $p \leq .001$) levels were significantly and negatively correlated with shame. The SCS-SF (r = -.59, $p \leq .001$), RHI (r = -.26, p <.001), and PPS-R (r = -.63, $p \leq .001$) scores were significantly and negatively correlated with shame, whereas, the FEQ (r = .28, $p \leq .001$) was significantly and positively correlated with shame.

T-tests and ANOVAs were used to investigate differences on shame among categories of ethnicity, sexual orientation, and religious orientation. In order to run group comparisons, ethnicity was collapsed into two groups: People of Color (n = 55) and Caucasian (n = 227), with no significant difference on shame scores. Likewise, sexual orientation was collapsed into two groups: Sexual Minorities (n = 43) and Heterosexual (n = 236). There was a significant difference on shame scores: t (277) = 2.95, p = .003. However, given the significant difference in group size and small effect size (eta squared = .03), this predictor was not added to the regression analysis. Religious orientation was collapsed into four groups: Christian/Catholic (n = 178), Islam/Buddhist/Other (n = 56), Agnostic/Atheist (n = 26), and no religion (n = 23). Again, there was a significant difference on shame scores: F (3, 279) = 2.7, p = .05.

Despite reaching statistical significance, the actual difference in mean scores between the groups was quite small. The effect size, calculated using eta squared, was .03. Post-hoc comparisons using the Tukey HSD test indicated no significant mean score differences between groups. Consequently, this predictor was not added to the regression analysis.

Multiple Regression Model

Hierarchical multiple regression was used to assess the combined and individual contributions of self-compassion (i.e., SCS-SC), critical awareness (i.e., PPS-R), and relational health (i.e., reaching out; RHI) in predicting shame (i.e., SI), after controlling for the influence of income, education, and number of troubling family experiences (i.e., FEQ; see Table 2). The total model was significant and predicted 50% of the variance in shame scores [$F(6, 273) = 45.53$, $p < .001$, $R^2 = .50$ (adjusted $R^2 = .49$)]. At the first step, income, education, and FEQ total score were entered and predicted a significant amount of the variance [$F(3, 276) = 12.03$, $p < .001$, $R^2 = .12$ (adjusted $R^2 = .11$). At step two, SCS-SC, PPS-R, and RHI total scores were entered and significantly predicted an additional 39% of variance. In the final model, only SCS-SF, PPS-R, and FEQ were individually significant (all at $p \leq .001$) predictors. Income, education and RHI were nonsignificant. PPS-R made the largest unique contribution to shame score variance ($\beta = -.42$), followed by SCS-SF ($\beta = -.34$), and FEQ ($\beta = .17$).

Discussion

The purpose of this study was to examine some of the theoretical assumptions of SRT by exploring the theoretical relationships among shame and three of the four elements of shame resilience: self-compassion, critical awareness, and reaching out

(Brown, 2006, 2010). Specifically, the study's aim was to assess the individual and combined ability of self-compassion, critical awareness, and reaching out to predict shame in adult women. In order to control for potentially shame-inducing experiences, a measure for troubling family experiences and relevant demographic variables were added to the analyses.

Regarding the first research question, the model as a whole (i.e., income, education, troubling family experiences, self-compassion, critical awareness, and reaching out) significantly predicted 50% of the variance in shame scores. Regarding the second research question, critical awareness and self-compassion, but not reaching out, were significant individual predictors of shame scores. Additionally, the number of troubling family experiences emerged as a significant individual predictor of shame scores. As previously noted, critical awareness made the strongest unique contribution to explaining shame scores, followed by self-compassion, and troubling family experiences.

These results suggest that increased critical awareness and self-compassion contribute to lower shame levels, lending support for the SRT assumption that these elements contribute to shame resilience. Specifically, the finding that greater critical awareness was significantly associated with lower shame scores is congruent with what is understood about the nature and influence of both shame and critical awareness. Critical awareness redefines problematic experiences as emerging from a lack of power (Gutierrez, 1995). This feeling of powerlessness is well documented throughout the shame literature as rising from the belief that change is impossible due to a fundamentally flawed self (Lewis, 1971; Tangney & Dearing, 2002; Brown, 2006).

Engagement in critical awareness may safeguard against powerlessness by rejecting the assumption of individual pathology to examine the interaction between oneself and the environment as the source of distress (Freire, 1973; Gutierrez, 1995). In other words, the attributional mechanisms of shame are challenged and shame is mitigated when the focus of change is shifted from the self to the external environment (e.g., social supposition, media messages, family expectations, and community norms; Brown, 2006; Worell, 2001).

Feminist theorists (e.g., Freire, 1973; Gutierrez, 1995) have suggested that critical awareness emerges from three cognitive components: identification with similar others (e.g., reaching out to supportive others), a reduction of self-blame for past events (i.e., self-compassion), and a sense of personal responsibility for solving future problems. Thus, critical awareness may reduce the isolation, self-silencing, withdrawal, and self- and other-blaming symptoms of shame. For example, critical awareness, as part of the empowerment process, has contributed to increased resilience against stress and trauma, fewer psychological symptoms, and decreased PTSD symptom severity (Johnson et al., 2005; Perez et al., 2012). This may be especially salient for resilience against PTSD-like symptoms associated with early shame memories (Matos & Pinto-Gouveia, 2010). Last, critical awareness leads to regaining a sense of control over one's resources and affairs, so may engender adaptive ways for shamed individuals to work through the externalized anger and aggression that can accompany shame (Stuewig et al., 2010).

Regarding self-compassion, the finding that greater self-compassion was significantly associated with lower shame scores is corroborated by previous research

that identifies self-compassion as an effective treatment for shame symptoms (Brown, 2010; Gilbert & Proctor, 2006). The attributes of self-compassion, including self-kindness, common humanity, and mindfulness, appear to help individuals to combat or lessen the vulnerability and detrimental reactions to a shaming experience (Johnson & O'Brien, 2013). Coupled with the previously discussed research suggesting that self-compassion is positively correlated with good mental health and negatively correlated with negative affect and neuroticism, it is likely that self-compassion attenuates the severity and duration of certain shame-related symptoms (e.g., avoidance, isolation, aggression).

It is not surprising to find that shame scores increased with the number of troubling family experiences. As Matos & Pinto-Gouveia (2010) have shown, early memories perceived as shameful (e.g., experiences of abandonment, rejection, emotional negligence, abuse) were associated with current internal and external shame, psychopathology, and depression in adulthood. Similarly, many researchers (e.g., Gilbert, 2003; Stuewig & McCloskey, 2005) have concluded that childhood experiences are the scaffolding for self-beliefs. If negative and shaming experiences are internalized, they are likely to become the essence of one's self-perception as flawed, inferior, and rejectable, and increase vulnerability to shame (Mikulincer & Shaver, 2005).

It is interesting that reaching out was not a significant individual predictor of shame. This finding could reflect the salience of the intrapersonal processes of critical awareness and self-compassion as frontline protective factors against shame. Relational health had a significantly positive and moderate correlation to critical awareness and

self-compassion, which suggests that relational health may indirectly impact shame resilience through these other elements. As previously discussed, research has shown that high relational health is related to less psychological distress (Frey et al., 2004; Frey et al., 2006) and loneliness, as well as to higher self-esteem (Liang et al., 2002a). Perhaps meaningful relationships foster an environment in which critical awareness and self-compassion can take place, strengthening the likelihood of shame resilience. Jordan (1992) suggested that vulnerability is acknowledged within the context of safe, supportive relationships. Participants in Brown's (2006) study identified this process when critical awareness and self-compassion resulted from exchanging, normalizing, and demystifying shaming experiences with supportive others. Future research to examine the interaction of relational connection and shame may reveal an indirect influence of relational health on shame and shame resilience.

Clinical Implications

The results of this study have direct clinical implications for mental health clinicians and add to the literature base informing the use of shame resilience for the treatment of shame and shame-related disorders. Specifically, these results support the SRT-proposed use of critical awareness to help clients identify their shame web and increase self-compassion to reduce one's personal vulnerability to shame (Brown, 2006). Although reaching out (i.e., relational health) did not appear to be a significant individual predictor of shame, its correlation with critical awareness and self-compassion combined with previous research (e.g., Frey et al., 2006; Liang et al., 2002a) suggests that the quality of and value placed on interpersonal connection impacts (perhaps indirectly) the experience of shame.

Regarding interventions, these findings support the continued use of teaching self-compassion as a therapeutic intervention specifically designed to treat and build resilience against shame (e.g., Brown, 2009; Gilbert & Procter, 2006; Johnson & O'Brien, 2013; Rizvi & Linehan, 2005). In fact, Gilbert and Proctor (2006) found that for clients who experience high levels of shame, focusing exclusively on other-focused interventions at the expense of self-compassion skills actually exacerbated feelings of shame.

Similarly, feminist theorists and psychologists have long known the importance and clinical utility of interventions designed to engender critical awareness and facilitate empowerment (Gutierrez, 1995; Worell, 2001). These results support that endeavor and suggest that such interventions would be useful for the treatment of shame and shame-related disorders, regardless of clinician theoretical orientation. For example, Gefter, Bankoff, Valentine, Rood, and Pantalone (2013) found that feminist beliefs, including beliefs related to critical awareness and empowerment, provided resilience against male-perpetrated abuse by (a) decreasing self-blame and shame, (b) promoting a connection to, and support from other women; (c) recognizing that one is not alone; and (d) enhancing personal agency and power. Counseling psychology training programs could promote this initiative by teaching critical awareness and providing training on empowerment interventions that would be particularly salient for clients from marginalized groups (Johnson et al., 2005; Wright et al., 2010). Brown (2006) proposed that SRT could be applied in diverse practice settings and recommended group psychoeducation as an effective way of teaching clients (or students) about shame and for increasing critical awareness skills.

Of note is that Scheff (2003) reminded clinicians that the topic of shame continues to be a taboo and misunderstood concept in our society, despite its description as the "master emotion of everyday life" (p. 239). Counselors may find that clients are resistant to acknowledging shame and may need help understanding its nature and role in their presenting problems (Gilbert & Procter, 2006). For example, Pauley and McPherson (2010) found that individuals with depression and anxiety found it daunting to develop and maintain a self-compassionate stance, despite their belief that self-compassion was a meaningful and useful concept. They suggested that clinicians first help individuals realize that they have the capacity for self-compassion and then provide self-compassion skills training. Additionally, the very process of psychotherapy can be a shaming experience as clients must admit they need help and then are encouraged to discuss intimate details of their lives (Dearing & Tangney, 2011). Thus, teaching clients self-compassion and critical awareness skills may not only attenuate symptomology, as previously discussed, but also may ultimately aid the therapeutic process and allow clients to experience change more quickly and completely.

Last, it must be considered that counselors are not immune to the human nature of shame and may encounter their own shaming experiences throughout the therapy process. Koerner, Tsai, and Simpson (2011) suggested that therapists might find themselves immersed in a shame experience evoked by a client's shame issue (e.g. addictive behaviors, body shame, shame about affect or interpersonal needs). Moreover, counselors have reported feeling shame over scheduling mistakes, forgetting or confusing client information, being visibly tired, falling asleep, or arriving late (Klinger, Ladany, & Kulp, 2011). Critical awareness of the influence of social and

professional expectations on therapist shame could address the shame inherent in these perceived failures. Likewise, self-compassion can be a useful tool for therapists to counter the reactions to shame that would disrupt the therapeutic alliance and lower the therapist's own self-efficacy.

Limitations and Future Research

This study endeavored to be the first to quantitatively examine some of the theoretical assumptions of SRT, including the combined relationships among several elements of shame resilience and shame. Although the study had solid theoretical grounding, adequate sample size, and empirically validated measures, there are some limitations to consider. First, the cultural diversity of the sample was limited and although preliminary analyses did not find effects related to ethnic group membership, it is important to note that the sample was predominantly White, with the other ethnic/racial groups consisting of relatively small numbers of participants. Similarly, the sample was primarily heterosexual, with a small number of sexual and gender minorities represented. Finally, the sample was largely well educated, Christian, residing in the Southern region of the U.S., and with an annual income over $50,000. Thus, the generalizability of this study beyond the scope of this subset of women has yet to be determined.

A second limitation was that all instruments used were self-report measures and susceptible to social desirability bias. Notably, the area of study most reported by participants was in the social sciences. Education in the social sciences may have influenced participant awareness of the constructs being measured, resulting in an increase of social desirability bias. Last, because the analyses were correlational, the

reported results are associational, not causal. Although relationships supporting those found in this study have been previously reported (e.g., Gilbert & Procter, 2006; Gefter et al., 2013) and the current study's design was theory-driven, definitive causal inferences cannot be drawn at this point.

Further research that examines additional aspects of SRT (e.g., empathy and speaking shame) would add to the shame literature and strengthen the SRT model. A thorough and multifaceted understanding of the intersection and clinical utility of the SRT elements would aid clinicians in developing more precise shame resilience interventions, perhaps resulting in more efficacious treatment for those struggling with the vulnerable and disorienting experience of shame. Likewise, clinicians would benefit from research focused on better understanding the role of reaching out and relational connection in shame resilience, including the possibility of indirect effects on critical awareness and self-compassion.

Given the homogenous characteristics of the study sample, future research with various groups, particularly with those who may experience chronic shame due to marginalization and discrimination (e.g., sexual minorities, ethnic/racial minorities), would provide insight into the efficacy of SRT with these populations. Likewise, future research should examine the application of SRT to men. Certainly the literature on men and masculinities addresses the ways in which shame may be experienced and expressed in men's lives (e.g., Krugman, 1995, Vasquez, 2006). Thus, it is also important to understand the ways in which shame resilience operates in the lives of men.

Conclusion

Overall, the results of this study provide empirical support for some of the theoretical assumptions of SRT and encourage the use of critical awareness and self-compassion to increase shame resilience for the treatment of shame and shame-related disorders. Given the growing awareness that shame has a negative impact on psychological adjustment, interpersonal relationships, and overall mental health, there remains an urgent need for effective shame treatments (Tangney & Dearing, 2002). Further exploration of SRT and the significance of shame resilience is warranted and could lead to improved outcomes for women.

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Table 1

Means, Standard Deviations, and Intercorrelations on Variables of Interest

Variable	*M*	*SD*	*a*	*1*	*2*	*3*	*4*	*5*	*6*	*7*
1. Income	3.23	1.53		--	.30***	-.23***	.24**	-.25**	.16**	.28***
2. Educ	4.02	1.36			--	-.21**	.12*	-.26***	.11	.20**
3. SI	1.61	.73	.93			--	-.59***	.28***	-.26***	-.63***
4. SCS-SF	3.02	.73	.89				--	-.11	.40***	.63***
5. FEQ	25.96	6.65	.79					--	-.15*	-.17**
6. RHI	3.46	.54	.91						--	.43***
7. PPS-R	4.97	.81	.90							--

Note. Educ = education; SI = Shame Inventory; SCS-SF = Self-Compassion Scale-Short Form; FEQ = Family Experiences Scale; RHI = Relational Health Indices; PPS-R = Personal Progress Scale-Revised.
*$p < .05$. **$p < .01$. ***$p < .001$.

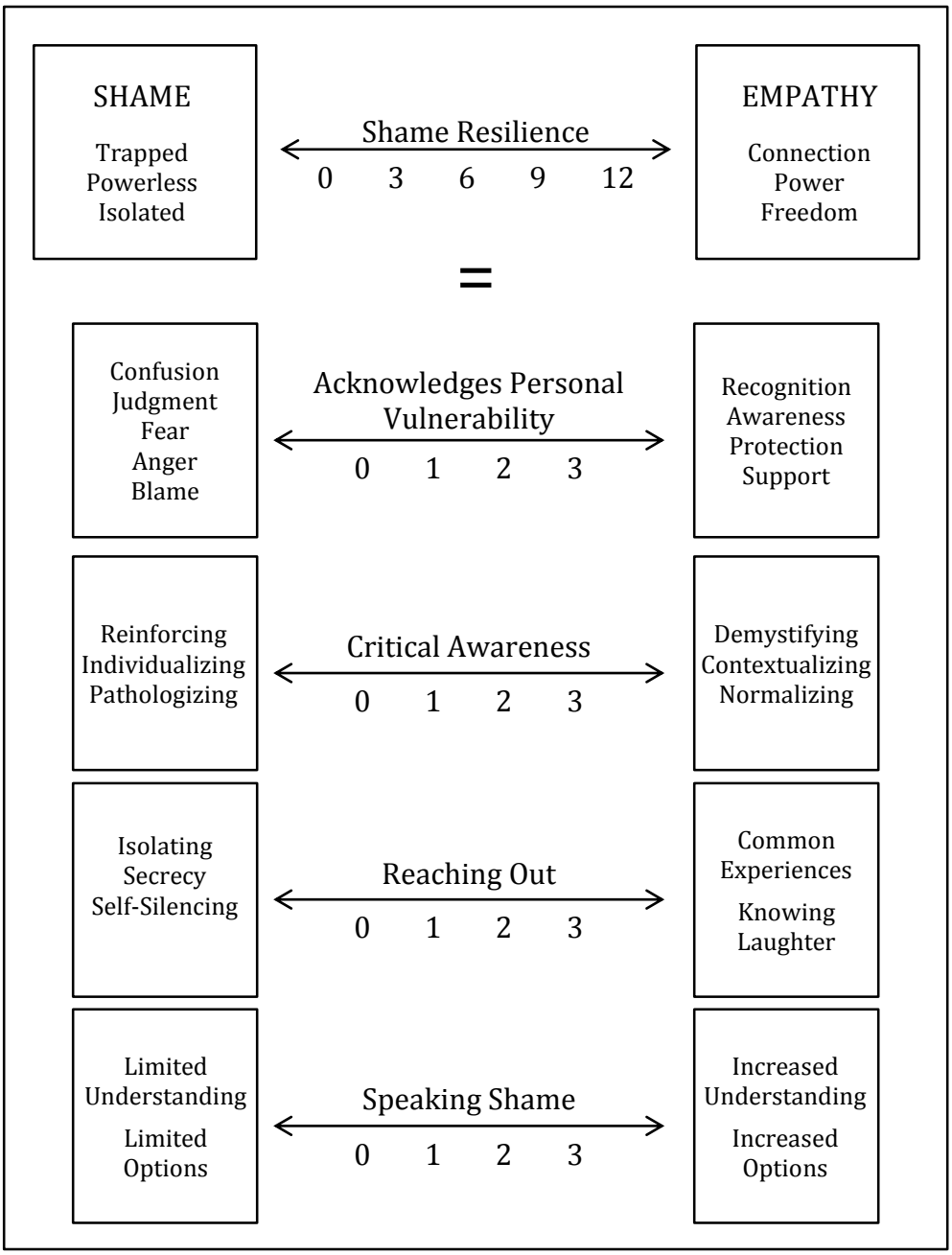
Table 2

Final Step of Hierarchical Multiple Regression Analysis for Variables Predicting Shame

Predictors	*Step*	R^2	ΔR^2	*F Change*	*df*	*B*	*SE B*	*β*
Educ	1	.12	.12	12.03***	(3,276)	-.03	.03	-.05
Income	1					.00	.02	.01
FEQ	1					.02	.01	.17***
SCS-SF	2	.50	.39	70.01***	(6,273)	-.34	.06	-.34***
RHI	2					.12	.07	.09
PPS-R	2					-.38	.05	-.42***

Note. Educ = Education; FEQ = Family Experiences Scale; SCS-SF = Self-Compassion Scale-Short Form; RHI = Relational Health Indices; PPS-R = Personal Progress Scale-Revised.
*p < .05. **p < .01. ***p < .001.

Appendix A: Shame Resilience Theory



Note. Shame Resilience Theory. This figure represents shame resilience as a continuum between shame and empathy, and as a sum of the four elements of shame resilience, which are also represented as continuums between maladaptive and adaptive reactions. Adapted from "Shame Resilience Theory: A Grounded Theory Study on Women and Shame," by B. Brown, 2006, *Families in Society: The Journal of Contemporary Social Services, 87,* 43-52. Copyright 2004 by B. Brown.

Appendix B: The Shame Inventory

Part I

Shame is a negative and painful feeling in which the entire self is viewed as bad and/or worthless. It may be accompanied by urges to withdraw or conceal some behavior or aspect of yourself. Shame is different from just generally being upset or distressed, because it relates to how you feel about *yourself*. Some people experience shame on a regular basis; others hardly experience shame at all. The questions below are about *overall* shame feelings that you may experience.

1. Circle the number which indicates *how often* you typically experience shame.

Never	Seldom	Occasionally	Often	Always
0	1	2	3	4

2. Circle the number which indicates the *intensity or severity* of shame that you typically experience.

None	Slight	Moderate	Considerable	Extreme
0	1	2	3	4

3. To what extent does shame negatively affect the quality of your life?

No Effect	Slight Effect	Moderate Effect	Considerable Effect	Extreme Effect
0	1	2	3	4

Part II

This is a list of situations and behaviors that may be related to the experience of shame for you. Please write a number (between 0-4) beside each statement, which indicates the intensity of your *shame* about that event. If the statement does not apply to you, write an "X" beside the statement.

Didn't Happen/Does Not Apply to Me	No Shame	Slight Shame	Moderate Shame	Considerable Shame	Extreme Shame
X	0	1	2	3	4

Rate 0 – 4	A time when I …
____	
____	1. Was laughed at in front of others
____	2. Was criticized in front of others
____	3. Cried in front of others
____	4. Made a scene in public
____	5. Lost something important
____	6. Had sex with someone when I didn't want to
____	7. Forced/coerced someone to have sex with me
____	8. Had an affair/was unfaithful/was sexually promiscuous
____	9. Was sexually harassed

____ 10. Made a suicide attempt/threat or harmed myself on purpose
____ 11. Didn't know the answer to a question I felt I should know
____ 12. Was caught saying negative things about others
____ 13. Overate or ate unhealthy/high fat food
____ 14. Missed an important appointment
____ 15. Was praised for something I didn't do
____ 16. Didn't live up to a really important standard of mine
____ 17. Didn't live up to others' standards
____ 18. Told a lie
____ 19. Broke a promise
____ 20. Committed a crime
____ 21. Knew someone talked badly about me behind my back
____ 22. Received a compliment
____ 23. Found out someone I cared for didn't feel the same way
____ 24. Was turned down for a date/request to spend time with someone
____ 25. Could not afford something
____ 26. Was slow to learn something
____ 27. Hurt someone emotionally
____ 28. Hurt someone physically
____ 29. Hurt an animal
____ 30. Was physically or sexually abused
____ 31. Saw a picture of myself/saw myself in mirror
____ 32. Was afraid to do something
____ 33. Failed at work
____ 34. Lost a friendship
____ 35. Had fantasies of violence or death
____ 36. Had sexual/kinky fantasies
____ 37. Betrayed a friend
____ 38. Was betrayed by someone I care about
____ 39. Hated a family member
____ 40. Had an abortion
____ 41. Had a private aspect of myself exposed
____ 42. Other, describe:
____ 43. Not being in an intimate relationship
____ 44. Not having children
____ 45. Being gay/lesbian/bisexual
____ 46. Feeling unattractive/ugly
____ 47. Having a mental disorder
____ 48. Being a certain race/ethnicity
____ 49. Not having a good career
____ 50. Being adopted

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Appendix C: Personal Progress Scale – Revised

The following statements identify feelings or experiences that some people use to describe themselves. Please answer each question in terms of any aspects of your personal identity that are important to you *as a woman*, such as gender, race, ethnicity, culture, nationality, sexual orientation, family background, etc. Circle the number that best corresponds to your answer, and keep in mind that there are no right or wrong answers.

Almost never **Sometimes true** **Almost always**

1----------2----------3----------4----------5----------6----------7

1. I have equal relationships with important others in my life.
2. It is important to me to be financially independent.
3. It is difficult for me to be assertive with others when I need to be.
4. I can speak up for my needs instead of always taking care of other people's needs.
5. I feel prepared to deal with the discrimination I experience in today's society.
6. It is difficult for me to recognize when I am angry.
7. I feel comfortable in confronting my instructor/counselor/supervisor when we see things differently.
8. I now understand how my cultural heritage has shaped who I am today.
9. I give in to others so as not to displease or anger them.
10. I don't feel good about myself as a woman.
11. When others criticize me, I do not trust myself to decide if they are right or if I should ignore their comments.
12. I realize that given my current situation, I am coping the best I can.
13. I am feeling in control of my life.
14. In defining for myself what it means to be attractive, I depend on the opinions of others.
15. I can't seem to make good decisions about my life.
16. I do not feel competent to handle the situations that arise in my everyday life.
17. I am determined to become a fully functioning person.
18. I do not believe there is anything I can do to make things better for women like me in today's society.
19. I believe that a woman like me can succeed in any job or career that I choose.
20. When making decisions about my life, I do not trust my own experience.
21. It is difficult for me to tell others when I feel angry.
22. I am able to satisfy my own sexual needs in a relationship.
23. It is difficult for me to be good to myself.
24. It is hard for me to ask for help or support from others when I need it.
25. I want to help other women like me improve the quality of their lives.
26. I feel uncomfortable in confronting important others in my life when we see things differently.
27. I want to feel more appreciated for my cultural background.
28. I am aware of my own strengths as a woman.

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Appendix D: Self-Compassion Scale – Short Form

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

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

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

_____1. When I fail at something important to me I become consumed by feelings of inadequacy.
_____2. I try to be understanding and patient towards those aspects of my personality I don't like.
_____3. When something painful happens I try to take a balanced view of the situation.
_____4. When I'm feeling down, I tend to feel like most other people are probably happier than I am.
_____5. I try to see my failings as part of the human condition.
_____6. When I'm going through a very hard time, I give myself the caring and tenderness I need.
_____7. When something upsets me I try to keep my emotions in balance.
_____8. When I fail at something that's important to me, I tend to feel alone in my failure
_____9. When I'm feeling down I tend to obsess and fixate on everything that's wrong.
_____10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
_____11. I'm disapproving and judgmental about my own flaws and inadequacies.
_____12. I'm intolerant and impatient towards those aspects of my personality I don't like.

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Appendix E: Relational Health Indices

Instructions: Below are statements about thoughts or feelings you might have regarding certain relationships. For each statement, select the appropriate number indicating your response. Please keep the following definition in mind as you respond to the statements:

- **Peer** – a close friend to whom you feel attached to through respect, affection, and/or common interests; someone you can depend on for support and who depends on you.
- **Community** – your relationship with or involvement in your (self-defined) community.

Peer/Close Friend: Please select the appropriate number to for each question below that best applies to your relationship with a close friend.

1=Never 2=Seldom 3=Sometimes 4=Often 5=Always

1.	Even when I have difficult things to share, I can be honest and real with my friend	1	2	3	4	5
2.	After a conversation with my friend, I feel uplifted	1	2	3	4	5
3.	The more time I spend with my friend, the closer I feel to him/her	1	2	3	4	5
4.	I feel understood by my friend	1	2	3	4	5
5.	It is important to us to make our friendship grow	1	2	3	4	5
6.	I can talk to my friend about our disagreements without feeling judged	1	2	3	4	5
7.	My friendship inspires me to seek other friendships like this one	1	2	3	4	5
8.	I am uncomfortable sharing my deepest feelings and thoughts with my friend	1	2	3	4	5
9.	I have a greater sense of self-worth through my relationship with my friend	1	2	3	4	5
10.	I feel positively changed by my friend	1	2	3	4	5
11.	I can tell my friend when he/she has hurt my feelings	1	2	3	4	5
12.	My friendship causes me to grow in important ways	1	2	3	4	5

Community: Please circle the appropriate number that best applies to your relationship with or involvement in your community.

1=Never 2=Seldom 3=Sometimes 4=Often 5=Always

1.	I feel a sense of belonging to this community	1	2	3	4	5
2.	I feel better about myself after my interactions with this community.	1	2	3	4	5
3.	If members of this community know something is bothering me, they ask me about it	1	2	3	4	5
4.	Members of this community are not free to just be themselves	1	2	3	4	5
5.	I feel understood by members of this community.	1	2	3	4	5
6.	I feel mobilized to personal action after meetings within this community	1	2	3	4	5
7.	There are parts of myself I feel I must hide from this community	1	2	3	4	5
8.	It seems as if people in this community really like me as a person	1	2	3	4	5
9.	There is a lot of backbiting and gossiping in this community	1	2	3	4	5
10.	Members of this community are very competitive with each other	1	2	3	4	5
11.	I have a greater sense of self-worth through my connections with this community	1	2	3	4	5
12.	My connections with this community are so inspiring that they motivate me to pursue relationships with other people outside this community	1	2	3	4	5
13.	This community has shaped my identity in many ways	1	2	3	4	5
14.	This community provides me with emotional support	1	2	3	4	5

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