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Buddhist Psychology and Mindfulness: Does It Provide a Remedy for Western Shame?

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Abstract

This writing explores shame and its distress. It does so through a historical examination of Western psychological theories of emotion compared to emotions as seen through Buddhist psychology, based upon scholars and authorities within these respective fields. Further, it explores some Western psychotherapeutic approaches used to alleviate (unhealthy) shame compared to Buddhist mindfulness methods for alleviating aversive emotions and their efficacy, alone or in combination. The question examined is whether mindfulness grounded in Buddhist psychology and teachings, when applied within Western therapeutic settings and populations, is an effective and appropriate means to help alleviate aversive states of shame.

To identify therapeutic approaches utilizing mindfulness-based or other approaches to alleviate shame and psychological distress, database searches (primarily PubMed and PsycInfo with some auxiliary searches of Google Scholar) were conducted of Mindfulness-Based Stress Reduction, Mindfulness-Based Cognitive Therapy, Compassion Focused Therapy, and Shame Resilience Theory to locate systematic reviews or meta-analytic research studies of their therapeutic effectiveness, primarily on psychological disorders, published from 2010-2020. After an overview of study outcomes, a discussion follows of their respective benefit (or harm) as well as opportunities for greater integration or further exploration of the application of mindfulness meditative techniques to shame or other aversive emotions.

Keywords: mindfulness, shame, Western theories of emotion, Buddhist psychology

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In recent decades, after a period of prolonged neglect, Western psychotherapists have given considerable attention to the human pain and suffering resulting from the experience of shame in its various forms, as well as its common role in psychopathological conditions including addictions, intra- and interpersonal violence, as well as mood disorders, particularly depression (Brown, 2012; Harper, 2011; Kim et al. 2011; Nathanson, 1987; 1992; Tantum, 1998;). Even more recently, Western Buddhist teachers have directly addressed the harm of shame and self-aversion (Brach, 2003; Goleman, 2003; Kornfield, 2008), which has been described as "the most pervasive type of contemporary suffering" (Brach, 2012).

Despite the availability of Western psychotherapeutic methods which have increasingly employed mindfulness-based interventions (MBIs) (Shapiro & Carlson, 2017) and the incorporation of Buddhist psychology (Tirch et al., 2016), mental health disorders, particularly mood disorders, continue to dominate adverse health trends globally, with depression being cited as the leading cause of disability, and anxiety disorders being ranked sixth in this regard (World Health Organization, 2017). Hence, there is an urgent need to determine to what extent emotions, specifically shame, cause suffering and contribute to adverse health conditions, and to better understand the effective means that help alleviate the harm and suffering they cause.

To assist in this aim, this writing engages in a historical review of affect psychology as well as the specific affect, shame, and its potentially long-term adverse impact on personal well-being. This historical review is followed by an overview of the evolution of theories of emotion in Western psychology and a focus on Tomkins' (1987) and Nathanson's (1987, 1992, 1996) body of work on affect theory, that integrates two of the three evolved theories of emotion (Mills, 2005), and then compares it to Buddhist views of aversive emotions and mindfulness

meditative approaches to alleviate suffering from them (Analayo, 2003; Gethin, 1998, 2016; Goleman, 2003; Silva, 2014, 2017). Lastly, a discussion follows of recent research of the benefits and limitations of mindfulness meditation and its integration within therapeutic treatment and the potential harm that can occur (Van Dam et al., 2018).

A central focus for this discussion and its conclusions is the state of knowledge on the application of mindfulness meditation approaches to alleviate the harmful effects of shame, alone or in combination with Western psychotherapeutic methods, their effectiveness in doing so, and when they should be avoided in addressing shame and related conditions. Four principal means of alleviating the harmful effects of shame will be examined: MBSR (Mindfulness-Based Stress Reduction), MBCT (Mindfulness-Based Cognitive Therapy), CFT (Compassion Focused Therapy), and SRT (Shame Resilience Theory) with its related shame resilience curriculum. The first modality, MBSR is selected because it substantially utilizes mindfulness meditation in conjunction with supportive modalities (e.g., gentle yoga) without any other psychotherapeutic techniques (Kabat-Zinn, 2013; Lehrhaupt & Meibert, 2017) and due to its being one of the most extensively studied, clinically and otherwise, forms of meditation (Strauss et al., 2014). The next two modalities – MBCT and CFT – use some form of mindfulness-related practice in conjunction with Western psychotherapeutic techniques (Chiesa & Serretti, 2011; Gilbert, 2009, 2014; Segal et al., 2018). SRT with its related curriculum is selected for its innovative and atypical approach to shame and its mitigation, which does not rely upon mindfulness-based modalities, but rather seeks to alleviate the suffering of shame in substantial part by cultivating "empathic relationships" with others wherein feelings can be safely and mutually shared as an indispensable means of developing shame resilience (Brown et al., 2011, p. 368).

The Many Faces of Western Shame

While shame is a universal human experience (Nathanson, 1987), it occurs within unique cultural contexts. Cultures that promote individualism via "independent" self-renderings and that "value personal achievement" often have greater negative experience of shame than cultures that promote collectivism, i.e. "interdependent" self-renderings and "shame-affirming ethnotheories" (Sheikh, 2014, pp. 390-391). Further, there is some indication that cultures wherein there is greater relational mobility tend to be less shame prone than in cultures where relational mobility is low and thus the cost of relational loss is likely to be greater (Sznycer et al., 2012). However, the focus of this writing is directed primarily toward the experience of shame within Western culture. To begin, there first must be a fundamental understanding of the nature and experience of shame as viewed through Western culture via related psychological literature.

With rare exception, during much of the last century, attention to the origin, nature and manifestation of shame in the contemporary lives of individuals suffered substantial neglect in Western psychotherapeutic educational gatherings and writings (Nathanson, 1987, 1992). In contrast, an exceptional and revealing light was "the pioneering work of Silvan Tomkins" (Nathanson, 1987, p. 11) as reflected in his 1962-1963 published volumes I and II of *Affect Imagery Consciousness*, which discussed positive and negative affects, respectively. In his first volume, Tomkins parted way from Freudian psychoanalysis (Tomkins, 1987) and the subsequent emergence of the influence of cognitive and behavioral psychology (Tomkins Institute, n.d.-a) in his description of innate affects, one of which is shame-humiliation, as biological states activated by environmental stimuli to prompt action (Tomkins Institute, n.d.-b).

Tomkins explored affect (biology of emotion) and its impact on the formation of personality which resulted in the "most surprising and important [of his] contributions…his

theory of shame" (Tomkins Institute, n.d.-c). Tomkins' work was expanded upon by Donald Nathanson and was published in 1992 in his book*, Shame and Pride: Affect, Sex and the Birth of Self*. Much research has followed to better define shame, its experience, and how it shapes human behavior – for better and for worse. So, what is known about shame?

Notwithstanding recent decades of research, there is still substantial debate in the psychological field regarding theories of emotions, and more pointedly, the experience of and the role of shame. Some of the debate concerns the timing of the emergence of shame, either from the time of birth (Nathanson, 1987) or as a later developmental experience dependent upon cognitive maturation (Dearing & Tangney, 2011), the experience of shame as an affective state (Nathanson, 1987, 1992, 1996; Tomkins, 1987) versus shame-proneness or shame trait (Dearing & Tangney, 2011), whether or when shame is beneficial or detrimental (Cibich et al., 2016; Morrison, 2011), whether shame and guilt are related (Nathanson, 1992) or different states of self-evaluation (Morrison, 2011) and their individual or collective correlation with human distress associated with adverse mental health conditions and psychopathology (Brown, 2012; Cook, 1996; Harper, 2011; Kim et al. 2011; Nathanson, 1987, 1992). While some of these areas of debate will be explored in the following discussion, it is not intended or possible to definitively resolve any of these existing debates within this writing. Rather, the intent is to illuminate some insights from the field of psychological research and related academic discussion to frame the later discussion of the role of emotions, and specifically shame, within Buddhist psychology. Once established, discussion follows regarding Buddhist meditative methods and their potential benefit in alleviating the suffering resulting from shame, or their potential ineffectiveness or harm compared to Western psychological interventions, with or without the inclusion of meditative methods or specific elements thereof.

Theories of Emotion, Shame Affect and the Compass of Shame

Mills' (2005) review of the developmental literature on shame provides some insight into its place within three theoretical views of emotion: 1) "functionalist theories" that view emotions generally as adaptive and directly related to survival interests, 2) "cognitive-attributional" theories that view emotions, such as shame, as the product of cognitive processes of evaluation and the attribution of an emotion(s) to a global sense of self, and 3) object relational attachment theories that view emotions, and within this discussion, shame, as instrumental to social attachment and psychosocial development (pp. 28-33). Mills notes that the theories vary not so much in their specific content but rather in their emphasis on the role of emotions.

Tomkins, who falls within the functionalist view of emotions (Mills, 2005), identified nine affects which serve as "*the primary innate biological motivating system*" and which are "sets of muscular, glandular, and skin receptor responses" that manifest as "primarily facial behavior" and which are experienced as either positive or negative in their influence toward the achievement of "an ideal state – one that…implicitly or explicitly entails the maximizing of positive affect and the minimizing of negative affect" (Tomkins, 1987, pp. 137-138). The positive affects are identified as: "*interest* or *excitemen*t," "*enjoyment* or *joy*," and "*surprise* or *startle*;" the negative affects are identified as: "*distress* or *anguish*," "*fear* or *terror*," "*shame* or *humiliation*," "*dismell*," "*disgust*," and "*anger* or *rage*" (p. 139). In the case of both negative and positive affects, the pairing of affect labels, e.g. shame or humiliation, is intended to identify the lessor (first affect named) versus its more intense form (second affect named) (Nathanson, 1987). Interestingly, Nathanson (1992, p. 89) later labels the affect, surprise or startle, as a "neutral" affect which serves the purpose of shifting one's "attention from whatever else might have been occupying it…[to] focus on whatever startled it."

Of these nine affects, Tomkins (1987, p. 143) identified shame-humiliation as an affect "auxiliary" since it is activated by the "incomplete reduction of interest or joy." Shame as a regulator of positive affects serves to "[interrupt] our attention so we recognize the problem and deal with it" (Tomkins Institute, n.d.-c, para. 6). In addition to this unique view of shame as a regulator of positive affects, which was a significant distinction and contribution to the study of emotion, Tomkins' overall view of affects as primarily being facial expression prior to any conscious recognition was seminal (Nathanson, 1987). Specific to shame, Tomkins (1987) described the physiological response to shame as including "lowering the eyelid, decreasing the tonus of all facial muscles, lowering the head via a reduction in tonus of the neck muscles, or tilting of the head in one direction" (p. 143).

Nathanson (1992, pp. 49-52) expanded this discussion to the broader conversation of "a new vocabulary of emotion" beyond "*affect*" ("the strictly biological portion of emotion") to include "*feeling*" (the awareness of affect), "*emotion*" (the interlinking of affect with stored memories acting as "a script or a story"), "*mood*" ("a persistent state of emotion") and "*disorder*" (of mood) – some of which will pertain to later discussion. Of additional relevance, according to Mills (2005, p. 33), is the integration by Nathanson and others of affect theory, a functionalist perspective, with an "object relations perspective" in the viewing of shame as "an interpersonal or attachment emotion that occurs when the relational bond is disrupted," and which subsumes that shame manifests at infancy and does not require "abstract cognitive processes…[or] self-reflection." This view is in contrast to and in potential conflict with the later view of other researchers that perceive shame as a self-conscious emotion requiring self-assessment and self-judgment (Dearing & Tangney, 2011).

A noteworthy contribution to the understanding of human response to shame is Nathanson's (1992, p. 312) conceptualization of the "compass of shame." The experience of the affect auxiliary of shame can result in acceptance at its first arising, followed by curiosity and personal introspection, or in defense against it, involving "all the habits, defenses, tricks, strategies, tactics, excuses, protections, buffers, apologies, justifications, arguments, and rejoinders" that have previously been cultivated in past experiences (p. 309). However, the transition between affect and response is often so brief that there is no perceivable nexus between the awareness of the originating stimulus and the resulting affect feeling and cognitive phase that follows. Rather, Nathanson asserts that what is more likely is the subsequent association of the stimulus with "the angry or tearful or humorous style of reaction that comes to define us as individuals" (p. 309).

The compass of shame is comprised of four categories of responses based upon scripts that entail physiological, behavioral and cognitive elements from memories of past experiences, and that manifest as avoidance, withdrawal, and attack (either of self or other) (Nathanson, 1992). Each category of response is an arrangement of strategies to facilitate affect management. Withdrawal responses emerge quickly and seek to minimize shame affect and often involve mood altering through psychoactive substances or pleasure-seeking pursuits; the avoidant response, less quick in nature, is a movement away from the discomfort and triggering stimulus of shame. The attack response, when directed toward self, may involve displays of helplessness, dependence, self-effacement and even self-violence; the attack other response may involve belittlement, bullying, social distancing, physical harm and many other forms. In regard to the compass of shame, Nathanson declared that:

> Rather than pay attention to what the spotlight [of shame] showed us…we don't, we don't look at reality. We're not terribly good at that we humans. What we do is we try to avoid shame and we go through any of these four poles of the compass. (Nathanson, 2008, 3:55)

Nathanson (1996) asserted that shame experience was likely to be triggered within the following contexts of life circumstances: 1) "matters of personal size, strength, ability, skill," 2) "dependence/independence," 3) "competition," 4) "sense of self," 5) "personal attractiveness," 6) "sexuality," 7) "issues of seeing and being seen," and 8) "wishes and fears about closeness," and that upon reaching adulthood, any "failure or inadequacy in any of these eight groups will trigger shame" (p. 18). However, the moment of truth and potential reconciliation of shame, regardless of its source, is determined by whether a person experiencing it meets the affect state with acceptance, followed by an integration of understanding gained by facing it to re-shape one's self-image, or whether one (or more) of the four paths along the compass of shame are invoked to protect against the experience of it and the awareness and inner integration that it necessitates (Nathanson, 1992).

Notwithstanding the seminal work of Silvan Tomkins and Donald Nathanson in the field of affect psychology, an often-ignored dimension of the study of the psychological manifestation of shame is its predominant social context. From their study of Western cultural shame over decades, sociologists Scheff and Retzinger (2000) coined shame as the "master emotion" due to its expanded sociological and psychological functions including: 1) its central role in morality and as an internal indication of social transgression, 2) its prominence in social relationships as a warning of threat to relational bonds in contrast to a more narrow psychological view of shame

as a form of self-judgment in relation to an idealized self, and 3) its key role "in regulating expression, and indeed, the awareness of all of our other emotions" (para. 30-33).

What makes shame problematic to identify, much less to acknowledge according to Scheff (2016, p. 1), is its invisible nature in modern societies, in that the "s-word, like the f-word is usually taboo, both in the public and in publications." This observation is underscored by an examination of Google Ngrams for the f-word versus the s-word, revealing that the former has shown more frequency in written works since 1961 while the latter has shown less frequency over the two hundred year period from 1800-2000 – not just in the publications printed in English, but also those published in French, German, and Spanish (Scheff, 2016).

Scheff (2016, p. 6) suggests that much of the ills of modern societies – "withdrawal, violence, and unnecessary conflict" – have some of their roots in unacknowledged and unresolved shame and that part of the solution to bringing shame out of hiding is through scholarly undertakings and then through public discourse.

Shame State vs. Shame Trait

While the biology of emotion (affect) and its felt state are relevant to subsequent discussion, it is not shame as a transitory state that is so much the source of Western suffering, but rather shame as a trait which is so challenging. Repeated experiences of shame, particularly when marked with intensity and which are not adequately resolved, can result in shame as an internalized trait – the identification of the self as being inherently flawed, often associated with various psychopathological conditions (Brown, 2012; Harper, 2011). This recognition of the prominence of internalized shame as an afflictive trait was publicly highlighted and popularized, in part, in the late 1980s through the published work and New York Times bestseller, *Healing the Shame That Binds You*, by John Bradshaw (1988). In this body of work, Bradshaw made the

distinction between healthy and unhealthy shame – healthy shame being that which serves to bring awareness to the recognition of human limits, acknowledgement of personal boundaries and provides a basis for moral behavior. In contrast, Bradshaw (1988, pp. vii, 10) identified toxic shame as a "state of being," a core identity wherein it is believed "that one's being is flawed, that one is defective as a human being," which then "becomes toxic and dehumanizing" and is ultimately "unbearable and always necessitates a cover-up, a false self."

In the past decade, shame researcher, Brene Brown, has provided an elevated visibility to Western shame through ground-breaking research. Brown (2010) initially set out to study human connection. Yet what emerged within weeks through the interaction with the research participants was the identified prevalence of shame as a troubling element in their lives, and thus prompted subsequent research. Based upon years of studying shame, Brown (2012, 14:24) stated that shame is "epidemic in our culture" and is "highly, highly correlated with addiction, depression, violence, aggression, bullying, suicide, eating disorders;" it proliferates in an environment of "secrecy, silence and judgment," and its antidote is "empathy."

The characterization of shame that evolved from Brown's (2006) research was that it is "an intensely painful feeling or experience of believing that we are flawed and therefore unworthy of love and belonging;" the participants, in defining shame, made the distinction between guilt, "a feeling that results from *behaving* in a flawed or bad way," and shame, "a flawed or bad *self"* (p. 45). The experience of shame was related to one of twelve categories identified via the research and included: "appearance and body image, sexuality, family, motherhood, parenting, professional identity and work, mental and physical health, aging, religion, speaking out, and surviving trauma" (pp. 45-46). As a result of this grounded theory study on women and shame, and subsequently the relationship of shame to vulnerability, Brown

(2006, p. 45) developed a shame resilience theory (SRT) which suggests that "shame is a psycho-social-cultural construct" that is reflected in emotions, cognition and behaviors within a relational and interpersonal context, as well as in the intrapersonal assessment of the fulfillment of cultural expectations.

More recently, psychotherapist Patricia DeYoung (2015), in an effort to bridge the "broad spectrum of relational theories of psychotherapy and psychoanalysis," proposed the following definition of shame: "*Shame is the experience of one's felt sense of self disintegrating in relation to a dysregulating other*" (p. 18). Further, chronic shame emerges from repeated experiences of shame, in the absence of a regulating other, that results in "a person's lifelong patterns of self-awareness and response to others" (p. 18). In addition, DeYoung clarifies that the felt sense of self disintegration, and its experience of a lack of coherence and inner cohesion, occurs when there is a failure by others "to provide emotional connection, responsiveness, and understanding" (p. 20). She explained the role of a regulating other from the perspective of a child as follows:

> A regulating other is a person on whom I rely to respond to my emotions in ways that help me not to be overwhelmed by them, but rather to contain, accept, and integrate them into an emotional "me" I can feel comfortable being. (p. 21)

DeYoung (2015) adds dimensions to the various aspects and experience of the shades of shame in human experience. While acknowledging the contribution of Tomkins and Nathanson to affect theory and the identification of shame as an affect, she noted that after fifty years, this view has evolved toward affect regulation theory in recognition of the key relational aspect of shame with its origin in "one person's affective relational need and another person's response to the need" (p. 23). Further, consistent with Nathanson's vocabulary of emotion, DeYoung also

characterized shame as an emotion with its related biographical context. In fact, she cited Nathanson's (1992, p. 50) claim that, "Whereas affect is biology, emotion is biography" (p. 23).

DeYoung (2015) continued further with the examination of shame as thought which she concluded does not arise concurrently with "the core affective experience of shame" (p. 25). Rather, she asserted that thoughts emerge subsequent to the initiating shame experience and from the perspective of an objectified self, "a self who has exited intersubjective space where primary communion should be, the space where regulation failed and disintegration rules" (p. 26).

While acknowledging the contribution of neuroscience to the understanding of the inner mechanisms of psychotherapeutic methods, identifying Affect Regulation Theory (ART) and its right-brain therapeutic orientation as an example, DeYoung (2015) stated that she holds such explanations "somewhat lightly…[believing] that all theory is interpretation" (pp. xii-xiii). From a therapeutic perspective, she highlighted the inevitable failure in trying to directly challenge clients' shame thoughts, which "are quintessentially alone thoughts," due to their deep biographical roots and apparent self-reaffirming truth (pp. 26-27). With repeated incidents of shaming that are not repaired through interpersonal connection, the experience of self as "disintegrating, fragmented, or depleted" can lead to "cognitive shame-ideas about the self" (p. 28).

It would be a shortcoming to leave this discussion without acknowledging recent commentaries that question the stigmatization of shame as primarily a negative experience. Cibich et al. (2016) recently endeavored to reconcile the polarization of shame research and its frequent portrayal of shame as a "negative emotion associated with problematic outcomes for well-being, an enemy from which we need to be released" which they stated has been popularized, in part, by Brene Brown through her "*Listening to Shame*" TED talk (p. 471).

Their review of shame literature was conducted to synthesize an integrated view of shame that acknowledges its potentially problematic and functional impact (Cibich et al., 2016). In this discussion, they highlighted the confounding of guilt and shame in research studies and the failing to acknowledge their often interrelationship, the imprecise instruments used to measure guilt and shame and to distinguish between the two, the oversimplifying and equating of shame with avoidance behavior, and thus its problematic effects while ignoring shame and its role in approach behavior to repair relational harm, the customization of definitions of shame that can dilute its complexity, and the neglect of socio-functional role of shame in repairing and maintaining social bonds. The researchers subsequently identified the role of shame as a socializing force when it leads to approach behavior to repair relational harm, motivates change in personal behavior, and discharges shame, thus promoting "personal growth, social cohesion, and moral repair" (p. 479).

With this brief overview of Western theories of emotion and shame, a discussion follows regarding Buddhist psychology, aversive emotional states and their causes as well as the Buddhist means to alleviate the suffering they cause.

Buddhist Psychology, Afflictive Emotional States and the Liberation from Suffering

Buddhism's origin in southern Asia brings with it a unique cultural view and a "psychospiritual technology" (Feuerstein, 2008, p. 6) influenced by pre-Buddhist yogic practices prevalent in the Indus Valley more than 2500 years ago (Boccio, 2010; Feuerstein, 2003). Given its distinctive historical and cultural origins, it should not be surprising that Buddhist views of emotions and the methods of relating to their associated states, and for this discussion, afflictive emotional states as well as their physiological and psychological correlates, differ significantly from the recent evolution of Western psychological thought and related therapeutic practices.

To this point, in 1991, at the third gathering of the *Mind & Life Dialogues* – a cross-cultural dialogue between Western scientists, scholars and Buddhist practitioners and the Dalai Lama – the Dalai Lama in response to a question about "fundamental emotions" responded that the Tibetan language had no word equivalent to the English word "emotion" and thus the concept of fundamental emotions was an "alien concept…[within] the Buddhist framework," making it difficult to adequately respond (Goleman, 2003, p. 81). Yet, he commented further:

> However, if you speak of one category of emotion, like negative emotions – *kleshas,* or afflictions – then definitely there are six primary ones, but even here it is tricky to use the English word *emotion*. The six prominent ones are ignorance, attachment, anger, pride, wrong views, and skepticism or afflictive doubt. (p. 81)

In 2000, a subsequent session of *Mind & Life Dialogues* focused on the intersection of scientific research on emotions and related Buddhist cultural views regarding them, with an emphasis on overcoming destructive emotions (Goleman, 2004). It is illuminating that in the preliminary dialogue between Daniel Goleman and the Dalai Lama about a proposed convening to discuss destructive emotions, that the Dalai Lama in his response to a request to better define such emotions replied that he was interested in scientific views on the "Three Poisons: hatred, craving, and delusion" (p. xix). The challenge of the lack of common cultural language with which to even begin such a dialogue was remedied after some discussion and yielded a consensus of the definition of destructive emotions "as those that harm self or others" (p. 160). At the subsequent convening, the Dalai Lama defined destructive emotions "as what disturbs the calm of the mind" (p. 160).

Interestingly, at the 1991 gathering, Buddhist teacher, Sharon Salzberg, asked the Dalai Lama how to teach compassion to Westerners for whom it was very common to have a "strong

hatred toward oneself" (Goleman, 2003, p. 189). The Dalai Lama, after extended conversation, acknowledged that this concept was "alien" to him (p. 189), which led a vigorous exchange between him and those attending to better understand this afflictive mental state and what those in attendance found beneficial in efforts to help those suffering from it.

Although shame was not specifically examined in these dialogues, the reference to self-hatred, and subsequent discussion of low self-esteem, are reflective of various aspects of shame and certainly can be considered as an "affliction" as referenced by the Dalai Lama (Goleman, 2003) although not specifically mentioned by him. As explained by the Dalai Lama in the 2000 convening of the *Mind & Life Dialogues,* freedom from suffering is accomplished by studying the mind and removing impediments (i.e., afflictions) to "the achievement of nirvana"[1] (Goleman, 2004, p. 159).

For those unfamiliar with Buddhist psychology and Buddhist teachings, these perplexing interactions provide some immediate insight to the potential challenge of such cross-cultural dialogue regarding human emotions and the unique views of Buddhist psychology. However, to develop a deeper understanding of Buddhist psychology and the related means to alleviate suffering, it is necessary to provide some additional background on Buddhist thought, teachings and their influence on Buddhist psychology.

The Four Noble Truths and the Noble Eightfold Path

From the outset, it is important to understand that it is Buddhism's aim to end suffering, all suffering, that is reflected in the Four Noble Truths, the first teaching of the Buddha upon his awakening into an enlightened state. The Four Noble Truths are delineated in the Samyutta

[1] Although the concept of nirvana is an intricate topic in its own right, Buswell and Lopez (2014, p. 589) comment, in part, that, "in a more technical sense, nirvana is interpreted as the cessation of the afflictions (klesa) [and] of the actions…produced by the afflictions…"

Nikaya (SN) Buddhist text, *Dhammacakkappavattana Sutta* (S.N. 56:11; V 420-24), "The Setting in Motion of the Wheel of Dhamma," as "the noble truth of suffering," "the noble truth of the origin of suffering," "the noble truth of the cessation of suffering," and "the noble truth of the way leading to the cessation of suffering" (Bodhi, 2005, pp. 76, 430).

As elaborated within this Buddhist text, the First Noble Truth of suffering is the awakened knowledge of its prominence in human life that manifests in birth, illness, aging and death as well as "union with what is displeasing…[and] separation from what is pleasing" and not getting "what one wants" (Bodhi, 2005, p. 76). It follows, within the Second Noble Truth, that the origin of suffering is "craving" whether for sensual pleasures, existence or extinction (p. 76). According to Gethin (1998, pp. 71, 73), such craving leads to "grasping" or "attachment" to those things which were first objects of desire; further, "the eventual unfulfilled craving and frustrated attachment become conditions for aversion, anger, depression, hatred, and cruelty and violence." Craving, with its unmitigated progression to attachment followed by aversive experiences, is rooted in ignorance – the distorted view of reality that emanates from "a mind that is often fundamentally unclear, unsettled, and confused" (Gethin, 1998, p. 73). Thus, "the defilements of the mind" – "greed," "aversion," and "delusion" – and the acts they motivate, result in suffering (Gethin, 1998, p. 74).[2]

The cessation of suffering, the Third Noble Truth, "is the remainderless fading away and cessation of that same craving, the giving up and relinquishment of it, freedom from it, nonattachment;" the path leading to this cessation, the Fourth Noble Truth, is the Noble Eightfold Path (Bodhi, 2005, p. 76).

[2] These three defilements are equivalent to the Dalai Lama's earlier reference to "hatred, craving, and delusion" and are also reflected, although in different terms, in the Dalai Lama's naming of the six negative emotions, or "afflictions" (Goleman, 2003. P. 81).

Further, the Noble Eightfold Path is comprised of the following elements – "*right view*, *right intention*, *right speech*, *right action*, *right livelihood*, *right effort*, *right mindfulness*, *right concentration*" (Bodhi, 2005, pp. 75-76). Moreover, it is the adherence to the Eightfold Path and the application of its meditative methods and other means that leads to the understanding of the causes (i.e., ignorance, craving, and clinging) of the "complex web of dependently originated processes"[3] and their eventual elimination (pp. 304, 315). If not successfully eliminated, the chain of causation (dependent origination) leads once again to another cycle of birth, illness, aging and death.

Yet Gethin (1998, p. 164-165) clarifies that one does not merely embark on the Noble Eightfold Path, but rather, much of the Buddhist journey is "*finding* the noble eightfold path," adding that the path is "a gradual progression from the fundamental practices of generosity (*dana*) and conduct (*sīla/śīla*), to the cultivation of concentration (*samadhi*) and wisdom (*prajna/panna*) by means of meditative development (*bhavana*)." He subsequently states:

> According to a cardinal principle of Buddhist psychology our minds are fundamentally clear and pure; they have become stained by the operation of adventitious defilements (*klesa/kilesa*)…The goal of Buddhist practice is to bring to an end the operation of these defilements. (p. 175)

It is through calm meditation (*samatha*) and its potential to "temporarily suppress or block the immediate defilements" and then "seeing clearly into the nature of the mind" through insight meditation (*vipassana*), that can "finally eradicate the defilements" (pp. 174-175).

Instrumental to and concurrent with finding and following the Noble Eightfold Path is its moral underpinnings. To this point, Padmasiri de Silva (2014, p. 21) comments that ethics –

[3] For a fuller discussion of dependent origination's centrality in Buddhist teaching, see Bodhi (2005, pp. 312-316).

based upon the "three-fold path of morality…concentration/meditation… and wisdom" – are integral to the Buddhist path and incorporate "a new component of 'experientialism' rather than 'empiricism', [*sic*] which is based upon the practice of mindfulness."

The Noble Eightfold Path, with its ethical underpinnings and meditative practices, is therefore the means to end all suffering through the ending of this cycle of causation.

Mindfulness and Its Buddhist Roots

Mindfulness is a topic of great breadth and complexity in Buddhist literature as well as commentaries by authorities in Buddhist writings. Gethin (2016) specifically acknowledges that the varied historic and contemporary definitions and use of the word, mindfulness (*sati* in Pali), makes it ambiguous what standard may be "use[d] to judge any given account of mindfulness as either wanting or fitting" (p. 9). Adding additional challenge is the prevalence of mindfulness within "some of the central categories of early Buddhism" (Analayo, 2003, p. 49) including its presence among the five basic faculties[4] (e.g., concentration, wisdom), awakening factors (e.g., concentration, equanimity), the elements of the Noble Eightfold Path (right mindfulness), and several others (Analayo, 2003; Gethin, 2016). While this writing does not further probe these other categories, it is important to acknowledge their existence and the elusiveness of a universally agreed upon definition of mindfulness, while acknowledging its centrality within Buddhism beyond meditative practices. Thus, mindfulness cannot be solely limited to its application within or as a meditative practice.

Nevertheless, some basic understanding of mindfulness within historic Buddhist teachings and its application within meditation is instructive in the context of the subsequent discussion. Analayos's (2003, p. 15) scholarly exploration of and subsequent commentary on the

[4] "Five 'dominants' or 'spiritual faculties' that are crucial to development along the path" include the following: faith, effort, mindfulness, concentration and wisdom (Boswell, R. E. & Lopez, D. S., 2014, p. 373).

Satipatthana Sutta, the "direct path" to realization and liberation from suffering, provides useful context for the understanding and practice of mindfulness meditation as illuminated by the foundational teachings attributed to the Buddha. The *Satipatthana Sutta,* as articulated by Analayo (2003), describes the "presence of mindfulness" or "attending with mindfulness" (p. 29) as applied to four areas of contemplation - contemplations of the body (e.g., "awareness of breathing, awareness of bodily postures") (p. 117), feelings (*vedana*) through awareness of "both bodily and mental feelings" (p. 156), the mind through awareness of its "ethical quality" (i.e., "the presence or absence of lust…anger…and delusion") (p. 173), and *dhammas* through awareness of "mental qualities," e.g., the five hindrances,[5] seven awakening factors,[6] and "analyses of experience into specific categories," e.g., the Four Noble Truths (pp. 182-183).

Analayo (2003) states that the definitional portion of the *Satipatthana Sutta* clarifies right mindfulness in describing how the four areas of meditation (i.e., the body, feelings, etc.) are to be contemplated by developing "four particular mental qualities" – "diligent, clear knowing, and mindful, free from desires and discontent" (p. 31) – which are representative of the "four mental qualities of…energy, wisdom, mindfulness and concentration" (p. 34). Analayo elaborates on the qualities of diligence and clear knowing by asserting that to be diligent is best understood as maintaining one's contemplative effort "with balanced but dedicated continuity, returning to the object of meditation as soon as it is lost," whereas clear knowing is best interpreted as "the ability to fully grasp or comprehend what is taking place" (pp. 39-40). Critical to clear knowing is the integration of the quality of mindfulness which Analayo (2003) distills from various

[5] Gethin (1998, p. 175), in rather simple language, lists the following "mental defilements" as the five hindrances: "sensual desire, ill-will, tiredness and sleepiness, excitement and depression, and doubt."
[6] Analayo (2003, p. 234) identifies the awakening factors as "mindfulness (*sati*), investigation-of-dhammas (*dhammavicaya*), energy (*viriya*), joy (*piti*), tranquility (*passaddhi*), concentration (*samadhi*), equanimity (*upekkha*)."

historical references to mean "awareness of the present moment" (p. 47); it is through mindfulness, "one is able to remember what is otherwise only too easily forgotten: the present moment" (pp. 47-48). The integration of the two – "mindful observation of phenomena with and intelligent processing of the observed data" – "leads to the arising of wisdom" (p. 42). Lastly, being "free from desire and discontent in regard to the world" is deemed to represent "the faculty of concentration" which is necessary to remove unwholesome states of mind (p. 67).

The "refrain" included within each of the four described areas of meditation (i.e., the body, feelings, etc.), mentions four specific aspects for the focus of attention within each defined practice. Analayo (2003, pp. 4-10, 92) explains that these four aspects are inclusive of both internal and external phenomena, their arising and passing away, as well as the attitude – bare knowledge, continuous mindfulness, and nonattachment (without clinging) - required for such contemplation. He adds further that:

> This shift of awareness from the individual content of a particular experience to its general features is of central importance for the development of insight. Here the task of *sati* is to penetrate beyond the surface appearance of the object under observation and to lay bare the characteristics it shares with all conditioned phenomenon. This move of *sati* towards the more general characteristics of experience brings about insight into the impermanent, unsatisfactory, and selfless nature of reality. (pp. 93-94)

Secular Mindfulness and Mindfulness Based Stress Reduction

Jon Kabat-Zinn and his early work in Mindfulness Based Stress Reduction (MBSR) with patients at the University of Massachusetts Medical Center, were catapulted into public light when featured in the PBS series, *Healing and the Mind*, with TV journalist, Bill Moyers. In the interview with Bill Moyers, Kabat-Zinn described the origins of his work of the past thirteen

years interacting with 5000 patients for whom modern medicine could not resolve their underlying conditions and related suffering, and stated the following: "They are not at all interested in yoga, or swamis, or gurus, or zen masters, or enlightenment, they're suffering! And they are coming because they want relief from their suffering!" (Wagner, 1993, 4:54)

This commentary likely underscored the impetus for the promotion of secular mindfulness meditation, even given its Buddhist roots, regarding which he proclaimed, "Its essence is and has always been universal" (Kabat-Zinn, 2013, p. *lxii*). He stated further that:

> It is a way of looking deeply into oneself in the spirit of self-inquiry and self-understanding. For this reason, it can be learned and practiced, as is done in mindfulness-based programs throughout the world, without appealing to Asian culture or Buddhist authority to enrich it or authenticate it. Mindfulness stands on its own as a powerful vehicle for self-understanding and healing. (p. *lxii*)

Kabat-Zinn (2005, p. 108) described mindfulness as "moment-to-moment, non-judgmental awareness, cultivated by paying attention in a specific way, that is, in the present moment, and as non-reactively, as non-judgmentally, and as openheartedly as possible." He emphasized that commitment as well as certain attitudes are needed to establish a foundation for mindfulness practice, such as: patience, non-judgment/non-reaction to personal experiences, a beginner's mind (i.e., "receptive to new possibilities and prevents us from getting stuck in the rut of our own experience"), trust of oneself to include one's "basic wisdom and goodness," non-striving by allowing the entirety of one's moment-to-moment experience to be as it is, acceptance as expressed by recognizing experiences as they are in the moment, and letting go of the inclinations to grasp or avoid experiences as they occur (pp. 21-29).

The MBSR program is an eight-week course, consisting of weekly group sessions (2.5-3 hours in duration) with one day of silent mindfulness practice between the sixth and seventh session, as well as one hour daily of formal practices which include "the body scan, mindful yoga, sitting meditation, or walking meditation." Each weekly group session has a specific theme (e.g., "mindful self-care," "origins of stress," etc.) and the homework sessions are augmented by a related workbook and CDs (Lehrhaupt & Meibert, 2017, pp. 60, 75, 149). Following its earlier successes in relieving distress in persons suffering from chronic pain conditions, MBSR has been applied to clinical and nonclinical populations to allay a broader range of physical and mental health conditions.

MBSR and Evidence of Its Effectiveness

The focus of this writing is trait shame, or generalized "shame proneness," rather than state shame, and thus is likely to be reflective of clinical populations (Zaslav, 1998). However, shame can be problematic in both clinical and non-clinical populations. Therefore, an examination of some studies of mindfulness-based interventions applied within populations of healthy individuals in addressing negative affects can be potentially instructive. Yet, shame as a negative affect is not often the specific focus of psychometric measurements used in clinical assessment, has not received noticeable attention within psychiatric journals (Tantum, 1998) or by mental and behavioral health clinicians (Brown et al., 2011), and has rarely been a principal area of focus in mindfulness meditation research. Thus, instruments which measure mood disorders and related negative affects, to the extent that they are used in studies involving nonclinical as well as clinical populations, can serve as a rudimentary proxy or surrogate measure to infer the effects of the mindfulness-based and other therapeutic modalities on the remediation of shame. Still, many of the included studies in this discussion, due to their meta-

analytic or systematic review characteristics, only reported relapse or recurrence rates for clinical populations or symptom reductions for clinical/nonclinical populations with sparse reporting on reduction of negative affects generally or shame specifically. Yet, it is a reasonable premise, subject to subsequent verification, that remission of psychopathological conditions and/or the reduction of their symptoms may entail a reduction in negative affects and potentially shame.

Multiple meta-analytic studies and systematic reviews have examined the effects of MBSR administered within healthy populations, sometimes also including its application in clinical populations. For example, Keng et al. (2011) conducted an empirical review of the effects of four mindfulness modalities on psychological health, eighteen of which were randomized controlled trials (RCTs) of MBSR's effectiveness on psychological health outcomes involving adult populations (six studies involving persons with physical or psychological illnesses). Participants (n=1207) from various populations (e.g., college students, health care professionals, clinical patients, etc.) participated primarily in the eight-week MBSR program with a few studies using variations of it, and were compared, in most cases, to wait list control groups. The researchers concluded that overall study results supported the findings that MBSR reduced self-reported levels of anxiety, depression, and general psychological distress as well as promoted positive affect and mindfulness, along with other additional findings, among both clinical and non-clinical populations (pp. 1044-1045). The effects of MBSR on negative affects was not reported in any of the included studies.

Noting the correlation between chronic somatic diseases and mental health disorders, Bohlmeijer et al. (2010a) conducted a systematic review and meta-analysis (k=8) involving randomized controlled trials of MBSR's effectiveness in addressing anxiety, depression, and psychological distress of different populations of individuals (N=667) with varied underlying

chronic somatic diseases. Seven of the studies utilized a wait list group as a control and one study used an education support group as a control. The studies utilized various measurement instruments to assess anxiety, depression and psychological stress with the overall outcome of small effect sizes for these three conditions (pp. 539, 541). The researchers subsequently responded to criticism that their study findings underestimated the benefits of MBSR by defending their inclusion of a study using an education support control group and their method of analysis regarding the use of subscales of one of the instruments (i.e., POMS – Profile of Mood States) used in one study in the overall analysis of effects (Bohlmeijer et al., 2010b, p. 614).

Similarly, Fjorback et al. (2011), in pointing out the ambiguity of existing evidence of the efficacy of MBSR/MBCT in improving physical and mental well-being or reducing anxiety, stress, or depression, conducted a systematic review of twenty-one RCTs of their effects on adults within non-clinical populations and clinical populations. Seventeen of the studies[7] – four involving non-clinical populations, eleven involving populations with physical illnesses (e.g., cancer) and two with psychiatric disorders – employed MBSR (with minimal variations) consisting of the eight-week program as previously described in this writing. Researchers concluded, based upon the evidence in eleven studies, that "MBSR improved mental health in 11 studies compared to wait list control or treatment as usual (TAU) and was as efficacious as active control group[s] in three studies" (p. 102). Regarding selected outcomes compared to control groups, researchers determined that MBSR "significantly reduced perceived stress and/or psychological distress" in seven of eight studies, "improved anxiety" in six studies but fared no better in two studies with an active control condition, and "alleviated depressive symptoms" in six studies but not so in four studies with a control group (p. 116). The researchers further

[7] Seven of the included studies were also examined in the empirical review by Keng et al. (2011)

concluded that due to the need for "active participation" in MBSR/MBCT as a key element of these interventions, the evidence of their effectiveness is "generalizable only to individuals who have the interest and ability to participate" in these programs (pp. 102). The researchers also opined that "cognitive decentering and acceptance" which are the mechanisms of change in mindfulness, "can possibly be reached through other activities than meditation, such as being in nature, through art, talking to a friend" (p. 118).

Khoury et al. (2015), building upon previous meta-analyses, conducted a systematic review of MBSR interventions published prior to September 19, 2014. Twenty-nine studies involving 2668 participants met the inclusion criteria of healthy participants, an evaluative study component with a non-qualitative design, stress/anxiety measures with no other stress reduction strategies and data sufficient to calculate effect size. The aim of the study was to determine the effectiveness of MBSR, as well as its likely mechanisms of action and any identifiable moderators. The included studies, which used within-group and between-group analyses, utilized a variety of psychometric instruments. Although the participants were healthy individuals, the instruments used allowed some measurement of clinical conditions including depression, anxiety and distress; however, there was no specific data provided on negative affects. The meta-analysis results revealed moderate effects for MBSR participants on measurements of these clinical conditions as well as an improvement in quality of life and a large decrease in stress (p. 524). Further, both treatment hours and assigned home practice positively moderated the average pre-post effect size of these clinical outcomes.

Regarding mechanisms of action, Khoury et al. (2015) concluded that study results revealed that MBSR participants were "more mindful and compassionate at the end of treatment, and that gains were higher at last follow-up" and also that there was a "strong positive

correlation" between the mindfulness and compassion levels of MBSR participants and "changes in their clinical outcomes," despite limitations of the included studies (e.g., lack of diversity of participants, limited use of a "validated measure of mindfulness and/or compassion") as well as in the meta-analysis itself (e.g., lack of active treatment comparisons) (pp. 525-526).

Another systematic review that examined the principal mechanisms of action of MBSR (and MBCT) was conducted by Alsubaie et al. (2017) of its application in eighteen RCTs or controlled trials with adults with either diagnosed physical and psychological conditions (four studies) or psychological conditions (fourteen studies). The researchers concluded that the study results, "consistent with two recent reviews (Gu et al., 2015; van der Velden et al., 2015)," showed "promising evidence that MBCT/MBSR treatment effects are mediated by hypothesized mechanisms, such as mindfulness and rumination" but that definitive conclusions are not possible due to the "lack of methodological rigour in the field of testing mechanisms and mediators of action in both MBCT and MBSR" (p. 88). The researchers commented further that:

> Moreover, the lack of a consensually agreed theoretical framework of what universal and specific mechanisms drive change in MBCT/MBSR means that we do not, as yet, have the basis for articulating what degree of change, in which mechanisms (e.g., orienting attention, executive control, compassion), through which components of MBCT/MBSR (e.g., particular formal mindfulness practices) drive change, with which populations (e.g., adults with recurrent depression, health related anxiety), for which aims (e.g., reduce depressive relapse). (Alsubaie et al., 2017, p. 88)

It is important to note that the results of one of the studies (Gu et al., 2015), cited by the researchers with outcomes consistent with their current findings, were subsequently modified due to an error in reported findings with the amended findings (Gu et al., 2016) being far less

promising. The initial study findings of "*strong, consistent evidence for cognitive and emotional reactivity* [emphasis added], moderate and consistent evidence for mindfulness, rumination, and worry, and preliminary but insufficient evidence for self-compassion and psychological flexibility as mechanisms underlying MBIs," were amended to reflect, "moderate and consistent evidence for mindfulness, rumination, and worry, and *preliminary but insufficient evidence for cognitive and emotional reactivity* [emphasis added], self-compassion and psychological flexibility as mechanisms underlying MBIs." (Gu et al., 2016, p. 1).

The underlying cognitive effects of MBSR and MBCT have also been an interest of researchers. Lao et al. (2016) conducted a systematic review of eighteen studies of the clinical application of MBCT and MBRS and their neuropsychological outcomes, published between January 2000 and February 2015, in order to better understand the cognitive effects and the underlying mechanisms of mindfulness, and thus potentially inform and refine its subsequent application within treatment programs and populations. The selected studies were controlled experimental studies involving the application of the MBSR (seven studies) or MBCT (eleven studies) within adult populations (both patient and healthy populations) and wherein there was at least one "objective neuropsychological measure of cognition" (i.e., measurement of attention, memory or executive function) and wherein the fidelity of MBSR/MBCT interventions were verifiable (pp. 111-112, 116).

The results of the examined studies were mixed, and in some elements, contradictory to expected outcomes. In relation to the attentional functions of alerting/sustained attention, orienting/selective attention, and executive attention, the researchers "found no evidence" that these were improved by mindfulness training and "limited evidence for improvements in executive functions;" conversely, there was "preliminary evidence" that working memory and

autobiographical memory specificity, as well as more global processes, such as cognitive flexibility and meta-awareness, were improved by MBSR/MBCT (Lao et al., 2016, p. 119). However, the limited number of studies and related methodological complexities precluded firm conclusion of the effects of these mindfulness interventions on the examined cognitive processes and thus researchers recommended additional studies be conducted and be "guided by a cognitive framework that describes mindfulness pathways" (p. 121).

Mindfulness-Based Cognitive Therapy

Mindfulness-Based Cognitive Therapy (MBCT) emerged in the 1990s as an integration of cognitive behavioral therapy, "a group of heterogeneous psychotherapeutic interventions linked by common philosophical principles" (Claessens, 2010, p. 296), with mindfulness meditation practices based upon MBSR (Chiesa & Serretti, 2011; Segal et al., 2018). Its specific design was to prevent relapse of clinical populations in remission of recurrent major depression (Segal et. al., 2018; Strauss et al., 2014). Informed by research that substantially refuted the premise and proposed change mechanism of cognitive therapy of altering "dysfunctional attitudes …as enduring traits that rendered some people vulnerable to clinical depression," and buoyed by the observation of MBSR's decentering approach to mental thoughts and reactiveness, Segal et al. (2018) developed a theoretical model based upon helping patients cultivate an awareness of and different relation to "negative thoughts and feelings." (pp. 27, 39, 43). Along with MBSR, MBCT shares the limelight as one of the most extensively studied therapeutic modalities that incorporate mindfulness practices as a therapeutic element (Strauss et al., 2014). However, as MCBT evolved, it was more broadly applied within clinical populations with active psychopathologies (Chiesa & Serretti, 2011; Strauss et al., 2014).

MBCT begins with an interview of participants to assess factors related to their depressive illness, to provide information on how the curriculum and practices may help them and the individual effort that will be required of them, and to determine their suitability (e.g., not actively suicidal, abusing alcohol or other drugs, etc.); the curriculum consists of eight sessions delivered over eight weeks, the first four of which are about learning the basics of mindfulness with the remaining sessions about how to manage mood shifts (Segal et al., 2018). Various mindfulness practices (e.g., body scan, seated meditation, mindful walking) are presented in the sessions and daily home practice of meditation is required and must be documented in a daily journal; a "three-minute breathing space" practice repeated three times daily is described as "the spine of the Mindfulness-Based Cognitive Therapy program" and is designed to incorporate the experience of longer meditative practices engaged in throughout the program to the activities of daily life (Segal et al., 2018, pp. 83, 384-386).

The following discussion regards the efficacy of MBCT within clinical and other populations to ameliorate the mental health and well-being of program participants.

MBCT and Evidence of Its Effectiveness

Noting prior systematic reviews of studies regarding the effectiveness of MBCT in treating major depression as well as a subsequent meta-analysis of its effectiveness in reducing anxiety and depression symptoms, Chiesa and Serretti (2011) conducted a systematic review and meta-analysis (k=16) of controlled studies of the potential benefits of MBCT in improving the conditions of persons suffering from various psychiatric disorders. The selected studies were limited to those that included quantitative data and an identified methodology of statistical analysis, and which included active or inactive control groups. The majority of studies involved patients with major depression, although there were limited studies involving populations with

bipolar disorder, panic disorder, generalized anxiety disorder, and social phobia. Outcome measures included relapse and recurrence rates (patients suffering from major depression) as well as standardized psychometric instruments to measure depression and anxiety.

The findings related to four studies of preventative interventions for patients in remission of major depression with three or more past depressive episodes revealed that patients in the MBCT + TAU treatment group experienced only 32% subsequent depressive relapses in the 12 months subsequent to MBCT, whereas 60% of the TAU treatment group experienced depressive relapses (Chiesa and Serretti, 2011). Additional studies found short-term improvement in major depression patients with current or residual depressive symptoms, as measured by a psychometric instrument, in the MBCT + TAU groups compared to TAU only control groups, but study quality, study design, limited sample size and other factors led researchers to conclude that "there is some evidence of positive additive effect of MBCT to TAU…" (p. 449). Further, examination of relevant studies of MBCT interventions within MD patient populations led researchers to conclude that "there is preliminary evidence suggesting possible changes related to MBCT in MD patients such as reduction of ruminations, overgeneral autobiographical memory and self-discrepancy between the real and the ideal self" but inadequate replication and methodological deficits (e.g., small sample sizes, lack of details about randomization methods) are problematic and may contribute to "false positive findings" (p. 451).

The following year, Galante et al. (2012) conducted a meta-analysis of RCTs (k=11) to evaluate the effectiveness of MBCT on mental disorders. Their study criteria required patients (N=430) to have a mental disorder diagnosis, participate in a valid MBCT program with minimal adaptions and include outcome variables for change in patients' mental health. Similar to the findings of Chiesa and Serretti (2011), researchers found that 38% of the MBCT + TAU group

relapsed compared to relapse of 62% of the participants in the TAU only group; patients with recurrent depression with three or more prior depressive episodes, based on a subgroup analysis, fared better with MBCT + TAU, experiencing 40% fewer relapses versus patients in the TAU only group, which was determined to be statistically significant and which remained consistent when subject to sensitivity analysis (Galante et al., 2012, pp. 142, 147). While multiple measures of depressive symptoms at one year post intervention were statistically significant, with one case of clinical significance, these results did not remain stable upon further analysis, with the researchers also noting that the studies used self-reported measures and that the measurement of relapse rate was "a more robust and objective measure compared to self-reported measures" (p. 147).

The meta-analysis of RCTs (k=12) of MBIs with individuals with diagnoses of current episodes of an anxiety or depressive disorder conducted by Strauss et al. (2014) was touted by the researchers as the only such analysis wherein all the participants in the selected studies had a diagnosis with a current episode of one of these disorders. The RCTs – six studies employing MBCT, five employing MBSR, and one using Person-Based Cognitive Therapy – involved adult participants (N=578) wherein each therapy session included a mindfulness practice and recommended daily practice and utilized "a psychometrically reliable and valid outcome measure" of the diagnosed mental health condition (p. 2). There were collectively five active (CBT=4, group psychoeducation=1) and seven inactive (TAU=5, aerobic exercise=1, wait list=1) control groups (pp. 3, 6). Given that the included studies with persons with depressive disorders only involved MBCT, no conclusion could be made regarding the effectiveness of MBSR on depression; however, researchers concluded that "MBIs, in comparison to control conditions, resulted in significantly lower levels of symptom severity for the primary problem

[anxiety or depressive disorders] with a medium between-group effect size" (p. 10). Further, researchers concluded that evidence from the meta-analysis suggested that persons with a current episode of depressive disorder "can benefit from MBIs;" however, "given the paucity of evidence in their favour," they would "caution against offering MBIs as a first line intervention for people experiencing a primary anxiety disorder" (p. 11).

The efficacy of group MBCT in decreasing symptomology in depressed individuals (N=2352) was assessed by Lenz et al. (2016) through a meta-analysis (k=31) with approximately half of the participants receiving MBCT and the remainder, in nearly equal numbers, receiving an alternate treatment or no therapeutic intervention. The meta-analysis study was undertaken due to the absence research that resulted in "definitive" and "adequately powered studies" on this subject (p. 49). The aim was to assess treatment effects upon follow-up and to identify moderators of treatment effect within the MBCT intervention group (p. 49). The selected studies were randomized controlled research designs utilizing the 8-session MBCT protocol intended to reduce depressive symptoms within individuals being treated for acute depression and who were assessed pre- and post-treatment and at follow-up to determine the efficacy of treatment; the studies were conducted across the globe with 22 studies conducted in Europe (11 in the UK), four (4) in the United States, two (2) each in Asia and Australia, and one (1) in South Africa (pp. 49-50, 52).

The mean effect sizes for the studies included in the meta-analysis revealed "large to medium effects size for MBCT interventions" in the decrease of depressive symptoms compared "no treatment or alternative treatments, respectively;" however, when comparing alternative treatments to the effectiveness of MBCT, MBCT showed "moderate differences when compared to treatment as usual…and a small effect when compared to other group CBT approaches" (Lenz

et al., 2016, pp. 60-61). Further, when looking at treatment effects over time, the reduction in MBCT treatment effect compared to alternative treatments suggests that the treatment effects of MBCT "tend to diminish over time when implementing treatments that are more viable, such as other group CBT approaches or medication management" (p. 62). Also noteworthy, is the examination of domicile (country of study participants) as a moderator of treatment effect wherein subgroup analysis for domicile produced "significant differences in mean size effect across study locations;" the researchers proposed that an explanation for the differences "may be that many European and Asian communities have integrated lifestyles that promote use of mindfulness activities to a greater extent when compared to the United States or the United Kingdom…[and] that within Western cultures such as the United States, the characteristic action-oriented and individualistic approach to meeting life demands may create a barrier between individuals in degree of connectedness with experiences" (p. 62).

Kuyken et al. (2016), while acknowledging the increasing body of evidence supporting the effectiveness of MBCT in the prevention of depressive relapse, embarked upon an individual patient data meta-analysis from randomized trials to determine whether the effectiveness of MBCT in preventing depressive relapses differs individually for subgroups of individuals at risk for depressive relapses and occurrences. To this end, the researchers identified nine randomized trials of MBCT for relapse prevention in adult patients (N=1258) in remission for major depressive disorder (MDD) that met selection criteria (MBCT delivered for the treatment group consistent with the treatment manual, an active treatment control group with at least one modality other than MBCT, and diagnostic criteria to assess new episodes of MDD during the follow-up study period) (p. 566). The researchers concluded that study results for the MBCT study group (n=596) provided "clear evidence that MBCT was associated with a significant

reduction in the risk of depressive relapse/recurrence over 60 weeks compared with usual care" (38% of MBCT participants had a depressive relapse over 60 weeks compared to the non-MBCT groups, of which 49% experienced depressive relapses within that time period) (pp. 569-570). They noted further that the benefits of MBCT were even greater (i.e., larger treatment effect) for those with "higher levels of depressive symptoms at baseline compared with non-MBCT treatment" and that subsequent analysis provided no support that MBCT had differential effects upon the treatment group based upon their age, sex, education or relationship status which suggests the generalizability of this intervention "across these characteristics" (p. 571).

Subsequent to a meta-analysis of the effectiveness of MBIs generally in treatment of psychiatric disorders involving many of the same researchers (Goldberg et al., 2018), Goldberg et al. (2019) conducted a meta-analysis specifically of the effectiveness of MBCT for patients with current depressive symptoms given the perceived lack of such research to-date. This meta-analysis included RCTs (k=13) that examined MBCT as a treatment modality delivered in real time for adult patients with current depressive symptoms and that had sufficient psychometric measures and data to assess treatment effects. The studies were conducted internationally with the largest portion conducted in Iran, followed then by the Netherlands, with the United States being the smallest portion (two studies), and therefore have limited application to Western culture. Nonetheless, study results indicated MBCT at post-treatment was "superior" in comparison to non-specific control conditions (10 studies) but "did not differ statistically from active control conditions at post-treatment" (p. 10). Assessment of effects at follow-up (four studies) indicated no statistical difference between MBCT and active controls meaning that the effectiveness of MBCT "may be of similar efficacy to other therapies that are routinely offered" but due to limited studies that included follow-up time points, the researchers concluded that

"these findings should be interpreted cautiously" and recommended further study of MBCT within patient populations that are actively depressed (pp. 11, 13).

While it is important to know that therapeutic modalities are effective in reducing symptomology and prevalence of psychiatric conditions, it is as important to know how they work, or more technically, their mechanisms of action. Due to the lack of clarity of MBCT's specific mechanisms of therapeutic change in treating recurrent MDD, despite empirical support of its efficacy, van der Velden et al. (2015) undertook a systematic review of studies published from the earliest date available through June 2014 of MBCT that investigated and examined its therapeutic mechanisms. Twenty-three studies (*N*=1880) matched study eligibility, i.e., "clinical trials on mediation or mechanisms in MBCT treatment of MDD" with adult participants diagnosed with recurrent MDD that received MBCT treatment consistent with its established protocol (pp. 28-29). Results of 12 of the 23 studies revealed "either mindfulness, rumination, worry, self-compassion, decentering or meta-awareness was associated with, predicted or mediated the effect of MBCT on treatment outcome" (p. 34). More specifically:

> In terms of mediation analyses, two out of the three studies found increased mindfulness to mediate treatment outcome. Two out of three studies found decreased rumination to mediate treatment outcome, and two out of two studies found decreased worry to mediate treatment outcome. No studies employed mediation analysis for meta-awareness, yet one study found increased meta-awareness to predict reduced relapse risk. Finally, one study found increased self-compassion to mediate reduced relapse risk, and to reduce the predictive relationship between cognitive reactivity and relapse risk. (van der Velden et al., p. 34)

Evidence from two studies did not produce support for the prediction that mindfulness or rumination were mechanisms of change in MBCT (van der Velden et al., 2015). Lastly, findings of changes in "attention regulation ability, memory specificity, self-discrepancy, emotional reactivity and momentary positive and negative affect" in eight studies preliminarily indicated that they may have a role in MBCT's effect on treatment outcomes (p. 35). The researchers noted that the study of MBCT's treatment outcomes for patients with recurrent MDD and its underlying specific mechanisms was "still in its early stages" (p. 35).

Compassion Focused Therapy

Compassion Focused Therapy (CFT), "rooted in an evolutionary, functional analysis of basic social motivational systems" (Gilbert, 2014, p. 6), is a movement away from a medical model of viewing and relating to the mind (Kirby & Gilbert, 2017). From this emerged view, it is the complexity of the interaction of evolved cognitive competencies of higher brain functions (i.e., "reasoning, reflecting, imagining, mentalizing, and creating a socially contextualized sense of self") with earlier developed emotional and motivational systems that creates potential psychological conflicts and "mental health problems (called 'tricky brain')" (Gilbert, 2014, p. 6). Inherent in the CFT construct is the recognition of the evolved capability of humans to harness emotional and motivational influences toward prosocial ("affiliative, caring and altruistic") behavior; CFT seeks to enhance this human capacity by cultivating "inner compassion as a way for organizing our human 'tricky brain' in prosocial and mentally healthy ways" (p. 6).

Within the CFT framework, *a three emotions-system approach* and its effective integration is integral to CFT's therapeutic approaches for self-regulation; these three emotion-systems are threat and protection, resource-seeking and excitement, and contentment, soothing and safeness (Gilbert, 2009, 2014). It is the compassionate self (as an identity), developed

through CFT, that is the epicenter as "an inner organizing process" of these systems (Gilbert, 2014, p. 30). CFT, as "the underpinning theory and process of applying a compassion model to psychotherapy" (Gilbert, 2009, p. 199), aspires to develop twelve competencies[8] of compassion by various methods such as "attention, awareness and mindfulness" practices, breathing practices, etc. (Kirby & Gilbert, 2017, p. 274), to intentionally engage the contentment, soothing and safeness emotional system. Compassionate Mind Training (CMT) is the means to develop the attributes and skills of compassion, "particularly those that influence affect regulation" (Gilbert, 2009, p. 199).

CFT and Evidence of Its Effectiveness

An initial effort to summarize the current knowledge of the effectiveness of CFT and treatment outcomes was conducted by Beaumont and Hollins-Martin (2015), who completed a narrative review of relevant studies involving clinical populations. Given its relatively recent emergence as a treatment modality, the twelve studies selected varied in type (e.g., case studies, case series study, RCT, etc.), psychometric measurement instruments used, and involved diverse mental health conditions (psychosis, trauma, personality disorder, eating disorder, etc.); seven of the studies had less than 20 participants. Some studies included other treatment modalities (e.g., CBT – Cognitive Behavioral Therapy) in conjunction with CFT, or integrated elements of other therapies (i.e., CBT) with CFT, making distinctions between the modalities and their individual effects undeterminable. Notwithstanding multiple limitations of the studies examined, many studies reported reductions in patient's depression, anxiety, shame and other symptoms as well as increases in compassion in few cases. Researchers concluded that the available evidence

[8] Kirby and Gilbert (2017, pp. 275-276) identifies these as six for engagement (care for well-being, sensitivity, sympathy, distress tolerance, empathy, and nonjudgment) and six for action (attention, imagery, reasoning, behaviour, sensory focusing, and feeling and emotion).

"supports that people referred for psychological intervention may benefit from developing compassion" (Beaumont & Hollins-Martin, 2015, p. 28).

An early systematic review of the effectiveness of CPT/CMT in psychotherapeutic interventions was conducted by Leaviss and Uttley (2015) and included fourteen studies[9] involving participants with clinically diagnosed or self-reported symptoms of a psychological disorder (and some participants with neither due to limited studies of CPT/CMT) and with reported therapeutic outcomes. The selected studies used a variety of psychometric measures to assess treatment outcomes, most often short-term in duration (p. 941). Only three of the studies were RCTs, of which only one involved a clinical population (schizophrenic spectrum disorder) and also reported on the duration of the intervention, with no effect sizes reported for any of the RCTs (pp. 937, 939). The remainder of the studies were either case series or case report (1 each), observational (7), or non-RCT (2) studies (p. 936).

The summary of outcomes for the RCT study of the clinical population revealed decreased depression and increased compassion compared to the control group (TAU) whereas outcomes for observational studies, six involving clinical populations, revealed a reduction in depression (five studies), a reduction in anxiety (four studies), a reduction in self-criticism (four studies) and an increase in self-compassion (five studies); however, all evidence was correlational and none of the included studies "specifically analysed whether 'compassion' mediated the relationship between intervention and outcome" (pp. 939, 940, 942). The researchers concluded that while existing evidence provides some support that CFT may be more effective compared to no treatment and potentially equivalent to TAU, the evidence is "currently insufficient to show that CFT is more effective than current standard treatments" (p. 943).

[9] Nine of the fourteen studies in this review were also included in the review by Beaumont & Hollins-Martin (2015).

Kirby et al. (2017) followed with a meta-analysis of twenty-one RCTs (*N*=1,285) of compassion-based interventions (consisting of more than one session and/or augmented with additional exercises or homework), and included at least one outcome measure related to compassion, mindfulness, well-being, or mood states, for which treatment and control group effect sizes were measured and compared. The examined studies involved various compassion-based interventions based upon Loving-Kindness Meditation, Compassion Meditation, Mindful Self-Compassion, Compassion Focused Therapy, Compassion-Mindfulness Therapy, Compassion Cultivation Training and Cognitively-Based Compassion Training (p. 782). The interventions were either group delivered (*k*=15) or self-directed (*k*=6)), with four of the studies overall using active control conditions. Due to the limited number (<10) of studies contributing data beyond self-compassion and psychological distress, as well as inadequate reporting on moderators (e.g., dosage), etc., no moderator analysis was conducted.

For the seventeen studies using wait list control conditions, significant moderator effect sizes were found for the following outcomes with the number of studies contributing to this outcome indicated in parentheses: compassion (4), self-compassion (13), mindfulness (6), depression (8), anxiety (8), psychological distress (14), and well-being (8), with significant heterogeneity found within effect sizes for self-compassion measures but not in the remaining outcomes (Kirby et al., 2017, p. 784). In the four studies using active control conditions, significant moderator effect sizes, although slightly less than effect sizes in the studies using wait list control conditions, were found for all outcomes other than compassion which was not captured as an outcome in any of the studies; once again, self-compassion outcomes revealed a significant amount of heterogeneity but was not the case for the remaining five outcomes (p. 786). It should be noted three studies contributed to the self-compassion outcome, whereas two

studies contributed to the mindfulness and psychological distress outcomes, and one study each contributed to the results for the remaining outcomes. Two of the key findings were that "the current evidence base for compassion-based intervention is small…[and] the significant moderate effect sizes across outcomes demonstrated the potential impact of compassion-based interventions; however, this finding is limited to largely nonclinical populations" (p. 787).

Wilson et al. (2018), noting that "the clinical significance of self-compassion is not limited to one therapeutic modality of therapy [and]…is also not limited to one psychological diagnosis," conducted a systematic review and meta-analysis to evaluate the effectiveness of self-compassion-related therapies in increasing self-compassion and decreasing psychopathology within clinical and subclinical mental health populations compared to a control condition ("active intervention or a waitlist/treatment as usual") involving adults (N=1172) with "at least one face-to-face session with a trained therapist" (pp. 980-981). The treatment modalities used in the individual studies were highly varied and included Enhancing Self-Compassion Program, Emotion Focused Therapy, Acceptance and Commitment Therapy, Loving-Kindness Meditation, MBCT, CBT, MBSR, CFT, and various mindfulness interventions. The studies (k=22) were conducted globally with half of the studies conducted in the United States (n=8) or the United Kingdom (n=4). Eleven of the twenty-two studies involved active controls. Meta-analytic results for the self-compassion outcome, based upon 26 comparisons to controlled conditions, were a "medium-sized effect for greater improvement in self-compassion," and similarly, a "small to medium effect" upon depressive symptoms based upon 22 comparisons, and a "borderline medium effect for anxiety" based upon 17 comparisons (pp. 987-988). While the researchers stated the results of the meta-analysis indicated "self-compassion-related therapies, compared to a control condition, successfully increase self-compassion and reduce levels of

depression and anxiety with medium effects," they concluded that these therapies "did not produce better outcomes than active control conditions," and thus, "such therapies are unlikely to have any specific effect over and above the general benefits of any active treatment" (p. 990).

The findings of Wilson et al., calling into question the benefit of compassion-based therapeutic approaches beyond current active treatments, was not met with silence. Kirby and Gilbert (2019) provided a rebuttal to the findings of Wilson et al. (2018) regarding the efficacy of these approaches. Some of their pointed criticisms of the study by Wilson et al. (2018) include: most of the studies (k=13) used in their meta-analysis were of "mindfulness-based therapies" while only eight (k=8) were "compassion-based interventions" that were mostly intended for self-help and personal improvement rather than as therapies (pp. 1009). Further, self-compassion reporting "is in its infancy" and many compassion-focused therapies concentrate on developing compassion more broadly than the narrow self-compassion focus and measure used in their study (p. 1011). Additionally, many of the included studies were of poor quality particularly due to lack of verification that the compassion interventions were implemented properly and that clinicians treating clinical populations were skilled in understanding and mitigating "fears, blocks and resistances, so common in clinical populations" (p. 1008) and most involved "interventions [that] are proof of concept with small numbers" (p. 1009). For these and other reasons, Kirby and Gilbert (2019, p. 1006) determined that the conclusions in the meta-analysis conducted by Wilson et al. (2018) "are misleading."

Shame Resilience Theory

Using a grounded theory research method, Brown (2006) conducted a study involving 215 women to learn how and why women experience shame, its impact on them, and their means of coping with and resolving shame experiences. The study cohort, identified through both

purposive and theoretical sampling, consisted of adult participants, – 47% Caucasian, 30% African American, 18% Latina, and 5% Asian. Analysis of the qualitative data derived therefrom was utilized to identify the "emergent concepts and their relationships" as well as "participants' main concerns and the emergence of a core variable" (p. 44). The questions that framed the analysis were: "What are the participants describing? What do they care about? What are they worried about? What are the participants trying to do? What explains the different behaviors, thoughts, and actions?" (p. 44).

On the basis of her study, Brown (2006) concluded that her findings do not neatly fall within existing approaches "found in the social sciences or in the humanities" for addressing shame. In contrast, Shame Resilience Theory (SRT) is a "contextualized and multidisciplinary understanding of shame" that integrates "sociological, psychological, educational, and cultural approaches to shame," building upon "theoretical underpinnings of relational-cultural theory (RCT), empowerment theory, feminist social work practice, and theories of critical pedagogy" (p. 49).

Brown's (2006) proposed model of shame resilience presumes that it occurs over a continuum, as does its four components which are:

> (a) ability to recognize and accept personal vulnerability; (b) the level of critical awareness regarding social/cultural expectations and the shame web;[10] (c) the ability to form mutually empathic relationships that facilitate reaching out to others; and (d) the ability to "speak shame" or possess the language and emotional competence to discuss and deconstruct shame. (pp. 47-48)

[10] Brown (2006, p. 46) describes the shame web as "a web of layered, conflicting, and competing expectations that are, at the core, products of rigid socio-cultural expectations."

One final observation by Brown (2006) in her shame study is noteworthy. When participants were asked about the methods they used to address shame, they "rarely identified psychotherapy or individual counseling as an effective tool" (p. 51). While their responses were too varied to describe as a singular strategy, "they can be characterized as 'being with others who have had similar experiences' or 'talking with people who've been there'" (p. 51).

Shame Resilience Theory and Connections: Evidence of Their Effectiveness

As an extension of this research, Connections, a psychoeducational shame resilience curriculum was developed (Brown et al., 2011). It is comprised of twelve sessions, with each session including didactic, experiential and process elements to help individuals develop shame resilience based upon, in part, developing an understanding of shame and individual triggers of shame states, cultivating and practicing awareness skills to include the recognition of the physical sensations and emotional states related to shame as well as social and intrapersonal forces fostering it, identifying personal strengths to cope with it, and developing interpersonal empathetic capacity. Although the overview of the curriculum references the emergence of mindfulness skills as an outcome of identifying sensations of shame and responses to it, as well as practicing critical awareness to identify shame triggers and their source, "unwanted" (versus "ideal") personal identities that contribute to the experience of shame, and personal abilities to cope with it (Brown et al., 2011, pp. 364-367), the curriculum cannot be reasonably described as employing mindfulness meditation practices.

Despite wide appeal for Brown's shame research, sparse empirical evidence exists of the effectiveness of the Connections curriculum in mediating the harmful effects of shame and related psychopathological conditions (Alvarez, 2020). Only two published studies appear to exist of its application within clinical populations to mitigate shame or related conditions.

Hernandez and Mendoza (2011) conducted a pilot study of the Connections curriculum as part of an intervention with women, primarily with Hispanic backgrounds, for substance use disorders. The women (*N*=19) were residents in one of three residential substance abuse treatment facilities in California and their participation in this pilot study was predicated, in part, upon participation in the 12-week treatment program, regularly attending group sessions, completing weekly homework assignments and pre- and post-test psychometric (six) and self-measurement (one) instruments. Pre- and post-test measurements included measurements of participants' levels of acculturation, general health, depression, perception of addiction stigma, shame- and guilt-proneness, shame/self-esteem and a Shame Resilience Model self-evaluation to measure participants' understanding of shame resilience and its four components.

Hernandez and Mendoza (2011) collected data from twelve measures and subscales in total from the pre- and post-test psychometric (excluding the acculturation measurement) and self-evaluation instruments. At the study conclusion, pre- and post-test data analysis and comparison revealed statistically significant differences for six psychometric measures and the four subscales of the Shame Resilience Model self-evaluation. Participants reported improvements in general health and well-being as well as self-esteem, and decreased levels of depressive symptoms, internalized shame, shame self-talk and blame self-talk and increased ability to identify shame and personal shame triggers, greater skills in mitigating shame provoking expectations, increase ability to access empathetic support from others and improved ability to express feelings and ask for what they need. The researchers acknowledged the limitations to their study due to the small sample size, exclusion of study measures for three participants due to missing data leaving data measurements for only sixteen participants, and the lack of diversity of the ethnicity and gender of the participants.

In an effort to add to research examining the relationship between shame and depression, Alvarez (2020) conducted a study to determine if increasing shame resilience would decrease depressive symptoms in a population participating in an intensive outpatient (IOP) program in a midwestern city in the United States. A shame resilience experimental group (*N*=20) was established to participate in a 12-session Connections curriculum delivered twice a week for 60 minutes per session over a six-week period, with minimum commitment of participants to attend at least six sessions All participants had a mental health diagnosis with depression as a primary symptom. Only eleven of the participants completed the entire curriculum of which only ten completed all stages of assessment (administered during sessions one, six and twelve). A pre- versus post-test comparison of the shame resilience group participants revealed that the group had statistically significant decline in depressive symptom scores but no significant changes in shame-proneness outcome scores. However, participants in the shame resilience group did "acknowledge feeling better prepared for dealing with shame-inducing situations" (p. 5).

Alvarez (2020) acknowledged the limitations created by the small study size, the access of study participants to other concurrent treatment modalities as part of the IOP that were not measured independently, and that all patients were also receiving psychotropic medications while participating in the program.

No other empirical studies (excluding dissertations) of SRT and the Connections curriculum could be identified in database searches.

Discussion

So, what can be said about the effectiveness of mindfulness practices as methods or components in treating mood disorders generally and what, if anything, can be said about their utility and effectiveness in mitigating the suffering of shame?

The general effectiveness of MBIs, compared to various control conditions (e.g., no treatment, minimal treatment, etc.) including established evidence-based treatments in mitigating "disorder-specific symptoms across psychiatric conditions" within clinical populations, was evaluated by a large systematic review and meta-analysis conducted by Goldberg et al. (2018). Included were 171 studies (*N*=12,005), of which nearly half (44%) were conducted in the United States. The majority (52%) of the included studies used a no treatment group comparison. Depression was the most frequent (30%) of the disorders represented in the studies.

Various treatment modalities were administered within the studies, with MBCT and MBSR employed in 74 studies and 58 studies, respectively (S. B. Goldberg, personal communication, February 14, 2020). However, the outcomes for specific MBIs were not captured as part of the meta-analysis of the selected studies since the researchers "were more interested in the efficacy of this family of therapies, rather than comparing various forms of MBI" (S. B. Goldberg, personal communication, February 14, 2020). Notwithstanding this limitation as it relates to the current discussion of the effect of specific MBIs on mood disorders and underlying emotions, the researchers concluded "results suggest that there is an empirical basis for mindfulness therapies" and that "mindfulness treatments were shown, in general, to be of similar potency with first-line psychological (and psychiatric) interventions when compared directly and superior to other active comparison conditions (as well as wait list control conditions), with relatively little variation across disorders" (Goldberg et al., 2018, p. 58). As it relates specifically to depression, the researchers stated, "it appears that the strongest recommendation can be made for mindfulness treatments for depression" (p. 58).

Regarding the effectiveness of specific MBIs, some insight can be gleaned from the assessment of the previously cited systematic reviews and meta-analyses of their effectiveness,

selected primarily for their focus on psychological and psychiatric health conditions (mood disorders in particular) rather than physical (e.g., chronic pain, cancer, etc.) or behavioral (e.g., eating or gambling disorders, etc.) conditions. Evidence for the effectiveness of MBSR in reducing self-reported symptoms of anxiety, depression, and generally psychological distress can be found in Keng et al. (2011) and Bohlmeijer et. al. (2010a), with the later revealing small effect sizes for these conditions, although both studies primarily utilized wait list control groups as comparisons. Further, Fjorback et al.'s (2011) systematic review of studies of MBSR compared to wait list, TAU and active control conditions provided evidence via most, but not all studies, of its mitigating effects on these conditions while also acknowledging that due to the active participation required by MBSR (and MBCT), the results were only generalizable to individuals with "the ability and interest to participate" (p. 102).

Khoury et al.'s (2015) systematic review of studies of MBSR involving healthy persons also provided evidence, with moderate size effects, of MBSR's efficacy in the improvement of depression, anxiety and distress, and also examined the potential mechanisms of action as did the study by Alsubaie et al. (2017). While Khoury et al. (2015) found "strong positive correlation" between mindfulness and compassion and clinical outcomes for MBSR participants, Alsubaie et al.'s promising evidence of the effects of MBSR (and MBCT) on mechanisms of mindfulness and rumination mediating treatment effects did not result in "definitive conclusions" due to "lack of methodological rigour in the field of testing mechanisms and mediators of action in both MBCT and MBSR" (p. 88). Alsubaie et al.'s (2017) sobering commentary, in part, on the state of knowledge, or lack thereof, of the mechanisms of action within the various components of MBSR/MBCT that impel desired changes, speaks bluntly to current challenges in understanding how and what components of MBIs effect change, under what circumstances, and within what

populations. In addition, the systematic review by Lao et al. (2016) to probe the mechanisms of mindfulness and their cognitive effects via neuropsychological outcomes led to mixed results, finding no evidence that attentional functions were improved by mindfulness training and only preliminary evidence for improved working memory, autobiographical memory specificity and more global processes (e.g., meta-awareness).

The effectiveness of MBCT, originally developed to prevent depressive relapse (Segal et al., 2018; Strauss et al., 2014), has repeatedly been the focus of evaluative studies (Strauss et al., 2014). Chiesa and Serretti (2011) and Galante et al. (2012) in their meta-analyses found that patients participating in MBCT and TAU experienced a significant reduction in depressive relapses compared to patients receiving TAU only. The meta-analysis conducted by Kulken et al. (2016) added to this body of research with the examination of randomized trials of treatment effects involving MDD patients in remission and found significant reduction in depressive relapses for the MBCT patient groups compared to patients receiving usual care.

In examining the effectiveness of MBCT within populations with active mood disorders, Strauss et al. (2014) completed a meta-analysis of RCTs involving persons with current episodes of anxiety or depressive disorders, and found "there was a significant effect of MBCT with a small to medium effect size" on primary symptom severity via psychometric measurements versus group psychoeducation or group cognitive behavioral therapy controls (p. 8). Similarly, the meta-analysis by Lenz et al. (2016) of studies of MBCT intervention with persons being treated for acute depression found that MBCT participants experienced reduced depressive symptoms compared to controls, with the largest effect sizes when compared to no treatment or alternative treatments and diminished effect sizes when compared to TAU or group CBT. Lastly, Goldberg et al. (2019) through a meta-analytic study of the effectiveness of MBCT with

patients with current depressive symptoms found that MBCT resulted in superior treatment outcomes when compared to non-specific controls but no statistical difference when compared to active controls.

Regarding the mechanisms of action of MBCT, van der Velden et al. (2015) conducted a systematic review of clinical trials of MBCT's therapeutic mechanisms that resulted in some evidence that treatment outcomes were related to "either mindfulness, rumination, worry, self-compassion, decentering or meta-awareness" while noting that such study of MBCT's treatment outcomes for patients with recurrent MDD is in its "early stages" (p. 35).

Due to its more recent emergence, CFT, unique in its specific focus on shame remediation as a treatment focus through the cultivation of compassion as well as other attributes and skills (Gilbert, 2009), suffers from a limited number of available systematic reviews or meta-analyses of its efficacy. Beaumont and Hollins-Martin (2015) produced a narrative review in an initial evaluative effort to assess its effectiveness in generating improved treatment outcomes within populations with various mental health challenges, which revealed some improvements in patients' depression, anxiety, shame and other symptoms and increases in compassion in some cases. Leaviss and Uttley (2015), in their early systematic review of CFT/CMT in therapeutic interventions with individuals with indications of psychological disorders, noted some correlational evidence of reductions of depression, anxiety and self-criticism and increases in self-compassion compared to no treatment controls and potentially equivalent to TAU but found "insufficient high-quality evidence to demonstrate that CFT is more effective than current standard treatments" (p. 941). Kirby et al.'s (2017) meta-analysis of RCTs of a variety of compassion-based interventions conducted globally and primarily compared to wait list controls provided "promising," albeit "small" evidence of the efficacy of these various interventions in

producing improved outcomes in compassion/self-compassion, mindfulness, psychological symptomology (e.g., depression) and well-being, stating "that there is still a lack of clarity and agreed-upon processes on how best to define and measure [compassion]" (p. 787). Lastly, the systematic review and meta-analysis by Wilson, et al. (2018) of RCTs of an array of compassion-based interventions found moderate effects on self-compassion, depression and anxiety outcomes" (p. 992) yet concluded based upon the limited studies involving active controls that the benefit of these interventions were not above that of an active treatment, an outcome which Kirby and Gilbert (2019, p. 1006) subsequently described as "misleading" due to the variety of factors already cited in this writing.

Despite the notoriety of Brown's (2006, 2010, 2012) research that culminated in the development of shame resilience theory and the psychoeducational curriculum, Connections (Brown et al., 2011), to mitigate the harm caused by shame, there has been very limited evaluation, thus meager evidence to assess its efficacy in reducing shame and its distress by cultivating shame resilience.

Regarding the amelioration of shame via these four therapeutic approaches, as reflected in the majority of the studies cited, there is a greater lack of intentional focus in collecting evidence (by psychometric instruments or other means) in clinical research studies regarding shame within the treatment of psychopathologies rather than a lack of evidence of the effectiveness of the discussed therapeutic modalities in reducing harmful shame, notwithstanding that CFT and SRT/Connections specifically focus on shame. This is confusing and troubling given the prevalence of shame in psychopathologies (Cândea & Szentágotai, 2013), particularly depression, as highlighted by the large meta-analysis by Kim et al. (2011) involving studies (k=108) of individuals (N=22,411) with depressive symptoms and measurement of the

prevalence of their shame (and guilt) wherein it was determined that shame (as well as pathological guilt) "is important to depressive symptomology…[and] shame warrants much greater prominence in understandings of the emotional underpinnings of depressive symptoms" (pp. 86-87). With the absence of sufficient and substantial data regarding the efficacy of MBSR, MBCT, CFT, and SRT/Connections in reducing harmful shame, their effectiveness in reducing relapse and symptomology of mood disorders (e.g., anxiety and depression) serve as the best surrogate measure of their potential effectiveness based upon the systematic reviews and meta-analytic studies of the past decade. Overall, the meta-analysis by Goldberg et al. (2018, p. 58) provides the best recent evidence of "the efficacy of this family of therapies" (primarily relating to MBSR and MBCT in their study) that appear to be of "similar potency with first-line psychological (and psychiatric) interventions when compared directly." Given this general state of research and understanding of the treatment effects of MBIs on shame and related conditions, what can be done to improve the understanding and treatment outcomes?

In a broad sense, an important step in advancing understanding of the effectiveness of MBIs in improving mental health conditions and related emotional distress is to better define how they influence emotional regulation strategies related to psychopathology. The corresponding relationship between emotion-regulation strategies employed by individuals and the nexus of these strategies to specific psychopathologies was explored by Aldao et al. (2010, pp. 217, 227) in a meta-analytic review of six emotion-regulation strategies – "acceptance, avoidance, problem solving, reappraisal, rumination, and suppression" – and the four psychopathological symptoms of "anxiety, depression, eating and substance-related disorders," and involved 114 studies (71 cross-sectional, 18 experimental, and 25 longitudinal), with appropriate control groups. Their findings revealed that avoidance and suppression were

positively correlated with psychopathology (medium to large effect sizes) as was rumination (large effect size) while problem solving (medium to large effect size) and reappraisal (small to medium effect size) were negatively correlated with psychopathology with acceptance not significantly correlated as such (p. 228). For the specific mood disorders of anxiety and depression, positive associations were found for avoidance, rumination, and suppression; problem solving was negatively associated with both disorders whereas reappraisal was negatively associated with depression yet marginally negatively associated with anxiety. Acceptance had no significant correlation with either anxiety or depression (pp. 229). Thus, an important question to allow a better understanding of the effectiveness of MBIs or other modalities (e.g., SRT/Connections), is how do they affect these emotion-regulation strategies that are positively or negatively associated with psychopathology?

As an example, Proeve et al. (2018) in their study of the effects of MBCT on self-compassion, shame and psychological distress is illustrative. Thirty-nine adult participants with a mood or anxiety disorder were assigned to one of three 8-week MBCT groups and assessed by self-report measures of self-compassion, shame/guilt, stress, anxiety, depression and rumination, via pre- and post-treatment questionnaires of which twenty-two participants completed both. Researchers noted that participants that completed the program showed significant increase in self-compassion (large effect size) and decrease in self-coldness (medium effect size) as well as significant decreases (with medium size effects) in shame-proneness, rumination and stress while noting a number of limitations of the study which they described as “one of few to assess the effects of mindfulness-based interventions on shame” (pp. 442-443). An earlier study by Woods & Proeve (2014), although of low quality, concluded “that self-compassion was a predictor of

shame-proneness, but mindfulness was not, [and] suggests that self-compassion should be a particular focus of shame interventions" (p. 29).

Furthermore, Fresco and Mennin, (2019) in their discussion of how to better integrate cognitive behavioral and mindfulness-based therapies in the treatment of distress disorders – i.e., "major depressive disorder (MDD), generalized anxiety disorder (GAD), post-traumatic stress disorder and dysthymic disorder" (p. 65) – assert there is a need for a "conceptual treatment development model" that includes "change principles" (pp. 65-66). They comment further that:

> One way to effectively forge a union between CBT and mindfulness is to identify key principles and accompanying mechanisms of action that synergistically result in a superior treatment response and then determine the sequence, dosage and tailoring of respective treatment elements. (Fresco & Mennin, 2019, p. 66)

Challenges to the Integration of Western Therapeutic Methods and Mindfulness

The integration of Western therapeutic methods and mindfulness meditative practices is not a simple matter. There are important differences in their conceptual underpinnings as well as approaches to alleviating suffering, emotional and otherwise. Yet, alignments can be found within their psychological views (e.g., shame as an "afflictive" state as well as a psychological state linked to psychopathology) and methods of intervention. But first, a brief discussion of their differences is necessary.

Buddhist mindfulness, as earlier described, emanates from within deep historical, cultural, and psychological roots. The challenge of retaining Buddhist psychological views within Western mindfulness practices is its cultural dissonance with many philosophic, religious or psychological views of the West. Sharf (2015) comments that:

> On purely *doctrinal* grounds…early Buddhist sutras in general, and Theravada teachings in particular, hold that (1) to live is to suffer, (2) the only genuine remedy to suffering is escape from *samsara* (the phenomenal world) altogether, and (3) escape requires, among other things, abandoning hope that happiness in this world is possible. (p. 471)

Further, as previously referenced, Analayo (2003) states regarding the progression of meditative practice, that, "[The] move of *sati* towards the more general characteristics of experience brings about insight into the impermanent, unsatisfactory, and selfless nature of reality" (p. 94). The impossibility of happiness and the "selfless nature of reality" can be difficult ideological pills and realizations to swallow.

Perhaps particularly challenging is the Buddhist assertion of the negation of an unchanging self, in the form of an identity or a permanent soul. Gethin (1998) comments that "both ancient and modern critics have argued that to do away with the self in the manner of Buddhist thought creates insurmountable philosophical and moral problems" (p. 140) for which his subsequent effort to mitigate through an explanation of the Buddhist rationale for doing so may fail to satisfy those believing otherwise. Further, Buswell and Lopez (2014) comment that "Buddhism…rejects any notion of an eternal, perduring soul that survives death, or which transmigrates from lifetime to lifetime" (p. 43). Thus, any inclination to lead someone with deeply held cultural views to the contrary, through therapeutic or other means, to the realization of no "permanent self" or the impossibility of happiness in earthly life runs the risk of incurring a psychological or existential crisis. While this may seem a remote possibility in the era of secular mindfulness, one need only look to the evolution of second generation MBIs which incorporate these core elements of Buddhist psychology (see Tirch et al., 2017) and the inclusion of other Buddhist practices "which place these MBIs squarely in the spiritual realm" (Singh, 2016, p.

viii), which should thus prompt greater consideration of some of the potential impacts of doing so. Furthermore, Western psychotherapeutic goals differ greatly from Buddhism's principal aim of alleviating all suffering and the means to achieve it, and regarding which Tibetan Buddhist scholar, Geshe Thupten Jinpa (2000), commented that:

> It is vitally important not to succumb to the temptation of reducing Buddhism to a form of psychoanalysis or therapy. We should be aware of the fundamental differences between Buddhism and modern psychoanalytic disciplines…To begin with, the goals of the two systems are different. Roughly speaking, psychoanalysis aims to bring about a harmony between the various elements of an individual's psyche so that a greater coherence can be achieved within the person's sense of self. In contrast, the aspiration in Buddhism is to transcend the bounds of the very concept of the self itself in that clinging to any sense of a 'core' is seen as an obstruction. (p. 13)

Even secular mindfulness practices are not without their risk and potential harm. Van Dam et al. (2018, p. 36) comment that "misinformation and poor methodology associated with past studies of mindfulness may lead public consumers to be harmed, misled, and disappointed." The researchers elaborate on the definitional challenges of mindfulness, as already briefly discussed and referenced (Gethin, 2016), as well as methodological challenges in mindfulness research studies (e.g., low quality of scientific studies, accuracy of self-reported measures or lack thereof, dosage of treatment, etc.). The researchers also explicitly reference adverse effects involving meditation-induced or meditation-related experiences "that were serious or distressing enough to warrant additional treatment or medical attention [and] have been reported in more than 20 published case reports or observational studies" (p. 47).

In addition, Western psychological views present a potential antithetical position to Buddhist psychology and the meditative practice via non-attachment, neither pursuing pleasant nor avoiding unpleasant experiences (Bodhi, 2005; Kabat-Zinn, 2005; Silva, 2017) generated when contact with internal or external stimuli result in feeling (i.e., "feeling" in Buddhism vs. "awareness of affect" in Western psychology). According to Tomkins (1987, p. 139), humans are "urged by nature and by nurture to explore, and attempt to control, the circumstances which evoke…positive and negative affective responses." They prompt action toward the achievement of "an ideal state – one that…implicitly or explicitly entails the maximizing of positive affect and the minimizing of negative affect" (p. 139). In fact, the Tomkins' Blueprint, delineates the subsequent motivation of the evolutionary affect system with its good and bad feelings (awareness of an affect) that prompts human action as follows:

1. Maximize positive affect.
2. Minimize (reduce) negative affect.
3. Both of these actions work best when all affect is expressed.
4. Anything that helps the performance of these three rules is good for human life; anything that interferes with them is bad for us. (Tomkins Institute., n.d.-b).

Yet, for individuals suffering from some dysregulated psychological and emotional states (e.g., anxiety and depression), avoidance and suppression of unpleasant emotions are linked to psychopathology (Aldao et al., 2010). Thus, how can mindfulness help?

Notwithstanding cautions regarding employing meditative techniques, particularly for a physical or psychological clinical condition outside of a therapeutic setting, mindfulness meditation can be helpful. By way of brief example, cultivating attention and increased awareness can help individuals develop the capacity to face the "spotlight" of shame with

compassionate presence and skillful action, rather than "shift to the compass of shame…[and its] four poles…that tell us what were gonna do about the awful feeling, rather than pay attention to what the spotlight showed us" (Nathanson, 2008, 3:43). If unable to identify the feeling state of shame, mindfulness meditation in cultivating present moment awareness could help individuals identify initial facial and postural responses of a shame state, i.e. "lowering the eyelid, decreasing the tonus of all facial muscles, lowering the head via a reduction in tonus of the neck muscles, or a tilting of the head in one direction" (Tomkins, 1987, p. 143), or behavioral responses reflective of the compass of shame (e.g., avoidance, withdrawal, etc.) which can the lead to a conscious choice of how to respond to it. Further, CFT or related practices, which include approaches focused on regulating physiology such as "breathing (e.g., rhythm soothing breathing)" exercises "that directly attempt to stimulate affiliative processes such as the parasympathetic nervous system" (Kirby, 2017, p. 435), as well as developing the capability to "regulate emotion through *affiliation* rather than through *attention*" (Germer & Barnhofer, 2017, p. 82), could help create greater self-compassion, a potential antidote to shame. Optimizing treatment outcomes through careful and skillful integration of mindfulness practices with therapeutic approaches (Fresco & Mennin, 2019) has the potential to quell shame and its harmful effects.

Conclusions

Mindfulness meditation, from its fledgling beginning in the United States 40 years ago to its exponential growth over the past two decades, has captivated the attention of scientists, academic institutions, medical and psychotherapeutic clinicians, corporate institutions, and a large segment of the general public (Wylie, 2015; Van Dam et al., 2018). Its therapeutic application has also emerged globally (Lenz et al., 2016; Goldberg et al., 2019). Furthermore,

notwithstanding its long historical roots in the east (Feuerstein, 2003, 2008; Boccio, 2010), it has become an established practice in its myriad of forms in the West, including its application in psychotherapeutic settings, and will continue to be so for the foreseeable future.

The prominence of shame in psychopathological conditions as well as its prevalence in personal suffering requires greater attention through Western therapeutic interventions and complimentary meditative modalities. The synergy of the two holds promise for improved treatment outcomes and increased personal well-being but additional research is needed to better understand and then apply integrated modalities to maximize beneficial outcomes while balancing and protecting against possible harm. Moreover, further research is needed on the role of shame-proneness as being predictive of and a measurement of psychopathology, as well as the regulation of shame-proneness (e.g., through mitigating rumination, strategies of avoidance, etc.), as a mechanism of change generally (Cândea & Szentágotai, 2013), and, how these are influenced by the application of MBIs in treating shame and related psychopathologies. The inclusion of Buddhist psychological and cultural views on emotion and liberation from suffering within therapeutic or secular settings require, at a minimum, further discussion and cultural sensitivity to views and ideologies that are incompatible with their underlying concepts, as well as, conscious consent of persons receiving therapeutic intervention based upon them.

Finally, the responses provided by the participants of Brown's (2006) shame study provide reason for pause as it relates the pervasiveness of mood disorders and reliance on therapeutic relationships for help and healing. The fact that the participants "rarely identified psychotherapy or individual counseling as an effective tool" but most often characterized "'being with others who have had similar experiences' or 'talking with people who've been there'" (p. 51) as being most helpful, speaks volumes about the need for, and perhaps too often absence of,

true human connection. Regardless of the promise of mindfulness-based interventions to reduce suffering and their potential for better integration within established therapeutic interventions to do so, this may be of limited benefit if individuals do not develop compassion for themselves and others and have their lives filled more with the compassionate presence of both.

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