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Comparison of the Effectiveness of Shame-Awareness Therapy and Cognitive-Behavioral Therapy on Body Image and Self-Esteem in Adolescent Girls with Gender Dysphoria

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A B S T R A C T

Objective: The present study aimed to compare the effectiveness of shame-awareness therapy and cognitive-behavioral therapy (CBT) on body image and self-esteem in adolescent girls with gender dysphoria.

Methods and Materials: This research employed a quasi-experimental design with a pre-test and post-test format, involving two intervention groups. The statistical population consisted of all girls who had sought treatment at various clinics in Zahedan, complaining about their acceptance of their gender. A purposive sampling method was used to select 36 girls, who were then randomly assigned to three groups. The experimental groups underwent 13 sessions of 60-minute interventions using either the shame-awareness therapy or CBT packages, while the control group received no such training. After the intervention period, a post-test was administered to all groups. The data were analyzed using multivariate analysis of covariance (MANCOVA) with SPSS statistical software.

Findings: The results indicated that both shame-awareness therapy and CBT had significant effects on body image and self-esteem in adolescent girls with gender dysphoria.

Conclusion: The study concludes that both shame-awareness therapy and cognitive-behavioral therapy are effective in significantly improving body image and self-esteem in adolescent girls with gender dysphoria, with no significant difference observed between the two interventions. These findings suggest that either therapy can be utilized to support psychological well-being in this population.

Keywords: *shame-awareness, cognitive-behavioral, body image, self-esteem, adolescent girls, gender dysphoria.*

1. Introduction

The period of adolescence and youth is considered one of the most critical stages of life, as the individual transitions from childhood to a new phase characterized by significant personality and physiological changes, constantly striving to adapt to new situations (van de Grift et al., 2016; Yazdanpanahi et al., 2022). The term "gender dysphoria" in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) refers to a distress that may arise from the incongruence between an individual's experienced or expressed gender and their assigned sex. Although not all individuals experience distress due to this incongruence, many do, particularly in the absence of desirable physical interventions such as hormone therapy or surgery. It is noteworthy that this term was previously known as "Gender Identity Disorder" in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (Taslim & Canales, 2023).

Among the issues and problems associated with adolescents experiencing gender dysphoria is body aversion and dissatisfaction with their physical appearance, leading to concerns about their body image (Becker et al., 2016; van de Grift et al., 2016). Body image is a broad and dynamic concept that includes an individual's perception of their body size and shape, as well as thoughts, feelings, and the views of others regarding their body. Body image has a multidimensional structure that includes two independent components: perceptual (body size estimation) and attitudinal (cognition and feelings towards the body). Individuals who have a positive perception of their appearance usually feel good about their life as well, but an unacceptable self-image can lead to changes in a person's sense of self-worth (Ahmadi, 2024; Arıkan et al., 2024). Studies have shown that it is challenging for individuals with gender dysphoria to develop a satisfactory body image and experience a positive mental image of their physical appearance. This issue sometimes leads to disturbances in body image, and individuals with gender dysphoria not only face social and environmental pressures regarding their physical appearance but also engage in obsessive body scrutiny and tend to develop body dysmorphia (Taslim & Canales, 2023). Research has also shown that concerns about physical appearance are directly related to sexual dysfunction and eating disorders. On the other hand, when an individual is satisfied with their physical appearance and body shape, they have higher self-esteem and a greater sense of self-worth (Becker et al., 2016; Soltani Zadeh et al., 2019; Taslim & Canales, 2023; van de Grift et al., 2016; Yazdanpanahi et al., 2022).

Having good self-esteem means being aware of one's abilities and weaknesses, accepting oneself as valuable, taking responsibility, affirming oneself, meeting one's needs, having goals, and choosing paths to achieve them (Al-Krenawi & Bell, 2022; Almurumudhe et al., 2024). Self-esteem is an indicator of an individual's mental health and can be considered a valuable personal asset that predicts the quality of life (Eklund et al., 2018; Khosh Lahje Sedq & Mohammadtahery, 2022; Szkody et al., 2020). Self-esteem, as the core of psychological structures, acts as a protective shield against anxiety and provides peace of mind. Low self-esteem emerges as a factor in the development of psychological and physical disorders in adolescents with gender dysphoria. Self-esteem plays an important role in determining individuals' self-regulatory behaviors. Those with high self-esteem respect themselves, recognize their worth, and typically make their best efforts to achieve their goals, using effective self-regulation to attain them (Karami et al., 2017).

Various therapeutic approaches have been adopted for treating depression, anxiety, and stress in patients with gender dysphoria. In the context of psychological interventions, one of these psychotherapies is cognitive-behavioral therapy (CBT). CBT is a type of psychotherapy that helps patients understand the thoughts and feelings that influence their behavior. Currently, CBT is used to treat a wide range of disorders, including phobias, addictions, depression, and anxiety (Atayi et al., 2018). CBT is generally short-term and focuses on helping patients address a specific problem. During the treatment period, the individual learns how to identify and change destructive or intrusive thought patterns that negatively affect their behavior (Amirkhanloo et al., 2022; Entezari et al., 2021; Kiani Rad, 2024; Navidian et al., 2016).

Another new therapeutic method in the field of psychology is shame-awareness therapy. Shame is defined in the Merriam-Webster dictionary as a painful feeling caused by the awareness of guilt, failure, or inadequacy, and alternatively, as a condition for disgrace or humiliating dishonor. In psychology, shame is referred to as anger turned inward or feeling bad about oneself. Nathanson (1993) described the "shame compass" as representing four typical sets of instructions for managing the impact of shame and defending against the painful experience of shame. A single shameful event can be sufficiently traumatic to cause more harm than a series of repeated but milder experiences. In

JAYPS Adolescent and Youth Psychological Studies
E-ISSN: 2981-2526

fact, other studies have also shown that any significant and traumatic shameful event in the past, especially those occurring during childhood, can make individuals more prone to feelings of shame (Barnes, 2022; Ollivier et al., 2022).

Therefore, it is essential to understand the effects of CBT and shame-awareness on body image and self-esteem in adolescent girls with gender dysphoria. Given the prevalence of psychological distress among adolescent girls with gender dysphoria and its negative effects on their self-esteem and body image, providing psychological services in the form of therapeutic strategies such as CBT or shame-awareness therapy may be effective in enhancing self-esteem and psychological symptoms in these girls. Thus, the main objective of this study is to address the question of whether CBT and shame-awareness therapy have an impact on body image, self-esteem, self-regulatory behaviors, and psychological symptoms in adolescent girls with gender dysphoria.

2. Methods and Materials

2.1. Study Design and Participants

The present study is a quasi-experimental research with a pre-test and post-test design involving two intervention groups. The study population consists of all girls who have sought treatment at various clinics in the city of Zahedan, reporting issues related to gender acceptance. These clinics include the Legal Medicine Organization, the Gender Dysphoria Support Unit of the Welfare Organization, specialized psychology and psychiatry clinics, and general surgery specialists who are active in this field. To select the sample, the main clinics and counseling centers in Zahedan were visited, and 36 adolescent girls meeting the inclusion criteria were selected. According to Cohen's table, to compare two groups with a minimum required test power, medium effect size, and an error probability of 0.05, 12 participants were considered for each group. The participants were randomly assigned to three groups, with each group comprising an equal number of adolescent girls with gender dysphoria, making a total sample of 36 girls selected through purposive sampling.

The inclusion criteria for the study were as follows: not receiving concurrent psychological interventions, no specific physical illness, adolescent girls aged 12-18 years, parental consent for participation in therapy sessions, not taking psychiatric medications, and having a psychiatrist's confirmation of gender dysphoria diagnosis. The exclusion criteria included missing more than two sessions and unwillingness to continue participation.

2.2. Measures

2.2.1. Body Image

This scale, developed by Hopwood et al. in 2001, consists of 10 items and provides a total score. It is designed to assess the body image of patients and can be applied to any type of treatment. The items are rated on a 4-point Likert scale ranging from "not at all" (0) to "very much" (3). The minimum and maximum scores on this scale are 0 and 30, respectively, with higher scores indicating greater distress or concern about body image. The scale's reliability was assessed using Cronbach's alpha, which was reported as 0.93. For validity, discriminant validity was used, which successfully distinguished between mastectomy and non-mastectomy groups. Rajabi et al. (2015) examined the psychometric properties of the Persian version of this scale, and the findings indicated that the one-factor model of the BIS had good fit indices. The Cronbach's alpha coefficient for this scale in the present study was 0.70, and the divergent validity coefficient with the Rosenberg Self-Esteem Scale was -0.21, which was statistically significant (Amirkhanloo et al., 2022). The Cronbach's alpha coefficient in the present study was 0.73.

2.2.2. Self-Esteem

The SEI, used to measure and assess self-esteem, was developed by Coopersmith in 1967 based on a revision of the Rogers and Diamond scale. This inventory consists of 58 items presented in a true-false format, with 8 items assessing lying and the remaining 50 items measuring four subscales: general self-esteem, family self-esteem, academic self-esteem, and social self-esteem. The scoring is 0 or 1, with "true" receiving a score of 1 and "false" receiving a score of 0. The total score ranges from 0 to 50. If a participant scores more than 4 on the 8 lying items, the validity of the test is considered low. The overall self-esteem score is calculated by summing the scores of the four subscales (Khosh Lahje Sedq & Mohammadtahery, 2022). The Cronbach's alpha coefficient for this study was 0.84.

JAYPS Adolescent and Youth Psychological Studies
E-ISSN: 2981-2526

2.3. Intervention

2.3.1. Shame-Awareness Therapy

The Shame-Awareness Therapy protocol consists of 13 sessions designed to help participants understand and manage feelings of shame, which often underlie psychological distress. The therapy focuses on the origins, functions, and impact of shame, aiming to reduce its negative influence by promoting self-awareness, emotional regulation, and healthier interpersonal relationships. Each session builds on the previous one, gradually guiding participants toward recognizing and overcoming shame in various aspects of their lives, including their thoughts, emotions, behaviors, and relationships.

Session 1: Introduction and Group Familiarization

In the first session, participants are introduced to each other and the therapist. The session begins with a general introduction and an overview of the therapy process. The rules and regulations of the group are explained, followed by a discussion aimed at fostering mutual understanding and self-awareness among the participants. This session lays the groundwork for a safe and supportive environment where participants feel comfortable sharing their experiences.

Session 2: Understanding Shame and Useful Shame

This session focuses on differentiating between harmful and beneficial aspects of shame. Participants explore bodily inadequacies and the expressions of shame. The session discusses how shame can be useful in moderating behaviors and maintaining healthy relationships. The goal is to help participants identify and harness constructive aspects of shame.

Session 3: Functions of Shame

Participants examine the role of shame in shaping individuals' behaviors and worldviews. The session explores the concept of shame-prone personalities, the consequences of excessive shame, and the development of shame spirals. The aim is to increase awareness of how shame influences daily life and interpersonal interactions.

Session 4: Lack and Absence of Shame

This session delves into the negative consequences of insufficient or absent shame, such as anger, denial, and perfectionism. It also covers the tendency to withdraw in individuals who experience excessive shame and the dangers of shamelessness and lack of insight. Participants are encouraged to reflect on their own experiences with these issues.

Session 5: Origins of Shame

Participants explore the early childhood origins of shame and how it evolves during the process of growing up. The session discusses the role of family dynamics in the development of shame and its impact on individuals. The aim is to help participants understand the roots of their shame and how it affects their current behavior.

Session 6: Everyday Shaming Relationships

This session focuses on recognizing and understanding shaming dynamics in daily relationships. Participants learn to identify signs of shaming and the power dynamics involved. The goal is to empower participants to navigate relationships more effectively, minimizing the impact of shaming interactions.

Session 7: The Role of Shame in Culture

Participants explore how cultural norms and expectations contribute to the experience of shame. The session discusses success orientation, conformity, and the emphasis on appearance as cultural factors that exacerbate shame. Organizational shaming is also covered, highlighting how institutions can perpetuate shame.

Session 8: Shameful Thoughts

This session addresses the internalization of shame through self-isolation, self-criticism, and self-hatred. Participants learn strategies to counteract these thoughts and behaviors, focusing on reducing the impact of shame on their mental health.

Session 9: Healing Shame Damages

The session centers on recognizing and addressing the damage caused by shame. Participants are introduced to solutions for dealing with shame, including increasing awareness and developing healthier coping mechanisms. The goal is to begin the process of healing and recovery.

Session 10: Overcoming Shame

In this session, participants explore common responses to shame, such as denial, withdrawal, arrogance, and pretending. The session emphasizes transforming these responses into healthier ways of managing shame, including recognizing and processing emotions rather than avoiding them.

Session 11: Healing Shame in the Family

Participants focus on strategies for overcoming shame within the family context. The session includes discussions on fostering healthy relationships within the family and the workplace, emphasizing the importance of creating supportive environments that reduce shame.

Session 12: Managing Shame in Daily Interactions

This session addresses managing shame in everyday situations, promoting calmness, respect, and self-worth.

JAYPS Adolescent and Youth Psychological Studies
E-ISSN: 2981-2526

Participants learn practical techniques for dealing with shame-triggering situations, aiming to maintain a sense of self-esteem and emotional balance.

Session 13: Review and Post-Test

The final session is dedicated to reviewing the topics covered in previous sessions and consolidating the skills learned. Participants practice the techniques discussed throughout the therapy and complete a post-test to assess their progress.

2.3.2. Cognitive-Behavioral Therapy

The Cognitive-Behavioral Therapy (CBT) protocol consists of 12 sessions designed to address dysfunctional thoughts, behaviors, and emotional responses. CBT is a structured, short-term psychotherapy that helps participants identify and modify negative thought patterns and behaviors. The therapy focuses on cognitive restructuring, behavioral interventions, and the development of coping skills to manage psychological distress effectively.

Session 1: Introduction and Group Familiarization

The first session introduces participants to the group and the therapy process. The session covers group rules and regulations and establishes a foundation of mutual understanding and rapport among participants. This initial session sets the stage for a collaborative and supportive therapeutic environment.

Session 2: Thoughts, Feelings, and Behaviors

This session focuses on distinguishing between thoughts, feelings, and behaviors. Participants learn about cognitive distortions and are introduced to different types of thinking errors. Techniques for identifying automatic negative thoughts are discussed, helping participants become aware of their cognitive processes.

Session 3: Cognitive Restructuring

Participants are introduced to the concept of cognitive restructuring, a key CBT technique. The session involves identifying and evaluating negative thoughts and beliefs, followed by techniques to change these thoughts and assess the impact of revised thinking on emotions and behaviors.

Session 4: Symptoms and Chains

This session covers the treatment process in CBT, with an emphasis on creating new behaviors and linking them to cognitive patterns. Participants learn about behavior chains and how to break them to reduce distress and promote healthier responses to triggers.

Session 5: Assertiveness

Participants are introduced to assertiveness, including its definition and various assertive behaviors. The session discusses the goals and benefits of assertiveness, as well as the negative consequences of lacking assertiveness. Techniques for developing assertiveness skills are practiced.

Session 6: Impulsivity, Self-Control, and Mood Enhancement

This session focuses on managing impulsivity and developing self-control. Participants learn strategies for controlling impulses and are introduced to positive cognitive strategies for mood regulation, helping them maintain emotional stability.

Session 7: Stress Management and Problem Solving

Participants explore different coping behaviors, distinguishing between problem-focused and emotion-focused coping strategies. The session also introduces techniques for boosting self-esteem and managing stress, helping participants navigate challenges more effectively.

Session 8: Self-Esteem

This session delves into the concept of self-esteem, discussing the causes and consequences of low self-esteem. Participants learn strategies for improving self-esteem, with a focus on fostering a positive self-concept and enhancing overall well-being.

Session 9: Understanding Gender Concepts

Participants receive education on gender-related issues, including identifying irrational beliefs and thoughts about gender. The session also covers techniques for expressing oneself assertively and accurately, helping participants navigate gender-related challenges.

Session 10: Recognizing Thoughts in Catastrophic Situations

This session addresses the identification of physical reactions related to psychological trauma and anxiety. Participants are introduced to relaxation techniques and learn to replace ineffective self-talk with more constructive alternatives, reducing catastrophic thinking.

Session 11: Imaginal Exposure and Gradual Exposure

The session focuses on processing trauma through imaginal exposure and gradual exposure techniques. Participants develop coping plans to manage distressing thoughts and emotions, enhancing their resilience to triggers.

Session 12: Review and Post-Test

The final session reviews the entire CBT process, consolidating the skills learned throughout the therapy. Participants engage in practice exercises and complete a post-test to evaluate their progress and plan for future maintenance of their mental health improvements.

JAYPS Adolescent and Youth Psychological Studies
E-ISSN: 2981-2526

2.4. Data Analysis

To analyze the data obtained from the above questionnaires, descriptive statistics were used to determine frequencies, percentages, means, standard deviations, and standard errors. Inferential statistics, specifically multivariate analysis of covariance (MANCOVA), were then employed using SPSS version 22.

3. Findings and Results

The results indicate that 44.4% of the target population is between the ages of 12 to 14, and 22.3% are between 17 to 18 years old. The majority of the target population, 41.6%, are studying at the middle school level. Based on the data collected and processed using statistical software, the most important central indices of the research variables are presented in Table 1.

Table 1

Descriptive Indices of Body Image and Self-Esteem Scores

Variable	Stage	Pre-Test Mean (SD)	Post-Test Mean (SD)
Body Image	Shame-Awareness Therapy	16.75 (2.34)	12.64 (2.33)
	Cognitive-Behavioral Therapy	16.9 (2.31)	12.8 (2.3)
	Control	15.9 (2.18)	15.7 (2.13)
General Self-Esteem	Shame-Awareness Therapy	13.77 (3.38)	20.32 (1.32)
	Cognitive-Behavioral Therapy	14.1 (3.1)	21.45 (1.41)
	Control	12.25 (3.31)	16.0 (3.75)
Family Self-Esteem	Shame-Awareness Therapy	4.41 (1.14)	7.0 (0.69)
	Cognitive-Behavioral Therapy	4.3 (1.6)	7.9 (0.64)
	Control	4.15 (1.93)	5.1 (1.99)
Social Self-Esteem	Shame-Awareness Therapy	3.68 (1.04)	5.77 (0.92)
	Cognitive-Behavioral Therapy	3.95 (1.01)	6.1 (0.88)
	Control	3.45 (1.36)	4.25 (1.55)
Academic Self-Esteem	Shame-Awareness Therapy	3.95 (0.78)	6.0 (0.82)
	Cognitive-Behavioral Therapy	3.7 (0.81)	6.2 (0.8)
	Control	3.3 (1.08)	4.95 (1.19)

First, the assumption of normality was tested using the Shapiro-Wilk test to determine the appropriate use of parametric or non-parametric tests. Based on the research hypotheses, the relationships between the variables were then examined. Depending on the measurement level of the variables, suitable statistical tests were chosen to address the research hypotheses.

If the significance level in the Shapiro-Wilk test (indicated as p-value) is greater than 0.05, the data can be assumed to be normally distributed with a high degree of confidence. Otherwise, the data cannot be assumed to be normally distributed. The significance levels for the research variables showed that the distribution of variables is likely normal ($p>0.05$). To examine the impact of shame-awareness therapy and cognitive-behavioral therapy on the body image of girls with gender dysphoria, an analysis of covariance (ANCOVA) was conducted. The results of the Levene's test for homogeneity of variances indicated that the variances of body image scores were homogeneous. There was no significant difference in the regression slopes of the dependent variable (control) between the two groups. In ANCOVA, the residual scores of the dependent variable are analyzed; any difference in the slope of the residual scores indicates that the dependent variable is in an illogical and meaningless state. The analysis of variance for the interaction of the independent variable and the covariate was not significant, indicating that the assumption of homogeneity of regression slopes was met.

Table 2

Results of Analysis of Covariance

Source of Variance	Variables	Sum of Squares	df	Mean Square	F	p-value
Group	General Self-Esteem	40.579	2	20.295	26.34	0.001
	Family Self-Esteem	32.414	2	16.207	29.049	0.001
	Social Self-Esteem	48.854	2	24.427	22.296	0.001
	Academic Self-Esteem	19.351	2	9.676	12.803	0.001
	Body Image	1.423	2	0.711	1.42	0.002

JAYPS Adolescent and Youth Psychological Studies
E-ISSN: 2981-2526

As shown in Table 2, there is a significant difference between the three intervention groups (shame-awareness therapy, cognitive-behavioral therapy, and control) in terms of self-esteem components. There is also a significant difference in body image between the three intervention groups. To compare the effectiveness of shame-awareness therapy and cognitive-behavioral therapy with the control group on body image and between the experimental groups, the Bonferroni post-hoc test was used. The results are presented in Table 3.

Table 3

Results of Bonferroni Test

Dependent Variable	Group (I)	Group (J)	Standard Error	p-value
Body Image	Shame-Awareness Therapy	Cognitive-Behavioral Therapy	0.75962	1
		Control	0.75962	0.000
	Cognitive-Behavioral Therapy	Shame-Awareness Therapy	0.75962	1
		Control	0.75962	0.000
	Control	Shame-Awareness Therapy	0.75962	0.000
		Cognitive-Behavioral Therapy	0.75962	0.000
General Self-Esteem	Shame-Awareness Therapy	Cognitive-Behavioral Therapy	7.59	1
		Control	7.59	0.000
	Cognitive-Behavioral Therapy	Shame-Awareness Therapy	7.59	1
		Control	7.59	0.000
	Control	Shame-Awareness Therapy	7.59	0.000
		Cognitive-Behavioral Therapy	7.59	0.000
Family Self-Esteem	Shame-Awareness Therapy	Cognitive-Behavioral Therapy	0.36	1
		Control	0.36	0.000
	Cognitive-Behavioral Therapy	Shame-Awareness Therapy	0.36	1
		Control	0.36	0.000
	Control	Shame-Awareness Therapy	0.36	0.000
		Cognitive-Behavioral Therapy	0.36	0.000
Social Self-Esteem	Shame-Awareness Therapy	Cognitive-Behavioral Therapy	0.49	0.22
		Control	0.49	0.000
	Cognitive-Behavioral Therapy	Shame-Awareness Therapy	0.49	0.22
		Control	0.49	0.000
	Control	Shame-Awareness Therapy	0.49	0.000
		Cognitive-Behavioral Therapy	0.49	0.000
Academic Self-Esteem	Shame-Awareness Therapy	Cognitive-Behavioral Therapy	0.42	0.742
		Control	0.42	0.000
	Cognitive-Behavioral Therapy	Shame-Awareness Therapy	0.42	0.742
		Control	0.42	0.000
	Control	Shame-Awareness Therapy	0.42	0.000
		Cognitive-Behavioral Therapy	0.42	0.000

The results of the Bonferroni test for comparing the means, as shown in Table 3, indicate that the mean body image in the intervention groups (shame-awareness therapy and cognitive-behavioral therapy) is significantly higher than in the control group. However, the difference between the mean body image in the shame-awareness therapy group and the cognitive-behavioral therapy group was not statistically significant. This means that both interventions led to a reduction in negative body image compared to the control group, but no significant difference was observed between the two experimental groups. The results of the Bonferroni test also show that the mean self-esteem in the intervention groups is significantly higher than in the control group. However, the difference between the mean self-esteem in the shame-awareness therapy group and the cognitive-behavioral therapy group was not statistically significant. This indicates that both interventions increased self-esteem compared to the control group, but no significant difference was observed between the two experimental groups.

4. Discussion and Conclusion

The results of the ANCOVA on the post-test scores, controlling for pre-test scores, indicated a statistically significant difference in the negative body image of individuals with gender dysphoria between the experimental

JAYPS Adolescent and Youth Psychological Studies E-ISSN: 2981-2526

groups (shame-awareness therapy and cognitive-behavioral therapy) and the control group. In other words, both shame-awareness therapy and cognitive-behavioral therapy significantly reduced negative body image compared to the control group. The results of the Bonferroni test for comparing the means showed that the mean body image in the intervention groups was significantly lower than in the control group. However, no significant difference was found between the shame-awareness therapy group and the cognitive-behavioral therapy group, indicating that both interventions were equally effective in reducing negative body image.

There has been no prior research comparing the effectiveness of shame-awareness therapy and cognitive-behavioral therapy in improving the negative body image of individuals with gender dysphoria. However, the effectiveness of these two therapies separately on the mentioned variables aligns with some prior findings (Almurumudhe et al., 2024; Amirkhanloo et al., 2022; Atayi et al., 2018; Entezari et al., 2021; Kiani Rad, 2024; Navidian et al., 2016). This finding can be explained by the fact that individuals with gender dysphoria often feel ashamed, which leads many to avoid appearing in social situations. Participation in a group, sharing thoughts and feelings, and receiving feedback from others help them realize that others do not evaluate and judge them as harshly as they imagine. These individuals often avoid looking at their bodies and engaging in body-checking behaviors, as they feel that their bodies have lost completeness, leading to a fragmented sense of identity. Through meditation, they learn to pay attention to their bodies and eventually accept and show compassion towards their bodies as they are. Another dimension of this therapy involves discussing cognitive concepts related to the body, helping individuals who were dissatisfied with their bodies, had negative beliefs about their self-worth, and avoided looking at their bodies in mirrors due to feelings of shame, anxiety, and fear. Through therapy, they learn to gradually and imaginatively look at their bodies, leading to a positive psychological perception of their bodies over time.

The ANCOVA results on self-esteem scores also revealed a statistically significant difference in self-esteem between the experimental groups (shame-awareness therapy and cognitive-behavioral therapy) and the control group. Both interventions significantly increased self-esteem compared to the control group. However, no significant difference was found between the shame-awareness therapy group and the cognitive-behavioral therapy group, indicating that both interventions were equally effective in increasing self-esteem.

No prior research has compared the effectiveness of shame-awareness therapy and cognitive-behavioral therapy in improving self-esteem in individuals with gender dysphoria. However, the effectiveness of these two therapies separately on the mentioned variables is consistent with some prior findings (Almurumudhe et al., 2024; Atayi et al., 2018). Self-esteem is considered a determinant of human behavior in social environments. It reflects the value individuals place on themselves as a person (Harter, 2009) and is a reflection of others' opinions about the individual, influencing how they handle various issues. The formation of self-esteem occurs over a long period, with positive and negative experiences influencing its increase or decrease. Girls with gender dysphoria experience extensive physical and psychological problems due to the nature of their condition, and the short-term or long-term effects of psychotherapy on self-esteem depend on their past experiences after treatment.

To explain how cognitive-behavioral therapy increases self-esteem, it is important to note that the most influential factors in the development and increase of self-esteem are cognitive components, self-comparison with others, and others' reactions. In this approach, cognitive factors are considered the most significant contributors to self-esteem. The underlying assumption of this approach is that cognitive changes lead to behavioral and emotional changes. Since self-esteem is an emotional and affective evaluation of oneself, this approach, by modifying and changing dysfunctional cognitive components that reduce self-esteem, can lead to emotional and behavioral changes and increase self-esteem.

The equal effectiveness of shame-awareness therapy and cognitive-behavioral therapy in increasing self-esteem can be justified by the fact that self-esteem is a cognitive aspect of human personality, and both therapies share the goal of cognitive change. Cognitive change in cognitive-behavioral therapy is achieved by encouraging individuals to view stress as a challenge rather than a threat and to accept their thoughts without judgment. Individuals are also taught to allow negative thoughts and feelings to remain in their minds and to practice mindfulness skills, using techniques that process information maintaining thought-mood cycles. In contrast, cognitive change in shame-awareness therapy is achieved by teaching individuals to think more rationally and to consciously challenge their negative thoughts.

JAYPS
Adolescent and Youth Psychological Studies
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5. Limitations & Suggestions

This research was conducted on individuals with gender dysphoria in the city of Zahedan, so caution should be exercised in generalizing the results to other populations. Other limitations include the small sample size and the use of self-report questionnaires, which can introduce response bias. It is recommended that this research be conducted on male gender dysphoric individuals and in different age groups, with the results compared across these groups. Since most individuals with gender dysphoria seek counseling services, it is suggested that specialized psychologists in psychological therapies be stationed at these centers to assist in successful treatment. For individuals with body image issues, shame-awareness therapy and cognitive-behavioral therapy should be prioritized as treatment options. Given the strong effectiveness of shame-awareness therapy compared to cognitive-behavioral therapy in cases of anxiety and stress, shame-awareness therapy is recommended. As effective treatment should address all aspects of the individual, using both therapies, if possible and welcomed by the client, can be effective in empowering the individual. Based on the research results, it is suggested that to increase self-esteem, individuals should use shame-awareness therapy and cognitive-behavioral therapy to enhance their self-esteem.

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Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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Authors' Contributions

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