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**An Exploration of Shame in PTSD Treatment and Psychosis.**

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This thesis is submitted in partial fulfilment of the requirements for the degree of  
Doctorate in Clinical Psychology

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## Contents

List of Appendices	7
List of Figures	8
List of Tables	8
List of Abbreviations	9
Acknowledgements	10
Declaration	11
Summary	12
<b>Chapter 1: Literature Review</b>	<b>13</b>
<b>The Efficacy of Post-Traumatic Stress Disorder Treatment Approaches in Relation to Shame: A Systematic Review</b>	
<b>1.1. Abstract</b>	<b>14</b>
<b>1.2. Introduction</b>	<b>15</b>
1.2.1. Defining Shame	16
1.2.2. The Role of Shame in PTSD	17
1.2.3. Models of PTSD and Shame	18
1.2.4. PTSD Treatment	19
1.2.5. Treatments for PTSD with Shame	20
1.2.6. Rationale for a Systematic Review of the Literature	22
<b>1.3. Method</b>	<b>23</b>
1.3.1. Search Strategy for the Identification of Relevant Articles	23
1.3.2. Data Sources	24

1.3.3.	Selection of Research	24
1.3.4.	Systematic Search Results: Study Selection	25
1.3.4.	Data Extraction and Synthesis	27
1.3.5.	Quality Review	27
1.3.6.	Quality Assessment Framework	27
<b>1.4.</b>	<b>Results</b>	<b>29</b>
1.4.1.	Overview of Reviewed Studies	29
1.4.2.	Key Findings	37
1.4.2.1.	Do trauma focused interventions reduce shame as well as PTSD symptoms?	37
1.4.2.2.	Are treatments effective in reducing shame in children with PTSD?	39
1.4.2.3.	What are the key elements in treatment for reducing shame in people with PTSD?	41
1.4.2.4.	Non-Trauma Focused CBT interventions	44
1.4.2.5.	Diagnosis of Comorbidities	45
1.4.2.6.	Do intervention studies help us to further understand the relationship between shame and PTSD?	46
1.4.2.7.	Are people who have higher levels of shame more likely to drop out?	47
<b>1.5.</b>	<b>Discussion</b>	<b>49</b>
1.5.1.	Summary of Key Findings	49
1.5.2.	Critique	50
1.5.3.	Clinical Implications	52

1.5.4.	Limitations of the Present Review	53
1.5.5.	Recommendations for Future Research	54
<b>1.6.</b>	<b>References</b>	<b>55</b>
<b>Chapter 2:</b>	<b>Empirical Paper</b>	<b>66</b>
<b>Shame in Psychosis: An Investigation into the Relationship between Shame, Childhood Trauma, Fears of Compassion, Delusional Beliefs and Auditory Hallucinations.</b>		
<b>2.1.</b>	<b>Abstract</b>	<b>67</b>
<b>2.2.</b>	<b>Introduction</b>	<b>68</b>
2.2.1.	Shame and Psychosis	69
2.2.2.	Childhood Trauma, Shame and Psychosis	71
2.2.3.	Shame and Compassion	73
2.2.4.	Aims and Research Questions	76
2.2.5.	Hypotheses	78
<b>2.3.</b>	<b>Methodology</b>	<b>80</b>
2.3.1.	Design	80
2.3.2	Participants	80
2.3.2.1	Estimation of Required Sample Size	80
2.3.2.2	Participant Description	80
2.3.3.	Measures	81
2.3.3.1.	Demographic Information	81

2.3.3.2.	Childhood Trauma	82
2.3.3.3.	Symptoms of Psychosis	82
2.3.3.4	Shame	83
2.3.3.5.	Fears of Compassion	83
2.2.5.	Procedure	84
2.2.5.1.	Ethics	84
2.2.5.2.	Recruitment	84
<b>2.3.</b>	<b>Results</b>	86
2.3.1.	Childhood Abuse and Neglect	86
2.3.2.	Shame	87
2.3.3.	Symptom of Psychosis	87
2.3.4.	Fear of Compassion	88
<b>2.4.</b>	<b>Analysis</b>	88
<b>2.5.</b>	<b>Discussion</b>	93
2.5.1	Shame in People and Childhood Trauma	93
2.5.2.	Shame and Psychotic Symptoms in People with Psychosis	94
2.5.3.	Does shame mediate the relationship between childhood trauma and symptoms of psychosis?	94
2.5.4.	Fear of Compassion	98
2.5.5.	Fear of Compassion and Childhood Trauma	99
2.5.6.	Fear of Compassion and Shame	100
2.5.7.	Fear of Compassion and Symptoms of Psychosis	100
2.5.8.	Implications	101
2.5.9.	Limitations	103

2.5.10. Conclusions	105
<b>2.6. References</b>	<b>106</b>
<b>Chapter 3: Reflective Paper</b>	<b>118</b>
<b>The Challenges of Conducting Sensitive Research with Vulnerable People Using Quantitative Methodology: A Reflective Account.</b>	
3.1 Abstract	119
3.2. Introduction	120
3.3. Idea development and my relationship with the topic	120
3.4. My choice of methodology	122
3.5. My experiences of conducting the research with clinicians	124
3.6. My experiences of conducting the research with participants	126
3.7. My own personal experiences of conducting the research	128
3.8. Conclusion	130
3.9. References	131

## List of Appendices

Appendix A:	Author Guidelines for the Clinical Psychology Review	132
Appendix B:	Data Extraction Tool	144
Appendix C:	EPHPP: Quality Assessment Tool for Quantitative Studies	146
Appendix D:	Quality Table	150
Appendix E:	Author Guidelines for the Clinical Psychology and Psychotherapy	152
Appendix F:	Demographic information sheet	160
Appendix G:	Childhood Trauma Questionnaire	161
Appendix H:	Psychiatric Symptoms Rating Scale	162
Appendix I:	Experience of Shame Scale	163
Appendix J:	The Other as Shamer Scale	165
Appendix K:	Fears of Compassion Scales	167
Appendix L:	Coventry University Ethics Committee Approval	170
Appendix M:	NHS Research Ethics Committee Approval	171
Appendix N:	Coventry and Warwickshire Partnership NHS Trust Research and Development Team approval	177
Appendix O:	Avon and Wiltshire Partnership NHS Trust Research and Development Team	180
Appendix P:	Worcestershire Health and Care NHS Trust Research and Development Team	184
Appendix Q:	Participant Information Sheet	186
Appendix R:	Consent Form	189
Appendix S:	Debrief Sheet	190
Appendix T:	Author Guidelines for the Reflective Practice	192

## List of Figures

Figure 1:	PRISMA flow diagram outlining the study selection process.	26
Figure 2:	Proposed relationships between childhood trauma, shame and psychotic symptoms.	78
Figure 3:	Path model (with beta coefficients) of the relationships between childhood trauma, external shame, and delusions.	90
Figure 4:	Path model (with beta coefficients) of the relationships between childhood trauma, internal shame, and delusions.	91
Figure 5:	Path model (with beta coefficients) of the relationships between childhood trauma, external shame, and hallucinations.	91
Figure 6:	Path model (with beta coefficients) of the relationships between childhood trauma, internal shame, and hallucinations.	92

## List of Tables

Table 1:	Search Terms Used.	23
Table 2:	Overview of Reviewed Studies.	32
Table 3:	Descriptive Statistics for Sample.	86
Table 4:	Pearson's Correlation Matrix of Variables under Investigation.	88

## List of Abbreviations

CBT	Cognitive Behaviour Therapy
CCT	Child-Centred Therapy
CFT	Compassion Focused Therapy
CPT	Cognitive Processing Therapy
CTT-BW	Cognitive Trauma Therapy for Battered Women
CTQ	Childhood Trauma Questionnaire
DBT	Dialectical Behaviour Therapy
DSM	Diagnostic and Statistical Manual of Mental Disorders
ESS	Experience of Shame Scale
IE	Imagery Exposure
IR	Imagery Rescripting
IPV	Interpersonal violence
OAS	Other as Shamer Scale
PE	Prolonged Exposure
PSYRATS-AH	Psychotic Symptoms Rating Scale – Auditory Hallucinations
PSYRATS-DS	Psychotic Symptoms Rating Scale – Delusions Scale
PTSD	Post Traumatic Stress Disorder
RCT	Randomised Control Trial
TF-CBT	Trauma focused CBT
SAM	Situationally Accessible Memory
VAM	Verbally Accessible Memory
WA	Written Accounts

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## **Declaration**

This thesis is my own work, carried out under the supervision of Dr Imogen Reid and Ian Hume. It has been written for submission as partial fulfilment of the requirements for the Universities of Coventry and Warwick Clinical Psychology Doctorate Programme. This thesis has not been previously submitted for another degree or to any other institution.

Chapter one has been prepared for submission in the Clinical Psychology Review Journal. Chapter two has been prepared for submission in the Clinical Psychology and Psychotherapy. Finally, chapter three has been prepared for submission in Reflective Practice. Authorship of published papers will be shared with supervisors.

## **Summary**

This thesis is an exploration of shame in Post-Traumatic Stress Disorder and Psychosis. It begins with a systematic review considering the effectiveness of psychological treatment for PTSD in reducing shame. The literature search revealed 16 articles which were included in the review. The reviewed literature suggested existing PTSD treatments effectively reduce feelings of shame and PTSD symptoms. No particular treatment or intervention component was indicated to be more effective for reducing shame in PTSD.

The second chapter reports on a quantitative study that explored the relationship between shame, childhood trauma, delusional beliefs, auditory hallucinations and fears of compassion. Self-report questionnaires were completed by 30 people with psychosis. The results showed people who reported childhood trauma also reported higher levels external shame. People who reported more feelings of external shame also reported higher levels of internal shame. There was a relationship between internal shame and delusional beliefs. Fears of compassion were found to correlate with shame and delusional beliefs. Shame was not shown to mediate between childhood trauma and delusional beliefs or auditory hallucinations. The findings are considered in relation to previous research, theoretical models and therapeutic models. Clinical implications and future research are also discussed.

The final paper is a reflective account of the researcher's experiences of conducting sensitive research with a vulnerable client group. Specific consideration is afforded to the impact of the research on clinicians, participants, as well as the researcher. The journey from the idea development through to its completion is deliberated.

**Overall word count = 19,837**

## **Chapter 1: Literature Review**

### **The Efficacy of Post-Traumatic Stress Disorder Treatment Approaches in Relation to Shame: A Systematic Review**

Chapter word count: 8033 (excluding tables, figures and references).

Subheading numbers, figures and tables will be removed prior to submission for publication.

Prepared for submission to

'Clinical Psychology Review'

(See Appendix A for author guidelines).

## **1.1. Abstract**

Individuals with Post Traumatic Stress Disorder (PTSD) often describe experiencing feelings of shame. This review considers the effectiveness of psychological PTSD treatment in reducing shame by systematically reviewing the existing literature. English language articles were identified by searching databases: PsycINFO, PsycArticles, Medline, PILOTS, Scopus, Web of Science and the reference lists of the included studies. Peer-reviewed articles which encompassed an intervention study with shame and PTSD outcome measures were selected. This revealed 16 articles that are included in this review. Data extraction was completed and the quality of the methodology was assessed using the Effective Public Health Practice Project Framework.

The included studies used a variety of populations and included both children and adults. The studies also employed an array of treatment interventions, although the vast majority fall under the umbrella of Trauma Focused Cognitive Behaviour Therapy (N = 14). The reviewed literature suggests PTSD treatments effectively reduce shame and PTSD symptoms. No particular treatment or intervention component was found to be more effective for reducing shame. Future PTSD intervention research would benefit from including an internal and external shame measure routinely, which would widen the research evidence base allowing further detailed comparisons.

*Keywords: PTSD, Shame, intervention, treatment, outcome, review*

## **1.1. Introduction**

The key emotions associated with the diagnosis of Post-Traumatic Stress Disorder (PTSD) were until recently considered to be fear, helplessness and horror in the Diagnostic and Statistical Manual of Mental Disorders (4<sup>th</sup> Ed.; DSM-4; American Psychiatric Association, 2000). However, recent research has shown other additional emotions such as anger, sadness and shame may also play a role in the development and course of PTSD (Grey, Holmes & Brewin, 2001). Consequently the diagnostic criteria has been disputed, resulting in shame, guilt and anger being accepted as primary emotional responses to traumatic events and are now included in the recently updated DSM-5 (American Psychiatric Association, 2013).

Due to the predominant emphasis on the importance of fear in PTSD, therapeutic approaches have on the whole historically been based upon reducing fear, primarily through imaginal exposure (Foa & Meadows, 1997). There is some debate about whether these treatment approaches are suitable for people with PTSD with high amounts of shame (Lee, Scragg & Turner, 2001; Harman & Lee, 2010). As the impact of shame has become more recognised, therapeutic interventions focusing on shame have begun to be developed, for example Compassion Focused Therapy (CFT). Knowing which treatment interventions to offer individuals who have PTSD with high amounts of feelings of shame could be an important clinical decision, but there is currently little guidance available. The aim of this paper is to systematically review the literature base on the effect of PTSD treatments on feelings of shame.

### **1.2.1. Defining Shame**

Shame is a debilitating emotion in which the self is perceived as incompetent and as an object of ridicule, contempt, and/or disgust (Harder & Lewis, 1986). Shame is argued to be an unproductive and incapacitating emotion. It is frequently associated with fears of rejection and abandonment which can motivate us to conceal, avoid or submit (known as safety behaviours, Clark & Wells, 1995). Lee et al. (2001) suggest shame can be a primary emotion experienced at the time of an event (innate hard-wired response) or as a secondary emotion activated through the meaning an individual applies to an event.

There are a number of psychological models of shame. Lewis' (1992, 2000) cognitive-attributional model of self-conscious emotions suggests that shame stems from when people compare themselves to others and perceive their actions or thoughts to have fallen short of internalised cultural standards. From the psychodynamic perspective shame is an internal negative self-object relationship that develops due to a lack of attunement in the parent and child relationship (Morrison, 2011). The Psycho-evolutionary approach (Gilbert, 1997) suggests that shame evolved to keep us safe and protect us from attack from others, as it provokes a submissive response, which could potentially de-escalate a difficult situation. In addition, humans have developed self-consciousness, so we can shame ourselves. When we feel we have failed, been devalued or lost attractiveness, self-criticism and shame tend to be activated.

### 1.2.2: The Role of Shame in PTSD

Previous research suggests that experiencing shame following trauma is significantly related to PTSD symptoms. Sippel and Marshall (2011), using a modified Stroop task, found a correlation between the severity of PTSD symptoms and shame. They found that individuals with higher severity of PTSD exhibited faster colour naming of shame-related words ( $\beta = -.35, p < .05$ ).

Shame has been established as playing a role in PTSD in a variety of populations.

Feiring, Taska and Lewis (2002) in a prospective study showed that shame and attributional style were associated with poorer psychosocial outcomes and higher levels of PTSD symptoms in children who have been sexually abused. This research was continued over a six year period revealing shame specific to the trauma of sexual abuse contributes to subsequent psychopathology (Feiring & Taska, 2005).

They also found that feelings of shame are likely to impede the emotional processing of the traumatic experience, which replicates previous findings (Ehlers & Steil, 1995; Riggs, Dancu, Gershuny, Greenberg & Foa, 1992). Victims of interpersonal violence (IPV) have also been shown to be very vulnerable to feelings of guilt and shame (e.g., Dutton, 1992; Kubany et al., 1996). Street and Arias (2001) have shown that feelings of shame significantly positively correlate with PTSD symptomology in people who have experienced IPV. Furthermore, Beck et al. (2015) showed that shame along with depression correlated with negative post traumatic thoughts about the self (partial  $\eta^2 = .29, p < 0.001$ ) whereas anxiety was not, in people seeking mental health support following IPV.

In a study considering prisoner of war veterans, Leskela, Dieperink, and Thuras (2002) found that shame-proneness was positively correlated with the severity of PTSD symptoms ( $\beta = .54, p < .001$ ) whereas other personality attributes such as guilt-proneness were not. Also, in a study of victims of violent crime and child abuse (Andrews, Brewin, Rose & Kirk, 2000) shame was the only emotion that predicted PTSD symptoms past the one-month diagnostic threshold and beyond six months ( $\beta = .15, p < .01$ ).

### **1.2.3: Models of PTSD and Shame**

There are a variety of models which can help to explain how PTSD develops. The Dual Representational Theory of PTSD (Brewin, Dalgleish, & Joseph, 1996) proposes that there are two levels in memory at which trauma information can be represented: Verbally Accessible Memories (VAMs) and Situationally Accessible Memories (SAMs). They propose that traumatic events need to be processed and a sense of resolution needs to be discovered in order for the event to be integrated. They suggest that both types of memories need to be activated for this to be successful. According to Ehlers and Clark's (2000) cognitive model, PTSD develops if individuals process the trauma in a way that causes them to experience a sense of ongoing current threat. The threat can be external, such as seeing the world as a more dangerous place, leading to fear. Alternatively, the threat can be internal, such as seeing oneself as inferior and socially unattractive. This is suggested to be part of a shame reaction (Harman & Lee, 2010).

Lee, et al. (2001) propose that there are two routes to the development of shame based PTSD: schema congruence and schema incongruence. With schema congruence, they propose shame arises because the meaning of the traumatic event is congruent with underlying 'shame schemas'. This leads to the schemas being reactivated and they become the dominant mode of thinking, which results in high levels of pervasive shame. However, with schema incongruence, shame may arise through the breaking of a positive self-identity (incongruent schemas), and the premorbid adaptive beliefs are replaced with the formation of new maladaptive beliefs.

#### **1.2.4. PTSD Treatment**

There are a number of psychological treatment approaches for PTSD; the majority of studies that consider effectiveness draw from Cognitive Behavioural Therapy (CBT) and are often referred to as Trauma Focused CBT (NICE, 2005). There are two key elements within Trauma Focused CBT which are emphasised in varying degrees: exposure and cognitive restructuring. Treatments may also include elements of psycho-education and anxiety management, although they are not the main focus within Trauma Focused CBT. The current guidelines for children and adults with PTSD (NICE, 2005) recommend that all people with PTSD should be offered a course of Trauma Focused psychological treatment which could be either Trauma Focused CBT or Eye Movement Desensitisation and Reprocessing.

Psychological exposure usually involves asking a person to relive a trauma in their mind. This is achieved by asking a patient to recall in present tense exactly what

happened. This is often audio-recorded so that an individual can listen to it over and over again. Alternatively, a patient may be exposed to cues associated with the traumatic event (for example, graded re-exposure to car travel following a road traffic accident). Exposure to traumatic memories has been shown to result in reduction of fear and avoidance (Watts et al., 2013). It is a behavioural treatment in which the presumed underlying mechanism is the loosening of the association between unconditioned and conditioned stimuli (Foa et al., 1999; Foa, Rothbaum, Riggs, & Murdock, 1991). Cognitive restructuring involves the identifying, challenging and modifying of distorted or maladaptive thinking patterns that an individual holds regarding themselves, the traumatic incident and the world.

Some treatments focus more on exposure (e.g. Foa & Rothbaum, 1998), some on cognitive techniques (e.g. Ehlers, Clark, Hackmann, McManus, & Fennell, 2005), and others use a more balanced combination (e.g. Blanchard et al., 2003). Although research has made use of these distinctions in evaluating therapeutic efficacy, it is acknowledged that there is somewhat of an overlap. For example, cognitive restructuring can involve imaginal exposure, not for habituation, but for initiating images and beliefs about the trauma so that cognitions can be accessed and adapted.

#### **1.2.5. Treatment for PTSD with Shame**

Research evaluating the effectiveness of psychological treatments in PTSD has been primarily assessed by measuring PTSD symptoms to compare pre and post ratings with waiting lists or other treatments. Some researchers have also considered

outcomes in terms of reductions in levels of anxiety and depression. For example, when comparing individual Trauma Focused CBT with treatment as usual or waiting lists, the recent Cochrane review (Bisson, Roberts, Andrew, Cooper & Lewis, 2013) identified and included 29 studies using a depression outcome measure and 18 studies that used an anxiety outcome measure. They concluded that the review indicated that symptoms of anxiety and depression generally improved in-line with improvements in traumatic stress symptoms.

While exposure-based treatments are documented for their efficacy in reducing fear and anxiety in the absence of a realistic threat or danger (Watts, 2013), it is argued that there is no compelling evidence indicating that other emotions such as anger, guilt or shame habituate to exposure alone when they are predominant (Smucker, Grunert & Weis, 2003). Others have suggested that feelings of anger, shame or guilt may even increase through exposure therapy and this could increase the potential of people dropping out of treatment (Kubany & Manke, 1995; Pitman, Altman, Greenwald & Longpre, 1991). On the other hand, cognitive therapies can be expanded to target other emotion states in PTSD such as shame, anger and helplessness. Therefore, it is suggested a combination of behavioural and cognitive intervention may be the most effective approach for people with PTSD with high levels of shame (Lee et al., 2001).

Research has shown that individuals with high levels of shame, guilt and anger improved when given imagery re-scripting and reprocessing therapy whereas as they had previously failed to improve when given prolonged exposure alone

(Grunert, Weis, Smucker & Christianson 2007). Oktedalen, Hoffart and Langkaas (2015) suggest that PTSD treatment should focus on reducing trauma-related guilt and shame in order to reduce PTSD symptoms.

Harmen and Lee (2010) suggest that for treatment of PTSD to be most effective patients might also need to be taught techniques that help them to develop self-reassurance and compassion to help address feelings of shame and the tendency to lean towards self-criticism. CFT is an approach which has been developed to do just this.

#### **1.2.6: Rationale for a Systematic Review of the Literature**

Research into PTSD treatment efficacy has tended to focus on measuring reduction in fear and rated success according to the reduction of PTSD symptoms. To the best of the researcher's knowledge no previous published literature reviews have specifically considered shame as an outcome variable for evaluating the effectiveness of interventions of PTSD. Little is known about how well current treatments address shame despite recent research establishing that shame has a role in the development and maintenance of PTSD. The question, of which PTSD treatments effectively reduce feelings of shame, is important for clinicians when planning and implementing treatment plans. As a result, this review attempts to draw together and critique the available literature.

The aim of this systematic literature review will be to attempt to answer the question: how effectively do current PTSD treatment approaches address the

problem of shame? This will include consideration of the relationship between shame, PTSD symptoms and treatment efficacy. The review will seek to consider whether improvement in the level of shame corresponds with a reduction in PTSD symptoms. This will be discussed in relation to relevant theories and clinical implications will be considered. This review aims to highlight gaps in current research and make recommendations regarding further research in this area.

### 1.3. Method

#### 1.3.1. Search Strategy for the Identification of Relevant Articles

Search terms were selected based upon the question: ‘How effectively do current PTSD treatment approaches address the problem of shame?’. Several different search terms were identified from published research in the field and synonyms were selected for different components of the question (Table 1).

Table 1. Search terms used.

Concept	1. Post-Traumatic Stress Disorder	2. Shame
Search Term	PTSD	Shame
Additional	Post-Traumatic Stress Disorder	
Variations	Posttraumatic Stress Disorder	
	Post Traumatic Stress Disorder	

Note. Terms taken from Concepts 1, and 2 were combined using the Boolean operator “and”.

### **1.3.2. Data Sources**

Initially, both the Cochrane Database of Systematic Reviews and Database of Abstracts of Reviews of Effects were searched to ensure that this review was an original contribution to the literature regarding PTSD and shame. No similar reviews were identified.

Identified search terms were entered into the following key databases: Psychinfo, PsycArticles, Medline, Web of Science and Science Direct. Scopus and Pilots database were also searched. The search was completed on 25<sup>th</sup> March 2015.

These databases were chosen to provide access to journals where the content reflected the psychological nature of the review. To maintain consistency of searches, each database was searched by keyword only. Searches of reference lists of accessed articles were also carried out.

### **1.3.3. Selection of Research**

To assess articles retrieved through database searches for eligibility, inclusion and exclusion criteria were applied.

#### **Inclusion Criteria**

Studies were selected for inclusion based on the following criteria:

- i) Published in a peer-reviewed journal (to ensure quality of the research).
- ii) Study included participants exhibiting a clinically diagnosable level of PTSD symptoms.

- iii) Study included a treatment group
- iv) The dependent variable (shame) was directly measured on at least two time points.

#### Exclusion criteria

Studies were excluded based on the following criteria:

- i) The paper was a review, commentary, book chapter, letter, conference proceeding, discussion piece or a legal paper.
- ii) The study utilised a case study or case-series design.
- iii) The paper was not written in English.

#### **1.3.4. Systematic Search Results: Study Selection**

Through initial searches of databases and journals of interest, 727 articles were identified. Titles and abstracts were screened and non-relevant articles were excluded generating 90 potential articles for inclusion. After duplicates were removed 36 articles remained. Full-text articles were then reviewed against the inclusion and exclusion criteria which revealed 16 articles suitable for inclusion in this review. The reference lists of the eligible articles were then screened, revealing a further 20 potential articles, however further scrutiny of full texts revealed they did not meet the inclusion criteria. Therefore, a total of 16 articles were deemed suitable for inclusion in the present review. The process of study selection followed guidance from the PRISMA Statement. The study selection process is detailed in Figure 1 below.

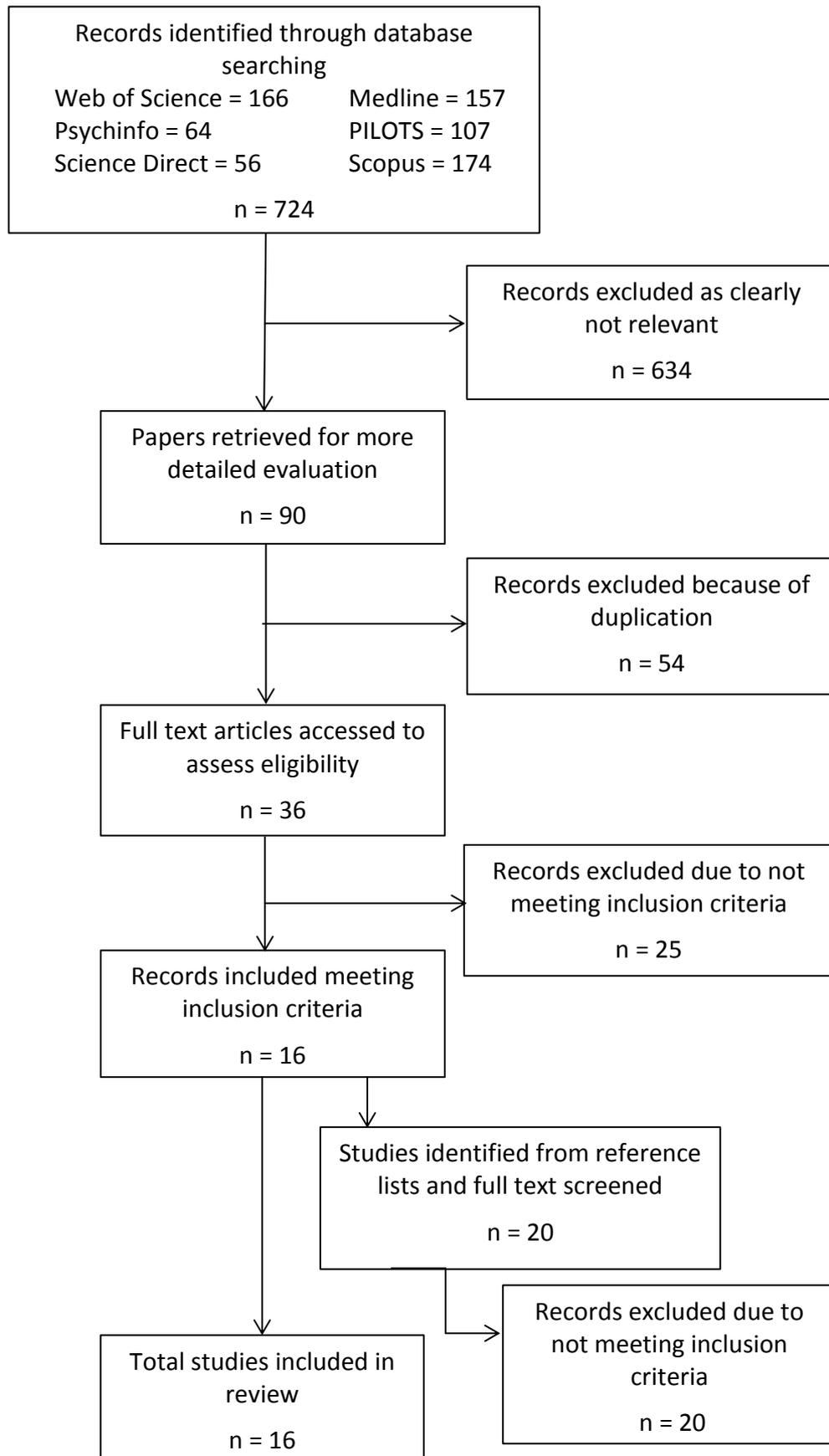


Figure 1: PRISMA flow diagram outlining the study selection process.

#### **1.3.4. Data Extraction and Synthesis**

In order to conduct the review a data extraction form was used to allow the relevant information to be consistently obtained and to assist in the reviewing of predominant themes for synthesis (Appendix B). The form used was based on the PICO framework of Population, Intervention, Comparison, Outcome framework (Joanna Briggs Institute, 2008). The measures used by each research article were also recorded.

#### **1.3.5. Quality Review**

In order to identify potential sources of bias the methodological quality of the research articles was assessed prior to analysis. Although the use of a quality framework is the advocated technique there is currently little consensus on the most reliable or appropriate framework to select. Crowe and Sheppard (2011) emphasise the importance of considering the context of the review being conducted when selecting a framework for assessing research quality. Research articles in the present review were quantitative and mainly utilised an experimental or quasi-experimental design.

#### **1.3.6: Quality Assessment Framework**

After consideration of the type of articles identified in the current review, the Effective Public Health Practice Project (EPHPP) Quality Tool for Quantitative studies (Appendix C) was utilised. The final grade assigned by the EPHPP has been shown to have excellent inter-rater reliability, (intra-class correlation coefficient = 0.77, 95% CI 0.51– 0.90; Armijo-Olivo, Stiles, Hagen, Biondo, & Cummings, 2010)

and construct validity (Thomas, Ciliska, Dobbins, & Miciucci, 2004). The main part of the framework comprises of six domains which are used to assess the quality of a given study: 1) selection bias, 2) study design, 3) control for confounding variables, 4) blinding of investigators and participants, 5) validity and reliability of data collection tools, and 6) the number of withdrawals and drop-outs. The EPHPP provides criteria for each domain and a rating of “strong”, “moderate”, or “weak” is given. There is also a global rating for each study which uses the same categories, whereby it is deemed “strong” if there are no weak ratings; “moderate” if one weak rating; and “weak” if two or more weak ratings are found.

Each of the 16 studies included in this review was assessed using the EPHPP, and ratings for individual and global domains were obtained and are documented in Appendix D (page 149). Studies were not excluded from the review on the basis of their quality ratings, instead the tool is used to provide further information regarding the articles quality when synthesising results. This is particularly relevant for the Arntz, Tiesema and Kindt (2007) study that was rated as weak overall, which despite this has interesting and relevant findings which merit discussion.

## **1.4. Results**

A number of studies in this review presented Hedges *g* effect sizes. Hedges *g* is argued to provide a similar but better estimate than Cohen's *d*, as it corrects for biases due to smaller samples using  $n - 1$  (Grissom & Kim, 2005). Therefore where possible studies that reported Cohen's *d* effect sizes were converted to Hedges *g*. This also allows easier comparison between studies.

### **1.4.1. Overview of Reviewed Studies**

A summary of the design and findings of the 16 studies included in this review are provided in Table 2. As this review focuses on shame in PTSD, and these were the designated search terms, only findings related to this are discussed in detail. In addition, the quality and methodological limitations of the studies will be addressed throughout the review. The feasibility of a meta-analysis was considered. However, a meta-analysis was not carried out as there was not sufficient homogeneity between the studies included in this review in terms of methodological design, clinical populations, interventions and outcome measures. As such, a systematic review was more appropriate

Eleven of the 16 studies applied randomised control designs. Of the eleven, two utilised a waiting list and two used delayed treatment as a comparison group. Furthermore, of these eleven, four compared two different treatments and four used a dismantling design. Of the five remaining studies, one did not use random allocation and compared treatment with a waiting list, three used a single group cohort design and one used a treatment moderator design. There were a number

of studies in this review which were connected to one another. There were two studies which were follow ups of two earlier studies comparing a longer follow up period. One study expanded on another with larger groups, more therapists and a longer follow up period. In addition there was one study which reported preliminary findings which was followed up with a comparison study.

The majority of studies were based on adult populations. However five used child populations. Participants in all studies had experienced a trauma, but the type of trauma varied. Six studies recruited participants with mixed trauma histories, five studies recruited participants with a history of sexual abuse, three recruited participants who had experienced interpersonal violence and one recruited war veterans. However, all studies noted that for a large number of participants in their study there were a number of other traumas in addition to the central reason that they were recruited into the research.

The studies included in this review used a number of different measures of shame and PTSD, which are listed in Table 2. There were a total of seven different measures for shame in the included studies with The Shame Questionnaire (Shame; Feiring, Taska & Lewis, 1999) being the most frequent as it was used in all five of the studies with children. The shame measure that was used most frequently with adults was the Experience of Shame Scale (ESS; Andrews, Qian & Valentine, 2002).

All studies assessed for PTSD, with 15 out of the 16 studies only including participants who met the PTSD diagnosis threshold. One study (Goldsmith et al.,

2014) included three participants (total participants N = 9) who did not meet the PTSD diagnosis criteria, but had a depression diagnosis. Two studies participants also had a diagnosis of borderline personality disorder (Harned, Korslund, Foa, & Linehan, 2012; Harned, Korslund, & Linehan, 2014). The majority of the participants in the articles reviewed were female in 13 out of the 16 studies, with six studies having 100% female participants. The majority of studies were from USA, there were also two studies from Netherlands, one from Norway and one from Zambia.

**Table 2. Overview of Reviewed Studies.**

<b>Author</b>	<b>Population</b>	<b>Design and measures</b>	<b>Findings (in relation to PTSD symptoms and shame)</b>	<b>Quality (EPHPP)</b>
Ragsdale et al. (1996).	Adult war veterans in an inpatient program in Virginia, USA 1) Inpatient Treatment N = 24, (95% male, M=43.3). Waiting list (WL) N = 24	Waitlist control group design with pre and post measures. 26 day inpatient PTSD group treatment including psychoeducation, adventure based activities and psychodrama. PTSD = Mississippi Scale for Combat-Related Post-Traumatic Stress Disorder (M-PTSD) Shame = Internalized Shame Scale (ISS)	Participants PTSD symptoms decreased following treatment but under significance. Participants shame scores decreased following treatment.	Strong
Minnen et al. (2000).	Adults with mixed trauma histories from Netherlands. Group 1 recruited from referrals outpatient clinics (N = 59, M = 34.8, 60% female) Group 2 referrals to an academic section of a CMHT. Both groups treated with prolonged imaginal exposure. (N = 63, M = 36.5, 74% female)	Treatment moderator design. Including pre, post and one month follow up. Individual prolonged imaginal exposure comprising of 9 weekly 90 minute sessions. PTSD = PTSD Symptom Scale Self-Report (PSS-SR) Shame = additional shame related question added to PSS-SR	PTSD symptoms improved for both groups.  No relationship between pre-treatment shame levels and treatment outcome or drop out was found.	Moderate
Kubany et al. (2003).	Adult victims of interpersonal violence recruited from referrals by victim service agencies in Hawaii. 1) Immediate Cognitive Trauma Therapy for Battered Women (CTT-BW) N = 19, 2) Delayed Cognitive Trauma Therapy for Battered Women CTT-BW, N =18. Total mean age= 42.2, 100% female	Randomised control design (RCT), including pre, post and 3 month follow up. CTT-BW – 1.5 hour 8-11 individual sessions PTSD = Clinician-Administered PTSD Scale (CAPS) & Distressing Event Questionnaire (DEQ). Shame = Personal Feelings Questionnaire (PFQ)	Participants PTSD symptoms improved following treatment and not during a waiting period.  Participants shame scores decreased following treatment.	Strong

<b>Author and year</b>	<b>Population</b>	<b>Design and PTSD and shame measure</b>	<b>Findings (in relation to PTSD symptoms and shame)</b>	<b>Quality (EPHPP)</b>
Kubany et al. (2004).	Adult victims of interpersonal violence recruited from referrals by victim service agencies in Hawaii. 1) Immediate CTT-BW, N = 63, 2) Delayed CTT-BW, N = 62 Total participants N=125 (M = 42.2, 100% female)	RCT including pre, post and follow up (at 3 and 6 months). CTT-BW – twice weekly 1.5 hour 8-11 individual sessions. PTSD = CAPS & DEQ Shame = PFQ	PTSD symptoms significantly improved following treatment and not during a waiting period. Participants shame scores significantly decreased following treatment. Participants who did not complete CTT-BW were significantly more shame prone than completers.	Strong
Cohen et al. (2004).	Children with sexual abuse histories recruited via referrals for treatment at two sites in Pittsburgh, USA. 1) Trauma-focused cognitive-behavioural therapy (TF-CBT) N = 89 2) Child Centred Therapy (CCT) N = 91 (M = 10.76, 79% female)	RCT including pre and post assessment TF-CBT & CCT 12 weekly individual 90 minute sessions PTSD = Schedule for Affective Disorders and Schizophrenia for school age Children-Present and Life time version (K-SADS) Shame = The Shame questionnaire	Children assigned to TF-CBT, compared to those assigned to child-centred therapy, demonstrated significantly more improvement with regard to PTSD and shame.	Strong
Deblinger et al. (2006)	Children with sexual abuse histories recruited via referrals for treatment at two sites in Pittsburgh, USA. 1) TF-CBT, N =92. 2) CCT, N = 91. M = 10.76, 79% female (Cohen, 2004).	RCT including pre and post and follow up (6 & 12 month) assessment. TF-CBT & CCT 12 weekly individual 90 minute sessions PTSD = K-SADS Shame = Shame	Children in CF-CBT had significantly fewer symptoms of PTSD and less shame than these treated with CCT at 6 & 12 months.	Strong
Arntz et al. (2007).	Adults with mixed traumas recruited from Community Mental Health Centre, Maastricht, Netherlands. 1) Imaginal Exposure (IE) N = 42 (M = 35.41, 69.2% women). 2) Imaginal Exposure with imagery rescripting (IE+IR) N=29 (M = 35.29, 60.7% women). 3) WL, N = 21	Dismantling and wait list control randomized treatment trial, including pre, post, 1 month and 6 month follow up. IE & IE+IR - 10 weekly 90 minute individual therapy sessions PTSD =PSS-SR Shame = additional shame related question added to PSS-SR	Both treatments reduced PTSD symptoms compared to the waiting list. Trend that reduction in shame was stronger in IE+IR compared to IE. More patients dropped out of IE than out of IE+IR	Weak

Author and year	Population	Design and PTSD and shame measure	Findings (in relation to PTSD symptoms and shame)	Quality (EPHPP)
Resick et al. (2008).	Victims of interpersonal violence recruited from referrals from victim agencies, Community Therapists and advertisements in St Louis, USA. 1) Cognitive Processing Therapy (CPT) N=47. 2) Written Accounts (WA) N=50. 3) Cognitive Therapy (CPT-C) N=53. Total participants N = 150 (M = 35.4, 100% female)	RCT using dismantling design, including pre, post & follow up at 6 months. CPT & CPT-C – 12 individual 60 minute sessions twice weekly. WA – 2 sessions of 60 minutes in first week then 120 minute sessions for a total of 7 sessions. PTSD = CAPS & PDS Shame = Experience of shame scale (ESS)	PTSD symptoms significantly improved for all groups. CPT-C reported significantly greater improvement in PTSD than WA during the course of treatment. Feelings of shame significantly improved across all conditions. Scores on CAPS & ESS decreased significantly for ITT and completers and no significant difference between the three groups was found.	Moderate
Ginzburg et al. (2009).	Adults with childhood sexual abuse recruited via newspaper advertisements and local community organizations in USA. 1) Trauma-focused Group (TFGT) N = 42 (M = 36.78), 2) Present-focused group (PFGT) N = 43 (M = 37.01), and 3) WL group N = 44 (M = 34.85). 100% female.	RCT -Comparative treatment and waitlist. Including pre, post and 6 month follow up TFGT & PFGT 24 weekly group sessions lasting 90 minutes. PTSD = The Posttraumatic Stress Disorder Checklist–Specific (PCL-S) Shame = Shame Subscale of the Abuse-Related Beliefs Questionnaire (ARBQ)	Significant treatment effect. No significant difference between treatments. Change in shame was a significant mediator of treatment outcome on change in PTSD symptoms	Moderate
Deblinger et al. (2011)	Children with sexual abuse histories recruited via referrals for treatment in Pittsburgh and Stratford, USA. 1) 8 week TF-CBT with Trauma Narrative = 39. 2) 8 week of TF-CBT without TN = 40. 3) 16 week TF-CBT with TN = 44. 4) 16 week TF-CBT without TN = 35. Completers M = 7.7 years, 61% female.	RCT –dismantling design, including pre & post assessment. 16 or 8 weeks of 90 minute individual TF-CBT with or without TN  PTSD = K-SADS Shame = Shame	No difference between inclusion of TN or treatment length on PTSD symptomology or shame.	Strong

Author and year	Population	Design and PTSD and shame measure	Findings (in relation to PTSD symptoms and shame)	Quality (EPHPP)
Mannarino et al. (2012)	Children - Childhood sexual abuse in Pittsburgh, USA 1) 8 week TF-CBT with Trauma Narrative = 27 2) 8 week of TF-CBT without TN = 35 3) 16 week TF-CBT with TN = 29 4) 16 week TF-CBT without TN = 33 (62% female, M = 7.6).	RCT dismantling including pre, post & follow up (6 & 12 month) assessment. 16 or 8 weeks of 90 minute individual TF-CBT with or without TN. PTSD = K-SADS Shame = Shame	Improvement in PTSD and shame sustained regardless of treatment or length.	Strong
Harned et al. (2012).	Adult participants with BPD and mixed trauma histories were recruited via outreach to area treatment providers and advertisements in USA. 1) DBT with DBT Prolonged Exposure (DBT PE) protocol (N = 13, M = 39.4, 100% female).	Open trial design - single group repeated measures including pre, mid, post and 3 month follow up. One year of standard DBT weekly 90 minutes of DBT PE (length of DBT PE based upon clients need). PTSD = PTSD Symptom Scale-Interview (PSS-I). Shame = ESS	Significant reductions in PTSD following treatment.  Significant improvements in shame following treatment.	Strong
Murray et al. (2013)	Children who were orphaned or vulnerable with mixed trauma histories recruited from Catholic Relief Services in Zambia. 1) TF-CBT (N = 58, M = 12.9, 50% female).	Open trial design - single group repeated measures including pre and post. Weekly individual sessions lasting 1–2 hours over an average of 11 weeks (range 8–23). PTSD = The Post-Traumatic Stress Disorder-Reaction Index (PTSD-RI). Shame = Shame	Significant reductions in PTSD following treatment.  Significant improvements in shame following treatment.	Moderate
Harned et al. (2014).	Adult participants were recruited via outreach to treatment providers and advertisements in USA. 1) DBT (N = 9). 2) DBT with DBT Prolonged Exposure (DBT PE) (N = 17). M = 32.6, 100% female.	RCT including pre, mid (every four months), post, and 3 month follow up. DBT = standard DBT. DBT PE = One year of standard DBT weekly 90 minutes of DBT PE (length of DBT PE based upon clients need). PTSD = PTSD Symptom Scale-Interview (PSS-I) Shame = ESS	DBT with PE led to larger and more stable improvements in PTSD compared to DBT alone.  DBT with DBT PE led to moderate to large effect sizes for shame which was favourable over DBT alone.	Moderate

Author and year	Population	Design and PTSD and shame measure	Findings (in relation to PTSD symptoms and shame)	Quality (EPHPP)
Goldsmith et al. (2014).	Adults with a mixed trauma history recruited via advertisements in USA 1) Mindfulness based stress reduction N = 10 (M = 44, 90% female).	Treatment group cohort design. Eight sessions of group mindfulness-based stress reduction. Including pre, mid and post. PTSD = Posttraumatic Stress Disorder Checklist. Shame = The Trauma Appraisal Questionnaire (TAQ).	Shame and PTSD symptoms significantly reduced following treatment.	Moderate
Oktedalen et al. (2015).	Adults with mixed trauma histories were referred for inpatient treatment in an anxiety unit located in Norway. 1) Imagery Exposure (IE) (N = 32, M= 46.32, 48% men) 2) Imagery Rescripting (IR) (N = 33, M = 44.15, 62% men).	RCT - comparative treatment design. Pre & Post measurement. Weekly self-rating for PTSD and shame. IE and IR - 10 individual treatment sessions over a 12 week period. PTSD = PTSD Symptom Scale-Interview (PSS-I) & Self-Rating (PSS-SR) Shame = Short-form trauma related shame.	Participants with higher levels of shame at the start of treatment had higher levels of PTSD symptoms over the course of treatment. Within-person change in shame predicted changes in PTSD symptoms from session to session during treatment. No significant difference between treatment types.	Strong

**PTSD Measures:** CAPS = Clinician-Administered PTSD Scale, DEQ = Distressing Event Questionnaire, M-PTSD = Mississippi Scale for Combat-Related Post-Traumatic Stress Disorder, PDS = Posttraumatic Diagnostic Scale, PCL = Posttraumatic Stress Disorder Checklist, PSS-SR = PTSD Symptom Scale Self-Report, PSS-I = PTSD Symptom Scale-Interview, K-SADS = Schedule for Affective Disorders and Schizophrenia for school age Children-Present and Life time version, PCL-S = The Posttraumatic Stress Disorder Checklist-Specific, PTSD-RI = The Post-Traumatic Stress Disorder-Reaction Index). **Shame Measures:** ESS = Experience of Shame Scale, ISS = Internalized Shame Scale, PFQ = Personal Feelings Questionnaire, ARBQ = Shame Subscale of the Abuse-Related Beliefs Questionnaire, Shame = The Shame Questionnaire, TAQ = The Trauma Appraisal Questionnaire. **Interventions:** CTT-BW = Cognitive Trauma Therapy for Battered Women, TF-CBT = Trauma-focused cognitive-behavioural therapy, CCT = Child Centred Therapy, IE = Imaginal Exposure, IR = Imagery Rescripting, WL = Waiting List, CPT = Cognitive Processing Therapy, WA = Written Accounts, CPT-C = Cognitive Therapy, TFGT = Trauma-focused Group, PFGT = Present-focused group, TN = Trauma Narrative, DBT = Dialectical Behaviour Therapy, DBT PE = DBT Prolonged Exposure. **Abbreviations:** CMHT = Community Mental Health Team, BPD = Borderline Personality Disorder, PTSD = Post traumatic stress disorder.

## **1.4.2. Key Findings**

### **1.4.2.1. Do trauma focused interventions reduce shame as well as PTSD symptoms?**

The studies included in this review showed that trauma focused interventions can effectively reduce feelings of shame as well as symptoms of post-traumatic stress disorder. This was demonstrated in the five studies included in this review which compared treatment with either delayed or waiting list control groups. Kubany, Hill and Owens (2003) conducted a randomised control trial (RCT) comparing Cognitive Trauma Therapy for Battered Women (CTT-BW) with delayed CTT-BW which revealed shame (as measured on the Personal Feelings Questionnaire) significantly decreased after treatment but not in the two pre-therapy time points in the delayed group. The effect size for this analysis ( $g = 2.3$ ) was large and exceeds Cohen's (1988) convention for the less conservative ( $d = .80$ ) large effect size. This was also shown to be the case for PTSD symptoms, with a significant reduction on the clinician rated and the self-report measures following treatment. This was also reported to have a large effect ( $g = 2.6$  and  $g = 3.4$  respectively).

This study was somewhat limited by the small sample size and lack of follow up data. However, this was rectified when the study was replicated and extended by Kubany et al. (2004). In this second study, the significant findings were duplicated and large effect sizes were also demonstrated (Shame:  $g = 1.9$ , Clinician rated PTSD:  $g = 2.4$  Self report PTSD:  $g = 2.4$ ). Furthermore the gains were also shown to be maintained at three and six month follow ups. When evaluating these studies

consideration needs to be placed on the possible impact of the inclusion criteria, as it states that women had to report at least moderate abuse-related guilt to be eligible to participate. Therefore the results indicate that CTT-BW is efficacious with battered women who experience guilt. However, it is not known whether the approach may or may not apply equally well with women who have minimal or no abuse-related guilt. It is possible that the same could be said in relation to shame as although guilt is a separate construct to shame there is some degree of overlap.

Ginzberg et al., (2009) compared a Trauma Focused Group Treatment, with a Present Focused Group Treatment and a waiting list group for people with PTSD who had experienced childhood sexual abuse and were at risk of HIV. Their study showed a significant reduction in shame ( $t(163) = 3.29, p < 0.01$  measured on the Shame Subscale of the Abuse-Related Beliefs Questionnaire) following both treatment groups, but not for people who were waiting for treatment. The significant limitation of this study is the large number of people that were assessed for eligibility but were then excluded from the study ( $n = 282$ ). This was partly because of the stringent detailed inclusion/exclusion criteria that led 133 to be excluded; however a further 128 were also excluded for not completing the baseline assessment. It is possible that this large figure could signify a selection bias. Also the population in this study is particularly specific and it could be questioned if the findings would be generalizable to other populations.

Ragsdale, Cox, Finn and Eisler (1996) also demonstrated a significant reduction in shame following PTSD inpatient treatment, consisting of adventure based activities,

psychodrama and psycho-education for war veterans but not for those on a waiting list for treatment. Although improvements in PTSD were observed following treatment this was just below a significant change, but calculation of the effect size revealed a small effect ( $g = 0.357$ ). However, there are a number of limitations with this research. There were no follow-up measures so it is unknown whether the reduction of shame was maintained after the person had returned to the community. It is possible that the reduction in shame was created by the supportive group environment but this might not have been representative of a lasting change. Furthermore, only 75% of people in the waiting list group returned outcome measures so it is possible this might have biased the findings.

Arntz et al. (2007) conducted a randomized control design study in which part of their analysis compared treatment (imaginal exposure with and without imagery re-scripting combined) with waiting. This showed that treatment was significantly more effective at reducing PTSD symptoms than waiting. Waiting produced no sizeable effect ( $g = .043$ ) whereas the treatment condition there was a large effect ( $g = .94$ ). Unfortunately, the authors did not report findings for comparisons between treatment and waiting for shame.

#### **1.4.2.2. Are treatments effective in reducing shame in children with PTSD?**

There were five studies included in this review that considered treatment for children. Cohen, Deblinger, Mannarino and Steer (2004) recruited children with a history of sexual abuse with PTSD and assigned them to either TF-CBT or Child-

Centred Therapy (CCT). They found that children who received TF-CBT significantly improved more than those who received CCT for PTSD as measured on the re-experiencing, avoidance and hypervigilance scales of the Kiddie-Sads-Present and Lifetime Version (K-SADS-PL; Kaufman et al., 1996) and shame as measured on The Shame Questionnaire (Shame; Feiring, Taska & Lewis, 1999). The effect sizes were small for all of the above measures apart from avoidance ( $d = 0.70$ ) which was medium (Cohen, 1992). Deblinger, Mannarino, Cohen and Steer (2006) followed up the participants and re-administered the outcome measures at six and twelve months and showed that the treatment gains had been maintained. Additionally Deblinger, Mannarino, Cohen, Runyon and Steer (2011) also showed children with PTSD with a history of sexual abuse, completing either TF-CBT with or without Trauma Narrative significantly improved in relation to their levels of shame and PTSD symptoms. They did not find a significant difference when comparing the treatments and there were comparable large effect sizes. Mannarino, Cohen, Deblinger, Runyon and Steer (2012) continued this study by re-administering outcome measures at six and twelve months and found that the treatment gains had been maintained.

Finally, Murray et al. (2013) conducted a study to assess the feasibility of offering children in Zambia who had been orphaned or were vulnerable TF-CBT. Local counsellors were trained in TF-CBT and offered weekly individual sessions to children who had experienced at least one trauma in their lifetime and met diagnostic criteria for PTSD. Children completed outcome measures prior to and after treatment which showed reductions in shame as measured on the Shame

Measure and PTSD as measured by self-report on the Post-Traumatic Stress Disorder-Reaction Index. However, the study suffered from a number of limitations. Firstly, there was not a control or comparison group used and secondly, it is likely there was a selection bias. Participants were recruited in an unsystematic manner. Furthermore despite an initial 202 cases meeting inclusion criteria and being offered treatment, only 58 went on to fully complete the treatment and complete the measures to be included in the study. Consequently this study was scored as being weak on this component of the EPHPP tool but this study's overall quality score was rated as moderate.

#### **1.4.2.3. What are the key elements in treatment for reducing shame in people with PTSD?**

Treatment length varied across the studies ranging from 8 to 52 weeks. However, the majority (11 out of 16 studies) had between 8 and 12 sessions. In 11 of the studies treatment was provided in an individual format, three studies used group treatments and two studies included both individual and group.

The studies included in this review utilised a range of psychological treatments, with a total of seventeen different names. Fourteen of the 16 studies included could be considered to fall under the umbrella of Trauma Focused CBT and as expected there appear to be four elements in the majority of treatments: exposure; cognitive restructuring; psycho-education; and anxiety management which are emphasised to varying degrees in each treatment programme.

Some of the studies in the review used a dismantling design in order to consider what the essential ingredients of treatment might be. Resick et al. (2008) conducted an RCT with female victims of interpersonal violence and compared full Cognitive Processing Therapy (CPT) with its constituent parts: Written Accounts (WA) and Cognitive Therapy. They found that participants' PTSD symptoms significantly improved for all treatments with comparable large effect sizes. However, the authors also found that participants receiving cognitive therapy reported significantly greater improvement in PTSD than WA condition during the course of treatment. They found that shame significantly improved across both components as well as the full treatment protocol. Interestingly there appears to be a similar pattern for shame as for PTSD, in that there was a medium effect on the improvement of shame scores following cognitive therapy ( $g = .697$ ) but a small effect following treatment with WA ( $g = .344$ ). However, at six months post treatment both produced comparable medium effect sizes (cognitive therapy:  $g = .649$ ; WA:  $g = 0.792$ ). These findings draw into question whether high levels of fear activation and emotional processing which are found in exposure treatments are necessarily needed for symptom reduction, suggesting that cognitive approaches might offer a more direct and palatable route to symptom improvement.

Oktedalen et al. (2015) conducted an RCT comparing Imagery Exposure with Imagery Rescripting in people with PTSD with mixed trauma histories. Similarly to Resick et al. (2008), they did not find any significant difference between the two treatment conditions (Imagery Exposure, IE or Imagery Re-scripting, IR) in reducing PTSD or feelings of shame. Comparably large effect sizes for each treatment

condition were also found (PTSD: IE,  $g = 1.021$ , IR,  $g = 1.388$ ; Shame: IE,  $g = 0.807$ , IR,  $g = 0.944$ ). Deblinger et al. (2011) also used a dismantling design comparing treatment length (8 or 16 weeks) and TF-CBT with and without Trauma Narrative showing children's levels of shame and PTSD symptoms improved in all four conditions with moderate to large effect sizes. Longer length of treatment was associated with a decrease in the number of avoidance and re-experiencing symptoms of PTSD symptoms. Manarino et al. (2012) found the same effects at 6 and 12 month follow ups.

Arntz et al. (2007) compared imaginal exposure with and without imagery re-scripting in people with mixed trauma histories. They found a trend for a stronger reduction ( $p = .066$ ) in shame in imaginal exposure with re-scripting compared to imaginal exposure alone at post-test, although there was a medium effect size ( $d = .55$ ). At follow-up the same comparison was significant ( $p = .037$ ) with a medium effect size ( $d = .64$ ). Although this finding needs to be interpreted with caution as this study used a non-validated measure of shame.

The studies included in this review appear to show that improvement to feelings of shame could equally occur in either exposure or cognitive restructuring. When differences were found they appeared to be small but show favour to the cognitive element of treatment. However, there are a number of methodological concerns in relation to the dismantling designs used. It is questionable whether it is truly possible to separate out the treatment parts as there is often an overlap between them. For example Oktedalen et al. (2015) suggest that the verbal processing

following imagery which was used in both treatment conditions in their study may have been the important factor in facilitating the processing of shame and guilt. Moreover, in order to make each part comparable in length and a treatment in their own right, the studies used altered extended versions of component parts, therefore making them different than they would appear in the standard treatment protocol.

#### **1.4.2.4. Non Trauma Focused CBT Interventions**

Some studies included in the review used alternative treatment methods: including the previously discussed study by Ragsdale et al. (1996) which utilised adventure based activities & psychodrama treatment; and mindfulness (Goldsmith, et al., 2014). Goldsmith et al. (2014) treated nine participants with mixed trauma histories with eight sessions of group mindfulness treatment. They compared pre, mid and post outcome assessment measures and found that participants shame and PTSD scores reduced significantly following treatment. The effect size of this improvement was medium at post treatment for PTSD ( $g = .74$ ) and shame ( $g = .70$ ). This is the only study included in this review that uses a treatment based on mindfulness probably because research on mindfulness in PTSD is presently in its infancy. The study's findings are somewhat limited due to its particularly small sample size and in addition three of the participants did not have a diagnosis of PTSD.

#### **1.4.2.5. Diagnosis of Comorbidities**

Although there were a number of the studies in the review where participants had secondary comorbidities, there were two studies where PTSD was the secondary diagnosis.

Harned et al.'s (2012) study was a trial to pilot whether a prolonged exposure protocol could be successfully added to Dialectical Behaviour Therapy (DBT) for people with Borderline Personality Disorder with PTSD. Prolonged exposure was implemented in the treatment after each participant had reached a degree of stability and had abstained from suicidal and self-injurious behaviours for at least two months. This revealed that the seven participants who completed the DBT with prolonged exposure (DBT PE) treatment programme significantly improved in relation to PTSD symptoms and shame ratings. At post treatment and 3 month follow-up effect sizes were large for both PTSD ( $g = 2.05 - 2.14$ ) and shame ( $g = 1.24 - 1.03$ ). Harned et al. (2014) then conducted an RCT to compare DBT PE with the standard treatment (DBT). The results revealed that DBT with PE led to larger and more stable improvements in PTSD ( $g = 2.9 - 1.6$ ) compared to DBT alone ( $g = 1.5 - 0.90$ ). DBT with PE also led to large effect sizes for shame ( $g = 3.9 - 2.0$ ) which was favourable over DBT alone ( $g = 0.8 - 1.00$ ). Unfortunately however this study has a low sample size which was compromised further by a high dropout rate 55.6%, in the DBT group and 58.8% in the DBT with PE group.

#### **1.4.2.6. Do intervention studies help us to further understand the relationship between shame and PTSD?**

Ginzberg et al.'s (2009) study suggests that a change in shame over the course of treatment mediates change in PTSD symptoms, as multiple linear regression analysis revealed that both the main effect and the interaction of shame slope by treatment condition were significant ( $\beta = 0.53$ ,  $F(3,165) = 11.25$ ;  $p < 0.001$ ). The authors suggest that about a third of the decrease in PTSD is due to the mediation effect of change in shame. They also found that the effect of treatment on shame and PTSD attenuates over time suggesting that if shame increased over time it did not necessarily increase PTSD symptoms, whereas in the waiting-list group if shame increased for a given participant, PTSD symptoms generally increased. However although this study establishes that there is a relationship, the finding is limited as it does not ascertain the cause. It is not possible to say whether the changes in shame caused the reduction of PTSD symptoms.

Oktedalen et al.'s (2015) study is therefore particularly interesting. Firstly, they found that patients with higher levels of shame at the start of treatment had higher levels of PTSD symptoms over the course of therapy. Although this was significant ( $p < .001$ ), the coefficient was small ( $B = .014$ ). Secondly, they found that if a participant's shame increased, relative to what was typical or expected for that individual, then this predicted higher symptoms of PTSD three days later. This finding had small unstandardised B coefficients ( $B = .005$ ), but was reported to be significant and was suggested to explain about 12% of the outcome variance. They found that the alternative reverse causal pathway, in which PTSD symptoms would

influence shame, was not supported by their findings. Therefore showing that within-person change in shame predicts changes in PTSD symptoms from session to session during treatment.

#### **1.4.2.7. Are people who have higher levels of shame more likely to drop out?**

The drop-out rates varied considerably ranging from 0% to 52% with a mean of 24%. The two studies with the highest dropout rate were Arntz et al. (2007) with their IE + IR group which had a 52% drop out and Harned et al. (2014) with their DBT group with a 41.2% drop out and their DBT PE group with a 44.4% drop out rate.

One study, Minnen, Arntz and Keijsers (2000), considered the characteristics of participants with PTSD with mixed trauma histories prior to prolonged exposure treatment and assessed their impact on treatment outcome and drop out. This revealed no relationship for shame, showing that levels of shame prior to treatment did not significantly impact how effective the treatment was or whether a participant might drop out of treatment. This finding is of interest as it contradicts theories which suggest that prolonged exposure therapy is not suitable for all trauma victims as they found no empirical reason for excluding participants from treatment based on pre-treatment characteristics such as shame. However, this finding should be interpreted with some degree of caution as they did not use a specific tool for measuring shame and instead measured shame by asking two

shame related questions which is not a technique which could be considered reliable or valid. Although Ginzberg et al. (2009) also found that participants who dropped out were not significantly different in reported levels of shame at baseline.

However, these studies measure shame at the beginning of treatment and it is not known what shame levels were prior to the participant dropping out. It is a possibility that shame may not have been reducing significantly or might have even been increasing prior to the person dropping out of treatment.

Other studies in this review had contradictory findings. Kubany et al. (2004) found that participants who did not complete CTT-BW were significantly more shame prone than completers, with a medium effect size ( $g = -.548$ ). However, similarly to Ginzberg et al. (2009) and Minnen et al. (2000), Kubany et al. (2004) also used shame baseline measure when making this comparison. Interestingly in the study conducted by Arntz et al. (2007) there was a 51% drop out in Imaginal Exposure (IE) compared to 25% drop out in Imaginal Exposure with Image rescripting (IE+IR), which was a significant difference. This is of particular note as it could be speculated that the cause could be related to their finding that participants in the IE condition had fewer reductions in shame than the IE+IR group.

## **1.5. Discussion**

### **1.5.1. Summary of Key Findings**

The studies included in this review show that trauma focused interventions can effectively reduce feelings of shame as well as symptoms of post-traumatic stress disorder. The positive findings were found in an array of different populations and with a variety of different psychological treatment protocols, although most were types of Trauma Focused CBT. Studies that used dismantling designs appeared to show that improvement to feelings of shame could equally occur in any combination of exposure and / or cognitive restructuring. However, it is questionable whether it is truly possible to separate out the component parts of exposure and cognitive restructuring, as exposure can inadvertently occur in cognitive restructuring and vice versa. Alternatively another process that was not under investigation could have been the essential ingredient that resulted in reduction in shame.

This review also adds to the literature on the role of shame in PTSD. Two studies appeared to show a relationship whereby reductions in shame were correlated with reductions in PTSD symptoms. Oktedalen et al.'s (2015) research gives weight to the argument that reductions in shame lead to reductions in PTSD symptomology.

The studies included in the review showed mixed findings about the relationship between shame and treatment drop out. Some studies showed that high shame rates pre-treatment did not make participants more likely to drop out of treatment.

Whereas others found that those who dropped out had higher levels of shame than those who completed treatment.

### **1.5.2. Critique**

The methodological limitations of the included literature has been considered throughout this review, however there are certain limitations that merit further discussion and attention.

Participants included in this review differed in relation to their demographic characteristics, for example age, gender and ethnicity. Without further exploration of the potential impact of these factors on shame, it is difficult to interpret the impact they may have upon the findings of the studies reviewed. There was a bias in the review towards samples of predominantly female participants. Out of the 16 studies included in this review, 13 had a greater proportion of female to male participants across their treatment and control groups. Furthermore six were based on samples of female participants exclusively. Therefore the findings might need to be considered with caution when relating the findings to males.

The interventions on the whole were broadly similar falling under a Trauma Focused CBT label; however the components parts from within treatments are emphasised to varying degrees. Therefore whilst at times it might appear that two studies have similar findings, it is difficult to know how generalisable any conclusions drawn from the studies might be. A number of studies used

dismantling designs but it was acknowledged by the majority of authors that there might have been flaws in their ability to truly separate out component parts of treatment.

Different studies used different measures to assess levels of shame and PTSD. This makes it difficult to be certain that the same concept was being measured in each study. Furthermore although some measures were clearly reliable and valid, some shame measures had been created for the purpose of the study and had not been formally assessed. In addition within the shame literature, researchers have broken shame down into two further concepts: internal and external shame (Gilbert, 1997). This is something that was not considered within any of the articles included in this review and consequently limits comparison and misses opportunities for advancing understanding of shame in PTSD.

Finally some researchers had selected to use a shame measure as they hoped their intervention would have a favourable effect on shame. These researchers were aware of the importance of shame for their client group and therefore were sensitive to this when designing and delivering the treatment. Therefore caution should be exercised from presuming standard treatment protocols would automatically reduce feelings of shame.

### **1.5.3. Clinical Implications**

The findings of this review highlight that shame in the context of trauma, should be considered in the treatment of PTSD. The evidence appears to suggest that there is a relationship between PTSD and shame, potentially even to the extent that a reduction in shame could lead to a reduction in PTSD symptomology (Oktedalen et al., 2015).

For therapists working with clients with PTSD with high levels of shame it appears treatment which falls under the umbrella of Trauma Focused CBT can be an effective approach. However, this review has not revealed any particular treatment or component part to be more effective than any other. It could be speculated that exposure, cognitive restructuring or any combination of the two might lead to shame being effectively processed in some way. This contradicts expectations as it has been argued that shame will not decrease in exposure treatment as it is unlikely to habituate like fear (Smucker et al., 2003). It is possible that the positive findings were due to something not measured such as the therapist's stance. For example, a therapist offering warmth and acceptance might be a corrective emotional experience for a person who has a high amount of shame.

Whatever the cause of the positive findings, it can be argued that as exposure might not be the preferred treatment choice for someone with high feelings of shame and does not appear to be a necessary component of treatment, cognitive restructuring might offer a more favoured alternative. Treatment choice might also lead to fewer drop outs during therapy. Alternatively a Trauma Focused treatment which focused

on shame (such as CFT) could potentially offer a more powerful and palatable option for patients.

#### **1.5.4. Limitations of the Present Review**

Firstly, a key consideration in the limitation of this review of shame in PTSD intervention studies is the vast differences between the studies included, in terms of the populations of participants and interventions. This limits how generalizable the findings may be for any particular population. However, given the apparent importance of shame in treating PTSD, this systematic literature review offers a synthesis of the available literature which offers a starting point and a place of reference. It is also of note that this review suggests that there is a general consensus between the findings of the studies included, despite their apparent differences.

This review may have a degree of bias due to its design. It is limited by the search terms chosen and the inclusion criteria used. It only included English language articles which may have resulted in the exclusion of relevant research published in other languages. Studies included were all published articles with no grey literature. This potentially creates a bias, as published articles tend to have a larger intervention effect than non-published literature (Hopewell, 2007).

### **1.5.5. Recommendations for Future Research**

Considering the large number of intervention studies in PTSD, generally there are relatively few that have measured shame as an outcome variable. In order for the understanding of shame and PTSD to progress further, future intervention studies could benefit the field by including a shame measure routinely. In particular a measure for both internal and external shame should be used. The importance of shame is increasingly being recognised and is now included in the DSM V criteria for PTSD therefore PTSD treatments need to evolve as our understanding of PTSD increases.

Further research which considers whether people who drop out of treatment were not responding to treatment in terms of their shame levels reducing could also be helpful as existing research has considered shame in relation to pre-treatment characteristics. Treatments specifically targeting shame in PTSD, for example Compassion Focused Therapeutic approaches are emerging and it will be exciting to see new studies comparing them with existing treatments in relation to shame reduction and PTSD symptomology.

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## **Chapter 2: Empirical Paper**

### **Shame in Psychosis: An Investigation into the Relationship between Shame, Childhood Trauma, Fears of Compassion, Delusional Beliefs and Auditory Hallucinations.**

Chapter word count: 8383 (excluding tables, figures and references).

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## **2.1. Abstract**

Shame has been recognised as a component of a range of mental health problems. It has been noted that shame may also play a pivotal role in the formation and maintenance of psychotic symptomology. However, so far these links have not been fully examined. This quantitative study uses a cross-sectional correlational design, in addition to regression and mediation analysis to investigate shame's impact on childhood trauma, delusional beliefs and auditory hallucinations. Furthermore, the relationship of fears of compassion was also considered. Patients with a diagnosis of psychosis (n = 30) completed self-report questionnaires measuring, childhood trauma, internal shame, external shame, fears of compassion, and auditory hallucinations and delusional beliefs.

The results showed positive correlations between childhood trauma and external shame, external shame and internal shame, and internal shame and delusional beliefs. Fears of compassion were found to correlate with shame and delusional beliefs. Shame was not shown to mediate between childhood trauma and delusional beliefs or auditory hallucinations. Shame is a prominent emotion in psychosis which appears to be associated with childhood trauma and symptoms of psychosis, however further research is required to further understand its role in psychosis.

*Keywords: psychosis, shame, childhood trauma, hallucinations, delusions, compassion.*

## 2.2. Introduction

Shame is known to be a powerful damaging self-conscious emotion (Gilbert, 1998; Tangney & Fischer, 1995), which plays a pivotal role in influencing an individual's thoughts, feelings and behaviours (Tracy & Robins, 2004, 2007). Shame is suggested to be related to the experience of the self as inferior: it is considered to be a separate emotion from guilt, which is linked to feelings of remorse (Tangney, 1995; Eisenberg, 2000). Shame has been recognised as a contributory factor in the onset and maintenance of a range of mental health problems including: depression (Thompson & Berenbaum, 2006); post-traumatic stress disorder (Lee, Scragg & Turner, 2001; Wilson, Drozdek & Turkovic 2006); eating disorders (Grabhorn, Stenner, Stangier & Kaufhold, 2006); and addictions (Dearing, Stuewig & Tangney, 2005).

It is becoming increasingly recognised that emotion plays a role in the development and maintenance of psychosis (Birchwood, 2003; Gumley, Gillham, Taylor, & Schwannauer, 2013). For example, Delespaul, deVries, & van Os (2002) reported that negative affect increased before the onset of auditory hallucinations, suggesting that negative affect may play a causal role in the development of auditory hallucinations. Similarly, Smith et al. (2006) found that low mood, low self-esteem and negative schematic beliefs can contribute to the development of symptoms in psychosis. Whilst it has been proposed that shame may play a pivotal role in the formation and maintenance of psychotic symptomology, as yet the

possible links have not been fully tested empirically in a clinical population (Freeman & Garety, 2003).

### **2.2.1. Shame and Psychosis**

Bleuler (1950) wrote that: *“In delusions everything which one wishes and fears may find its level of expression”* (p117). The psychological accounts of the influence of emotion on delusions and hearing voices contain two main types of mechanism: direct and defence.

Direct theories hypothesise that emotion has a direct causal and maintaining role in the development of delusions and hallucinations (e.g. Garety et al., 2001). Voices are said to be representations of real-life relationships, and they are negotiated as such and operate as an “emotional mirror” reflecting back elements of past or present real-world affiliations. The cognitive model suggests that appraisal of dimensions of the voice hearing experience influence emotional and behavioural reactions to voice hearing (Birchwood & Chadwick, 1997). Therefore according to this model, if a voice is appraised to be shaming, then it is likely to influence the emotional experience of shame.

Gilbert et al. (2001) found similarities between malevolent voices and self-attacking thoughts in people with depression and suggested that critical thoughts and voices may represent an internalisation of shame, criticism and rejection from significant others in early life. Such an idea is consistent with Close and Garety's (1998) finding

that 84% of their participants with negative self-evaluations had low self-esteem in their sample of predominantly malevolent voice hearers. This would suggest that both voice content and beliefs about voices may directly reflect underlying emotional themes, rooted in interpersonal schemata.

Birchwood et al. (2004) proposed that appraisals about an individual's own social power and rank are important factors underlying their evaluation of the power of hallucinatory voices, and the associated distress. They reported that voices which are perceived as powerful were also believed to have greater shame content and higher levels of omniscience as measured by the Beliefs about Voices Questionnaire (Chadwick & Birchwood, 1995). Voice hearers who regard themselves to have more affiliation with their voice report fewer self-critical thoughts and experience less external shame (Connor & Birchwood, 2013).

Recent research in relation to delusional beliefs offers further support for the direct hypothesis. Morris, Milner, Trower and Peters (2011) found the "poor me" paranoia group (where the individual believes persecution to be unfair and unjustified), experienced less internal shame compared to the "bad me" paranoia group (where it is believed the persecution is deserved). Matos, Pinto-Gouveia and Gilbert (2013) found that external shame is associated with higher paranoia scores ( $r = 0.61$ ) and internal shame is associated with social anxiety ( $r = 0.57$ ). However, this research was conducted in a general population study so it is difficult to ascertain how these findings would extrapolate to a clinical population.

An alternative hypothesis is that psychotic symptoms of delusions and hallucinations are a defence against negative emotions and self-representations (e.g. Bentall, Kinderman & Kaney., 1994; Lyon, Kaney & Bentall, 1994; Bentall, Corcoran, Howard, Blackwood, & Kinderman, 2001). The 'delusions-as-defence' account proposes that people with persecutory delusions maintain their self-esteem by seeking explanations in the outside world for the negative thoughts and feelings they have. This then results in attributing blame to those around them and the development of paranoia (Kinderman & Bentall, 1997). This prediction has been tested in a number of studies, although to date the evidence remains somewhat inconclusive (Bentall & Kaney, 1989; Fear, Sharp, & Healy, 1994; Kinderman, 1994; Freeman et al., 1998).

### **2.2.2. Childhood Trauma, Shame and Psychosis.**

There is an established link between childhood difficulties, such as trauma and dysfunctional attachment, with psychosis (Read, van Os, Morrison & Ross, 2005). For example, Janssen et al. (2004) conducted a longitudinal prospective study and found that reported childhood abuse was predictive of positive psychotic symptoms in adulthood and is suggestive of a dose–response effect. Varese et al. (2012) conducted a recent meta-analysis and noted that nine of the ten studies which considered the dose-response effect found significant positive associations.

It has been suggested that individuals with psychosis are likely to be particularly vulnerable to shame due to the high frequency of these early developmental risk

factors (Michail & Birchwood, 2013). Lutwark and Ferrari (1997) argued that developmental risk factors predispose individuals to shame in adulthood and increase sensitivity to 'put-downs' by others. They showed that maladaptive attachment and parental over-control and overprotection were correlated with the later development of shame proneness.

It has been suggested that feelings of shame may mediate the relationship between childhood trauma and psychosis symptomology. Matos et al's (2013) general population study utilised a path analysis and demonstrated that childhood shame memories rated on the impact of events scale were associated with higher paranoia scores ( $r = 0.47$ ). Connor and Birchwood's (2012) research revealed parental rejection and emotional abuse to be a predictor of internal and external shame cognitions in people with psychosis. They concluded that the voice/voice-hearer relationship functions as an emotional mirror reflecting elements of traumatic childhood affiliations, and that these affiliations are associated with present-day shame cognitions and depression.

Aherne (2014) replicated Matos et al's (2013) study in a first episode psychosis population. The researcher revealed both internal and external shame associated with psychosis moderated the relationship between childhood trauma and paranoia. Johnson et al. (2014) also considered whether shame might act as a moderator in young people with mental health needs and found that internal shame significantly moderated the relationship between stressful life events and paranoia.

### **2.2.3. Shame and Compassion**

As the experience of shame has become better understood and its importance appreciated, treatment approaches such as Compassion Focused Therapy (CFT) have been developed. CFT is an approach that was designed to help individuals with significant feelings of shame and self-critical thoughts to build the capacity to experience compassion. It is based upon Gilbert's (1998, 2002, 2007) biopsychosocial evolutionary model of affect regulation which comprises of the threat, drive and affiliative/soothing systems.

The model suggests that an experience of shame is a warning signal that one is: not valued positively by others; seen as undesirable; seen with contempt or criticism. It suggests that external shame is activated when we become concerned that others may reject, harm, attack, or marginalise us, which would place us in an unwanted social rank position (Gilbert, 1997, 1998, 2003). Gilbert perceived external shame to be a focus on what others think of us and a related belief that we are seen as unattractive or defective. Gilbert suggests that this triggers defensive strategies in order for us to feel safe, including internal shame which he argues to occur when we identify with the other and engage in self-devaluation and self-blame (Gilbert, 1998, 2003). According to this approach criticism and hostility activate the threat system producing feelings of anger, shame and anxiety, whereas warmth and compassion stimulate the soothing system.

Psychotic episodes expose individuals to a significant amount of threat. For example; threats from voices, fears of relapse, stigma, as well as feelings of loss and shame. There is evidence to suggest people with psychosis have difficulties with threat processing and regulation (Freeman & Garety, 2003). Research has shown that people with psychosis are likely to experience threat in a way that means they are more likely to remember and pay attention to threat related information. This heightened threat sensitivity has been linked to childhood adversity in people with psychosis (Myin-Germeys & Os, 2007). Some children experience conflict between wanting comfort from their parent versus being scared of their parent and so often remain in a state of fear (Liotti, 2010). Furthermore, it is suggested that as the system is constantly stimulated then it becomes more sensitised in later life.

A key aspect of CFT for psychosis involves helping individuals to develop a warm, caring, and attuned attitude towards their difficult inner experiences and self-soothe their emotional distress (Braehler et al, 2013). Connor & Birchwood (2013) suggest access to self-reassuring meta-cognitive capacity may serve as a protective factor for those who hear voices, resulting in more benign voice content.

CFT has been shown to be an effective treatment in a variety of mental health difficulties including anxiety, depression and PTSD. Gilbert and Procter (2006) demonstrated that CFT reduced shame, self-criticism, depression, anxiety, and stress in a chronic day hospital population. Although CFT as treatment approach in psychosis is in its infancy there have been some positive findings (Mayhew & Gilbert, 2008; Braehler et al., 2013; Heriot-Maitland, Vidal, Ball & Irons, 2014).

Mayhew and Gilbert (2008) found that in a small pilot study of three voice hearers, compassionate mind training significantly benefited two individuals, with a third finding it helpful but limited because he felt he did not deserve compassion (possibly due to undisclosed shame-linked fantasies). Braehler et al. (2013) conducted a feasibility randomised control trial of CFT for people with psychosis. They found that relative to treatment as usual, CFT was associated with greater observed clinical improvement ( $p < .001$ ) and significant increases in compassion ( $p = .015$ ). The CFT group also showed significantly more improvement in reductions of depression and in perceived social marginalization.

For some people developing self-compassion is not straightforward, as some individuals' experience avoidance or fear reactions to compassion (Gilbert, 2010). Gilbert (2010) suggested that the capacity for compassion is rooted in and developed from the attachment system. The attachment system is argued to close down if an individual experiences abuse or neglect and its reactivation can reactivate the emotional memories from childhood. The re-experiencing of these difficulties and feelings can underpin fear of compassion and be a major block to recovery, especially for people with high shame and self-criticism (Gilbert, McEwan, Matos, & Rivas, 2011). Lee et al. (2001) suggest for these individuals, compassion is experienced as a self-attack, particularly when compassion-like qualities have been adopted by a perpetrator and therefore avoidance of compassion can become key for self-regulation.

Research has shown links between fears of compassion with depression (Gilbert, McEwan, Catarino, & Baião, 2014), however as far as the author is aware, there has been no research which has considered whether people with psychosis that have experienced trauma and have high feelings of shame, are likely to experience compassion as frightening. Future research will aid understanding in order for therapeutic techniques to be further developed and aid therapists to engage with and help people resolve their fears of and resistance to compassion, which could potentially have important therapeutic effects (Gilbert & Procter, 2006; Laithwaite et al., 2009). Therefore this research will aim to explore these potential links.

#### **2.2.4. Aims and Research Questions**

Shame has been recognised as factor in a range of mental health problems. It has been noted that shame may also play a pivotal role in the formation and maintenance of psychotic symptomology (Freeman & Garety, 2003). However, at the current time these links have not been fully examined. There is a high incidence of childhood trauma in people who have experienced psychosis (Read, et al., 2005). It has been suggested that individuals with psychosis are likely to be particularly vulnerable to shame due to the high frequency of these early developmental risk factors (Michail & Birchwood, 2013). There is emerging evidence to suggest that feelings of shame may mediate the relationship between childhood trauma and psychosis symptomology (Matos, et al., 2013; Aherne, 2014; Connor & Birchwood, 2012). The present study will seek to explore the relationship of shame further in a clinical sample of people with psychosis, considering delusional beliefs and auditory

hallucinations, internal and external shame as well as childhood trauma (see Figure 2).

CFT is a treatment with an increasing evidence base which is particularly helpful for people who have difficulties with feelings of shame. It is based on the theory that criticism and hostility activate the threat system producing feelings of anger, shame and anxiety, whereas warmth and compassion stimulate the soothing system (Gilbert, 2010). Connor & Birchwood's (2012) study showed that a lack of capacity to self-reassure following self-critical thoughts tend to lead to greater shaming thematic voice content. Gilbert (2010) suggests that capacity for compassion is developed by the attachment system. Developing self-compassion is not always straightforward, as for some individuals experiencing compassion leads to avoidance or fear reactions. Lee et al. (2001) suggest for these individual's compassion is experienced as a self-attack and therefore avoidance of compassion can become key for self-regulation. The present study will consider the relationship between childhood trauma and fear of compassion in people with psychosis. It will look at the relationship between shame and fear of compassion in a psychosis population. Furthermore the study will attempt to see whether fear of compassion leads to greater distress from voice hearing or delusional beliefs.

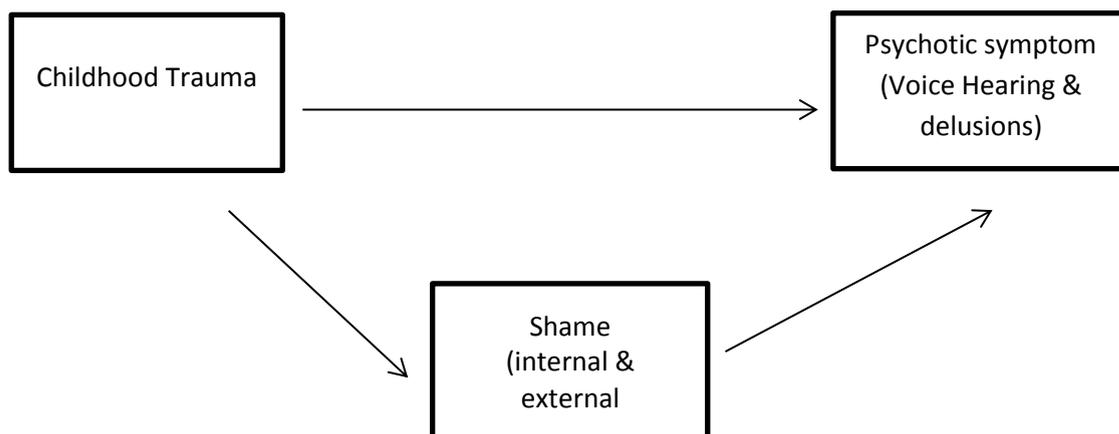


Figure 2: Proposed relationships between childhood trauma, shame and psychotic symptoms

### 2.2.5. Hypotheses

The current study hypothesises that within a group of individuals with psychosis:

1. There will be a positive correlation between experience of childhood trauma and shame (internal and external).
2. There will be a positive correlation between shame (internal and external) and psychotic symptoms (hearing voices and delusional beliefs).
3. There will be a positive correlation between childhood trauma and psychotic symptoms (hearing voices and delusional beliefs).
4. Shame will have a mediating role between childhood trauma experiences and psychotic experiences ( hearing voices and delusions)
5. There will be a positive correlation between experience of childhood trauma and fear of compassion

6. There will be a positive correlation between shame (both internal and external) and fear of compassion.
7. There will be a positive relationship between psychotic symptoms (delusional beliefs and hearing voices) and fear of compassion.

The above hypotheses are based upon the literature discussed in the introduction.

Research has found a high incidence of childhood trauma in psychosis and is thought to be related to the development of shame (e.g. Michail & Birchwood, 2013); therefore a positive relationship is predicted in hypothesis 1. Positive symptoms are suggested to act like an emotional mirror (e.g. Connor & Birchwood, 2012) consequently a positive correlation is predicted in hypothesis 2. A positive correlation is predicted in hypothesis 3 as previous research suggests a dose response relationship between childhood trauma and psychotic symptoms (Varese et al, 2012). In hypothesis 4, it is suggested shame will have a mediating role between childhood trauma and symptoms of psychosis, based upon the general population study (Matos et al. 2013), first episode psychosis study (Aherne, 2014) and the findings of Connor and Birchwood (2012) and Johnson et al. (2014).

Mediation was hypothesised as opposed to moderation as according to Baron & Kenny (1982) mediator analysis can best explain how external physical events take on internal psychological significance. Hypothesis 5 is based upon the assumption that people with psychosis who have high feelings of shame will be frightened of compassion due to the impact of childhood trauma on attachment relationships. Hypothesis 6 is put forward as it is believed that someone who has high amounts of shame will have difficulty using the soothing system due to fear of compassion.

Hypothesis 7 is two tailed as there is no previous research that the researcher is aware of that has considered the relationship between these variables.

## **2.3. Methodology**

### **2.3.1. Design**

The present study used a correlational design to investigate the associations between shame, childhood trauma, fears of compassion, hearing voices and delusions.

### **2.3.2 Participants**

#### **2.3.2.1 Estimation of Required Sample Size**

To calculate the sample size required in order to conduct a path analysis, an ideal number of participants to parameters ratio would be 20:1. However, a more realistic and adequate ratio would be 10:1 (Kline, 2011). In the proposed research the path models has 3 parameters (see Figure 2). Therefore in order to conduct a path analysis, the proposed research requires an optimum sample of 60 participants, and a minimum sample of 30 participants.

#### **2.3.2.2 Participant Description**

A purposive method of sampling was employed and a total of thirty participants were recruited from NHS services across three NHS sites: Worcestershire Health

and Care NHS Trust; Coventry and Warwickshire Partnership NHS Trust; and Avon and Wiltshire Partnership NHS Trust. All participants had received a diagnosis under the psychosis umbrella and had experienced symptoms within the past year. Fifteen had a diagnosis of schizophrenia, 11 had a diagnosis of psychosis, two of schizoaffective disorder, two of psychotic depression and one had a diagnosis of bipolar mood disorder. Period of time from the onset of symptoms varied ranging from 5 months to 32 years ( $M = 10.02$ ,  $SD 9.88$ ). Participants were all over 18 years old and ages ranged from 18 - 59 ( $M = 33.6$ ,  $SD 12.4$ ). The vast majority of participants were male ( $N = 26$ ; 86%) and only four were female. The predominant ethnicity was "White British" ( $N = 27$ ; 86%), with one participant describing themselves as "Mixed", one as "White Other" and one as "Black Caribbean".

Recruitment took place over a six month period. Due to the sampling technique it is not possible to give exact numbers of participants who were asked if they would like to take part but decided not to, however subjectively it appeared about half declined to take part. Only one participant withdrew after agreeing to take part.

### **2.3.3. Measures**

#### **2.3.3.1. Demographic Information**

Demographic and clinical information including: age, gender, ethnicity, diagnosis and length of illness were collected (see Appendix F).

#### 2.3.3.2. Childhood Trauma

*The Childhood Trauma Questionnaire (short form)* (CTQ; Bernstein & Fink, 1998; see Appendix G) is a standardized, retrospective 25 item self-report inventory that measures the severity of different types of childhood trauma, producing five clinical subscales: Emotional Abuse, Physical Abuse, Sexual Abuse, Emotional Neglect, Physical Neglect. Participants respond to each item in the context of “when I was growing up” and answering according to a five-point likert scale ranging from “never” = 1 to “very often” = 5, producing scores of 5 to 25 for each trauma subscale. A score of 8+ is representative of evidence of abuse/neglect (Bernstein & Fink, 1998). Research has shown it has high internal consistency with a Cronbach's alpha ranging from .81 to .95 (Bernstein et al., 2003).

#### 2.3.3.3. Symptoms of Psychosis

*Psychiatric Symptoms Rating Scale* (PSYRATS; Haddock et al. 1999; see Appendix H) is a clinician rated measure and comprises of two scales; auditory hallucinations (AH) and delusions sub-scale (DS). The AH assesses: frequency, duration, location, loudness, beliefs about the origin of voices, amount of negative content, degree of negative content, amount of distress, intensity of distress, disruption to life caused by voices and controllability of voices. The DS assesses; amount and duration of preoccupation with delusions, conviction, amount of distress, intensity of distress and disruption to life caused by beliefs. Items are rated on a (0–4) scale. PSYRATS

has good inter-rater reliability (Ranging from 0.79 – 1.0) and validity (Haddock et al, 1999).

#### 2.3.3.4 Shame

*Experience of Shame Scale* (ESS; Andrews et al., 2002; see Appendix I) is a self-report measure consisting of 25 items which measures: characterological shame, behaviour shame and body shame. Items are rated on a (0-4) scale indicating how frequently the participant has experienced, thought about and avoided any of the three areas of shame in the past year. The scale has high internal consistency (Cronbach's  $\alpha = .92$ ) with good test-retest reliability over 11 weeks ( $r = .83$ ) (Andrews et al., 2002).

*The Other as Shamer Scale* (OAS; Allan, et al., 1994; Goss, Gilbert, & Allan, 1994 adapted from Cook's, 1993 Internalized Shame Scale; see Appendix J). The scale consists of 18 items rated on a five-point scale according to the frequency of evaluations about how one thinks others judge the self (external shame). Research has shown it has high internal consistency with a Cronbach's alpha of .92.

#### 2.3.3.5. Fears of Compassion

*Fears of Compassion Scales* (Gilbert, McEwan, Matos, & Ravis, 2011; see Appendix K). This scale consists of three domains measuring fear of compassion for self (15 items), fear of compassion from others (13 items) and fear of compassion for others (10 items). Items are rated on a five-point likert scale (0 = don't agree at all, 4 =

completely agree). Cronbach's alphas for students and therapists range from 0.76 to 0.92.

## **2.2.5. Procedure**

### **2.2.5.1. Ethics**

Ethical approval for conducting the study was granted by Coventry University Ethics Committee (Appendix L), Frenchay NHS Research Ethics Committee (Appendix M), Coventry and Warwickshire Partnership NHS Trust Research and Development Team (Appendix N), Avon and Wiltshire Partnership NHS Trust Research and Development Team (Appendix O), and Worcestershire Health and Care NHS Trust Research and Development Team (Appendix P). An amendment was approved by all of the above to expand the inclusion criteria to people with psychosis who had experienced symptoms in the past year.

### **2.2.5.2. Recruitment**

Team Managers from appropriate mental health teams within the three NHS trusts were approached and the study was explained to them. The researcher then attended team meetings to present the research to the team members. Team members then spoke to their clients in their routine contact and gave them a participant information pack. This pack contained a letter introducing the study, a participant information sheet, reply "opt-in" slip and self-addressed stamped envelope. Participant information sheets were tailored for each NHS trust. In one trust participants were offered the potential possibility of meeting with the

researcher at home. In another trust, local details of how to make a complaint were added at the request of the local Research and Development Team. See Appendix Q, for an example of the participant information sheet.

Once the researcher was in receipt of the reply slip, the researcher then contacted the potential participant by telephone, to further discuss the research and answer any questions. If the potential participant then still wished to take part, a suitable time and location to meet was agreed. At the appointment prior to taking part in the research, the information sheet was reviewed to ensure the participant understood the information and was happy to participate in the research. They then signed the consent form (see Appendix R).

Participants were first asked some basic demographic and clinical information. Participants then completed the four self-report questionnaires with assistance (if required) from the researcher and were subsequently interviewed in order for the researcher to complete the "Psychiatric Symptoms Rating Scale". The assessment measures were administered according to instructions and the order of administration was alternated in order to help reduce order effects. Questions were responded to throughout the appointment and participants were debriefed at the end of the appointment (see Appendix S for the debrief sheet)

### 2.3. Results

The data were analysed using SPSS v.22. To test the hypotheses; correlations, regression, and mediation analyses were performed and the data were inspected to determine whether they were satisfactory for these analyses. For the various multiple regression analyses required for mediation analysis, histograms revealed that there was normality of residuals and a scattergram indicated that there was independence of residuals and no heteroscedasticity. There was linearity of relationship between the predictor variables and the dependent variables. Cook's D indicated that there were no multivariate outliers. Finally, variance inflation factors indicated that there was not excessive multicollinearity. Prior to the presentation of these findings the descriptive statistics will first be discussed and are displayed in Table 3 below.

Table 3: Descriptive statistics for sample (N = 30)

	<b>Range</b>	<b>Mean</b>	<b>Standard deviation</b>
<b>Childhood Trauma (CTQ)</b>	27-98	48.07	19.37
<b>External Shame (OAS)</b>	0-62	30.97	15.41
<b>Internal Shame (ESS)</b>	25-96	56.87	19.65
<b>Voice Hearing (PSYRATS-AH)</b>	0-39	18.33	14.85
<b>Delusional beliefs (PSYRATS -DS)</b>	0-20	7.10	7.12
<b>Fears of Compassion for others</b>	0-48	19.1	9.31
<b>Fears of Compassion from others</b>	1-39	21.57	13.47
<b>Fears of Compassion to self</b>	0-58	23.37	16.45

Note. CTQ = Childhood Trauma Questionnaire; OAS = Other as Shamer Scale; ESS = Experience of Shame Scale; PSYRATS-AH = Psychiatric Symptoms Rating Scale – Auditory Hallucinations; PSYRATS-DS = Psychiatric Symptoms Rating Scale – Delusions scale

#### 2.3.1. Childhood Abuse and Neglect

Ninety per cent of the sample reported experiencing at least one type of childhood abuse or neglect. Eighty per cent reported experiencing emotional neglect, 73%

emotional abuse, 46% physical neglect, 33% physical abuse, and 16% sexual abuse.

The CTQ total scores ( $M = 48.07$ ,  $SD 19.37$ ) were similar to a study with first episode of psychosis population ( $M = 54.1$ ,  $SD 21.1$ ; Sheffield et al., 2013).

### 2.3.2. Shame

The external shame, OAS scores ( $M = 30.97$ ,  $SD 15.41$ ) seem to be similar to a previous study with a sample of people with psychosis from an early intervention team ( $M = 27.53$ ,  $SD 19.11$ ; Turner et al., 2013) and but larger than in non-clinical populations ( $M = 19.60$ ,  $SD 9.45$ , Matos et al., 2013;  $M = 16.94$ ,  $SD 9.66$ , Pinot-Gouveia et al., 2014). The internal shame, ESS score ( $M = 56.87$ ,  $SD 19.648$ ) was lower than in a previous study with a sample of people who were at risk of developing psychosis ( $M = 65.88$ ,  $SD 19.648$ ; Johnson et al., 2014) but was quite similar to Turner et al., (2013) psychosis population ( $M = 54.96$ ,  $SD 17.19$ ). Finally it was larger than in non-clinical populations ( $M = 47.52$ ,  $SD 13.15$ ; Matos et al. 2013)

### 2.3.3. Symptom of Psychosis

Sixty three percent of the participants reported experiencing voices and 60% reported experiencing delusional beliefs in the past week. Mean scores for PSYRATS-AH was 18.33 ( $SD 14.85$ ) which was very similar to Smith et al., (2006) which used a psychosis population ( $M = 18.34$   $SD 14.49$ ). The mean scores for PSYRATS-DS were 7.10 ( $SD 7.12$ ) however this was lower in the comparable study ( $M = 14.11$ ,  $SD 6.59$ ; Smith et al., 2006).

### 2.3.4. Fear of Compassion

Fears of compassion were highest when directed towards ‘for self’ (M = 23.37, SD 16.45, followed by ‘from others’ (M = 21.57 SD 13.47), with ‘for others’ with the lowest mean score (M = 19.1 SD 9.31). The means in the present study were lower than in a clinical depression population study (M = 36.69 SD 12.34; M = 31.69 SD 11.69; M = 23.62 SD 7.56; Gilbert et al., 2014) respectively.

### 2.4. Analysis

Table 4 below presents Pearson’s correlations of the variables included in the hypotheses.

Table 4. Pearson’s correlation matrix of variables under investigation (N = 30)

	Childhood Trauma	Internal Shame	External Shame	Voice hearing	Delusional beliefs
Childhood Trauma	-				
Internal Shame	.187	-			
External Shame	.397*	.630**	-		
Voice Hearing	.258	.073	.165	-	
Delusional Beliefs	.069	.426*	.285	.143	-
Fears of Compassion for other	.095	.550**	.329	.254	.162
Fears of Compassion from others	.279	.556**	.583**	.196	.481**
Fears of Compassion to self	.141	.406**	.474**	.081	.299

\*  $p < .05$ , \*\*  $p < .01$  (two-tailed)

As can be seen in Table 4, there is partial support for hypothesis 1 as there was a significant positive relationship between childhood trauma and external shame but not childhood trauma and internal shame. Regarding the second group of hypotheses, only the relationship between internal shame and delusions was significant. There was not support for hypothesis 3 as no significant relationships were found between childhood trauma and psychotic symptoms.

To test the fourth group of hypotheses, mediation analyses were performed using a test developed by Sobel (1982) and popularised by Baron and Kenny (1986). To determine whether there is a mediating effect of one variable on the relationship between two others, regression analysis must be performed between the mediating variable and the DV and then multiple regression analysis of the effects of the predictor variable and the mediator variable on the DV. Essentially, these two regression analyses allow a comparison of the direct effect of the predictor variable on the DV and the indirect effect via the mediating variable. By using the unstandardized *b* coefficients and standard errors from the regression analyses, a *z*-score and associated *p*-value can be computed to determine if there is a mediating effect.

Figure 3 below presents the path model for the possible mediating effect of external shame on the relationship between childhood trauma and delusions. As can be seen, the direct relationship between trauma and delusions is small and negative. The analysis revealed that this was not significant:  $t_{(27)} = 0.26, p = .796$ . The relationship between childhood trauma and external shame was positive and

significant ( $t_{(28)} = 2.29, p = .030$ ) and although the relationship between external shame and delusions was positive, it failed to reach significance:  $t_{(27)} = 1.53, p = .139$ . The Sobel z-test revealed that the mediating effect of external shame was not significant:  $z = 1.19, p = .235$  (two-tailed).

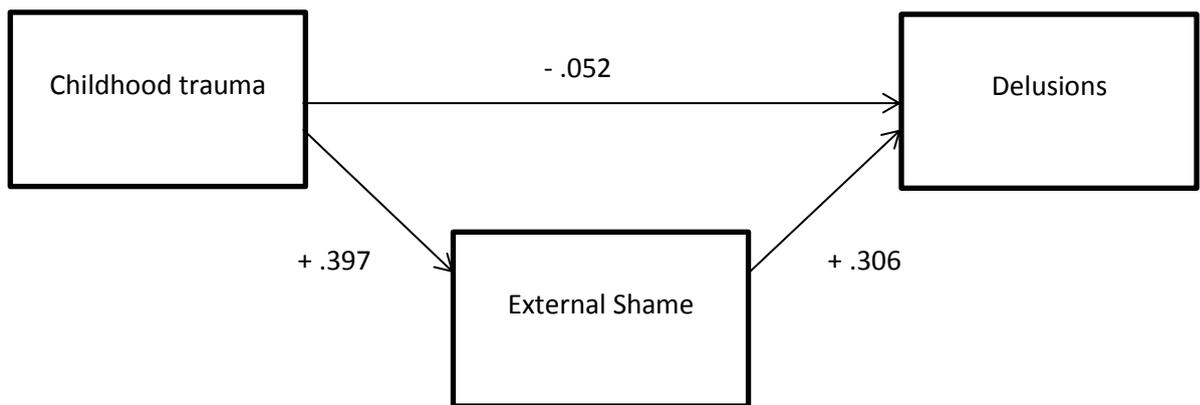


Figure 3. Path model (with beta coefficients) of the relationships between childhood trauma, external shame, and delusions.

Figure 4 presents the path model for the relationships between childhood trauma, internal shame, and delusions. As with the first model, it can be seen that there is a very small, negative and non-significant relationship between trauma and delusions ( $t_{(28)} = 0.06, p = .950$ ). The relationship between childhood trauma and internal shame was positive but also non-significant ( $t_{(27)} = 1.01, p = .322$ ). The relationship between internal shame and delusions was positive and significant:  $t_{(27)} = 2.42, p = .023$ . However, as with external shame, internal shame did not significantly mediate the relationship between childhood trauma and delusions:  $z = 0.77, p = .442$  (two-tailed).

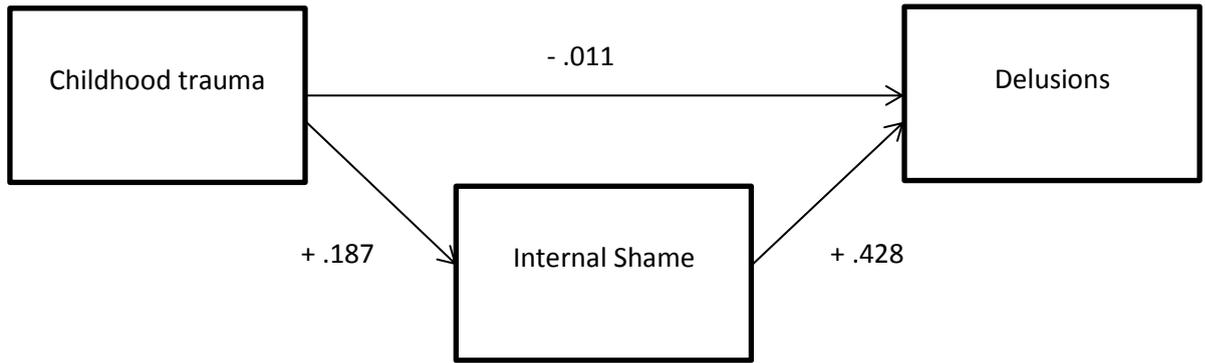


Figure 4. Path model (with beta coefficients) of the relationships between childhood trauma, internal shame, and delusions.

Figure 5 below presents the path model for the possible mediating effect of external shame on the relationship between childhood trauma and hallucinations.

The direct relationship between childhood trauma and hallucinations yielded a small to medium but non-significant coefficient ( $t_{(27)} = 1.13, p = .268$ ). The relationship between trauma and external shame was positive and significant ( $t_{(28)} = 2.29, p = .030$ ) but the relationship between external shame and hallucinations was not significant ( $t_{(27)} = 0.37, p = .714$ ). External shame did not mediate the relationship between childhood trauma and hallucinations:  $z = 0.33, p = .738$  (two-tailed).

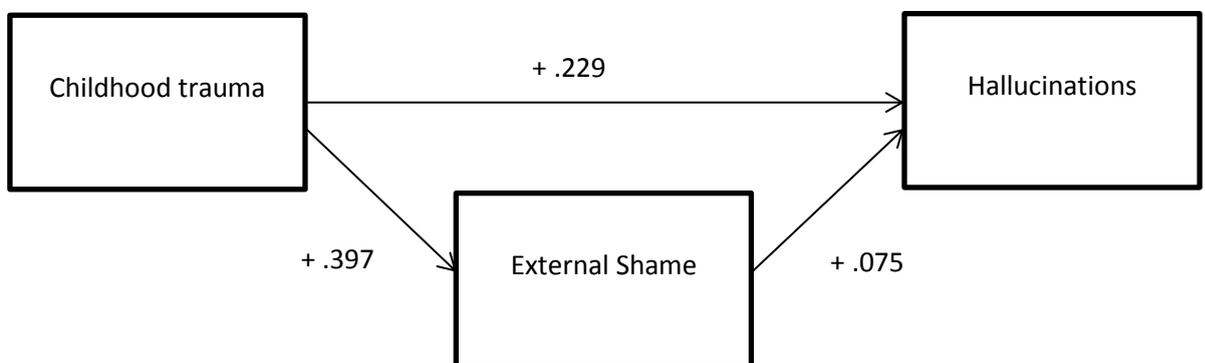


Figure 5. Path model (with beta coefficients) of the relationships between childhood trauma, external shame, and hallucinations.

Figure 6 presents the final path model considered in this research. It can be seen that the direct relationship between childhood trauma and hallucinations was in the expected direction. However, this relationship was not significant ( $t_{(27)} = 1.34, p = .192$ ). The relationship between trauma and internal shame was also positive but non-significant ( $t_{(28)} = 1.01, p = .322$ ) and this was also the case for the relationship between internal shame and hallucinations ( $t_{(27)} = 0.14, p = .893$ ). Internal shame did not significantly mediate the relationship between childhood trauma and hallucinations:  $z = 0.09, p = .925$  (two-tailed).

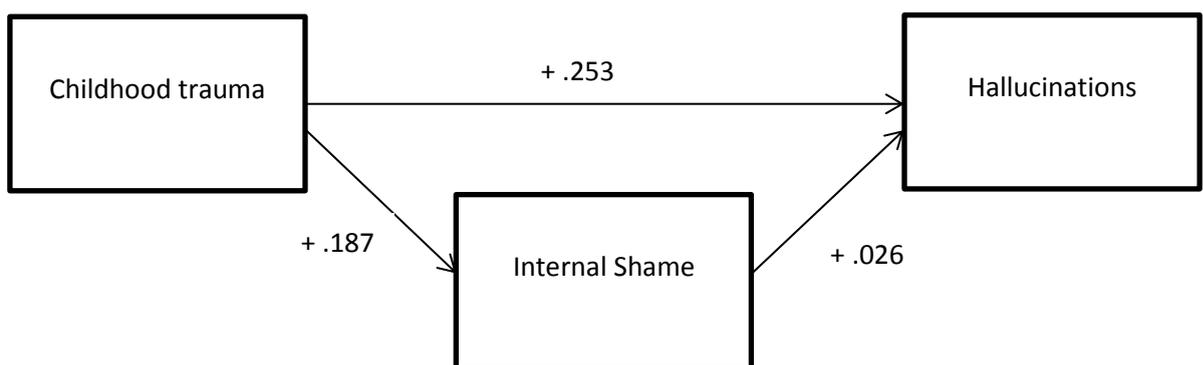


Figure 6. Path model (with beta coefficients) of the relationships between childhood trauma, internal shame, and hallucinations.

Hypothesis 5 predicted that there would be a significant positive relationship between experience of childhood trauma and fears of compassion. As can be seen in Table 4, although this relationship was positive for all three scales, Pearson's  $r$  is small and non-significant.

The sixth grouping of hypotheses presented in the introduction predicted that there would be a positive relationship between shame (both internal and external) and

fears of compassion. As can be seen in Table 4, there is support for these hypotheses with large, positive, and significant effect sizes for all relationships, except fears of compassion for others with external shame.

Finally, it was predicted there would be a positive relationship between fear of compassion and both delusional beliefs and auditory hallucinations. Referring to Table 4, it can be seen that there was a significant positive correlation between delusional beliefs and fears of compassion from others but not to self or for others. No significant relationships for fears of compassion scales with hallucinations were identified.

## **2.5. Discussion**

In support of previous research (Read, van Os, Morrison & Ross, 2005) this study found a high incidence of childhood trauma in people with psychosis. Furthermore high levels of internal and external shame were evident. These findings appear to show support for previous research suggesting a role for shame in psychosis (Matos et al., 2013; Pinto-Gouveia, Matos, Castilho, & Xavier, 2014). In order to explore this role a number of hypotheses were tested, which will now be discussed in detail.

### **2.5.1 Shame and Childhood Trauma**

The first hypothesis predicted that there would be a positive correlation between childhood trauma and both internal and external shame. The findings indicated

that there was a positive correlation between childhood trauma and external shame. The correlation for CTQ with OAS ( $r = .397$ ) is very similar to previous findings. For example Connor and Birchwood (2012) found a significant correlation between OAS and emotional abuse ( $r = 0.48$ ) and physical abuse ( $r = 0.31$ ) as measured on the CTQ. Gilbert (2003) suggested shame develops when an individual is exposed to critical or threatening relational experiences and they come to believe that they are undesirable or not valued. Therefore the finding that those participants who reported more childhood trauma reported more external shame supports this part of the model.

It was also predicted that a similar relationship would be found for internal shame with childhood trauma; however the current findings did not support this. This was unexpected as previous findings have found a positive correlation in general population studies (Pinto-Gouveia et al., 2012) and in a psychosis population (Connor & Birchwood, 2012). However, neither of these studies used the same measure for internal shame, so this could account for the disparity in findings. Gilbert (2003) suggests that internal shame develops as a result of external shame, where by an individual internalises what they think others think of them as a defensive strategy. A positive correlation between internal and external shame was found ( $r = .630$ ), which shows support for Gilbert's model.

### 2.5.2. Shame and Psychotic Symptoms in People with Psychosis

The second hypothesis predicted a positive correlation between shame (both internal and external) and psychotic symptoms (voice hearing and delusional beliefs) in people with psychosis.

The analysis revealed a significant relationship between internal shame and delusional beliefs ( $r = .426$ ), showing support for the hypothesis. Matos et al. (2013) found a very similar relationship ( $r = .46$ ) between internal shame (as measured on the ESS) with paranoia (as measured on the general paranoia scale) in the general population. The findings were also in keeping with Johnson (2014) who found that internal shame (as measured on the ESS) was strongly correlated with paranoia ( $r = .461$ ) in a population who were considered to be at risk of developing severe mental health difficulties. A small positive relationship was found in the current study between external shame and delusional beliefs although this was not a significant correlation.

The relationship between internal or external shame with hearing voices was small and not significant. Previous research considering emotion and auditory hallucinations appears to suggest that a relationship would be expected. Smith et al. (2006) using the PSYRATS measure found that individuals with more depression and lower self-esteem had auditory hallucinations of greater severity, and were more distressed by them. Gilbert *et al.* (2001) suggested that critical thoughts and voices may represent an internalisation of shame. Birchwood *et al.* (2004) proposed that appraisals about an individual's own social power and rank are

important factors underlying their evaluation of the power of hallucinatory voices, and the associated distress. This would suggest that the greater levels of shame, the greater the potential distress from voices. However, this hypothesis was not supported. Further research is needed to ascertain whether the current finding is replicated and to evaluate this relationship further.

### **2.5.3. Does shame mediate the relationship between childhood trauma and symptoms of psychosis?**

There is an established link between childhood difficulties, such as trauma and dysfunctional attachment, with psychosis (Read, van Os, Morrison & Ross, 2005). It has been suggested that feelings of shame may mediate this relationship (Matos et al., 2013; Pinto-Gouveia et al. (2012). Therefore a model was proposed where by shame was suggested to mediate the relationship between childhood trauma and psychotic symptoms. However the findings did not support this model as shame (neither internal or external) was not found to significantly mediate the relationship between childhood trauma and psychotic symptoms (either voice hearing or delusional beliefs). This was not expected as both internal and external shame in association to psychosis was found to be a moderator between childhood trauma and paranoia in a previous study (Aherne, 2014). Although research and theory would suggest that a similar pattern would have been identified for auditory hallucinations, this also was not supported, in the current study.

However, the current research differed from Aherne (2014) and Matos et al. (2013) in how delusional beliefs were measured. The previous studies used paranoia ideation scales which measure a phenomenon which exists within as well as outside of clinical categories whereas in the present study the PSYRAT-DS was used; a tool that assesses delusional beliefs at the more extreme end of the paranoia continuum. This could potentially explain the difference in findings.

The multiple regressions performed to test hypothesis 3, considered the effects of internal and external shame on delusions. This revealed a significant relationship for internal shame with delusions but not external shame. This is in contrast with a previous finding using the general population which found a very strong relationship ( $r = 0.61$ ; Matos et al., 2013) with external shame and paranoia. Matos et al. (2013) found that it was external shame that had the strongest regression weight in their study whereas internal shame had the smallest. Similarly, Aherne (2014) replicated Matos et al's (2013) study with a first episode of psychosis sample, finding a relationship between both internal and external shame with paranoia and found that multiple regression revealed external shame had the greatest weight. However the current study has found the reverse. Potentially showing that a different relationship exists when the relationship between shame and delusional beliefs are considered, as opposed to shame associated with psychosis and paranoia.

Internal or external shame was not found to be a mediator between childhood trauma and delusional beliefs in the current study, however significant relationships were identified. Childhood trauma was positively and significantly correlated to external shame. External shame was significantly positively correlated with internal shame. Finally internal shame was positively correlated with delusional beliefs. It would be interesting to consider these relationships in a path model, although analysis was not possible in the current study as it would be underpowered due to the sample size.

#### **2.5.4. Fear of Compassion**

According to Gilbert's (1998, 2003) biopsychosocial evolutionary model of affect regulation, criticism and hostility activate the threat system producing feelings of anger, shame and anxiety, whereas warmth and compassion stimulate the soothing system. Conversely, Gilbert suggest for some people the experience of compassion leads to avoidance or fear reactions (Gilbert, 2010). Gilbert (2010) suggests that for some individuals who have experienced abuse or neglect that the attachment system closes down, but its reactivation through compassion can also bring back emotional memories from childhood. This is argued to underpin fears of compassion and create a major block to recovery (Gilbert et al. 2011). It is argued that in these circumstances compassion can be experienced as an intra-psycho attack (Lee et al., 2001).

### **2.5.5. Fear of Compassion and Childhood Trauma**

It was predicted that a positive correlation between childhood trauma and fears of compassion would be found, however contrary to predictions the relationship was small and not significant. The present study suggests that people who experienced more childhood trauma do not have significantly more fears of compassion, suggesting the relationship is not one of dose response. The current population did have high incidence of childhood neglect and abuse, with 90% of the sample reporting some level of childhood trauma. Unexpectedly, in the current study the mean fears of compassion scores do not appear to be particularly high, as in comparison, the mean fears of compassion scores in Gilbert et al.'s (2014) depression study, were a third higher in the "for self" and "for others". It is possible that the participants in the current study were in a different stage of their recovery and so had found ways of reducing their fears of compassion.

Alternatively Gilbert et al. (2014) suggests a number of other reasons someone might develop fears of compassion. Firstly, they suggested that people might see compassion as a weakness or indulgence. On the other hand, Davanloo (2005) proposes that people can be fearful of compassion, if they are also fearful of their own damaging potential for rage. Finally Gilbert et al. (2014) also highlight unprocessed grief could be another possible mechanism involved in fears of compassion. Gilbert & Irons (2005) suggest that when compassion activates the attachment system then feelings of poor attachment come to the forefront which can be experienced as overwhelming.

### **2.5.6. Fear of Compassion and Shame**

It was also predicted that there would be positive correlations between shame (both internal and external) and fears of compassion. This was supported by a significant positive relationship with large effect sizes for all three fears of compassion scale with internal shame was found. A similar relationship was seen for external shame with fears of compassion from others and for self, but no relationship was found for external shame with fear of compassion to others. This finding appears to show support for Gilbert et al. (2014) as it suggests that people with more fears of compassion have more feelings of shame. This is as one would expect as if the theory is correct utilising compassion can reduce feelings of shame. However, fears of compassion would lead to blocks in using compassion and so lead to more feelings of shame.

It has been suggested that fears of compassion can be treated therapeutically in a similar way to anxiety such as gaining insight, desensitisation, exposure and building capacity to tolerate the emotion (Gilbert, 2010). CFT is emerging as an effective approach and so demonstrating the approach can overcome fears of compassion, although Gilbert et al. (2014) suggest clinicians should be aware of the apparent complexities and how fears might block someone in their recovery.

### **2.5.7. Fear of Compassion and Symptoms of Psychosis**

A significant positive relationship between fears of compassion and delusions were found. Further analysis revealed it was fear of compassion from others that was creating this significant finding. This suggests that people who have more

delusional beliefs (in terms of frequency and distress) have more fears of compassion from others. As far as the author is aware that has not been any previous research directly considering this relationship. Gilbert et al. (2013) found fears of compassion for self and from others correlated with depression in a study considering people with a diagnosis of depression. Further research would be useful to see if the findings in the current study are replicated.

### **2.5.8. Implications**

Further understanding of the relationships between emotion and psychosis is argued to be how psychological interventions are likely to ensure their future success (Birchwood & Trower, 2006). The findings of the current study support previous research and show support for shame playing a role in psychosis.

The current study revealed shame correlated with a number of variables.

Childhood trauma was found to be associated with a belief that others see you negatively (external shame). The belief that others see you negatively was related to evaluating oneself negatively (internal shame). The more someone evaluated themselves negatively (internal shame) the more likely they were to have more frequent and distressing delusions. Although it is not possible to attribute cause to these correlations, it is fair to say that the findings support previous research by demonstrating feelings of shame is a significant issue for people with psychosis. Therefore this suggests that treatment interventions directly targeting shame could be helpful.

As discussed in the introduction, CFT is a treatment approach which has been shown to be helpful to reduce feelings of shame by developing feelings of compassion (Braehler et al., 2013). The process of developing compassion however can be complicated, as cultivating compassion can be frightening for some people. The current study found feelings of shame were correlated with fears of compassion therefore clinicians are likely to run into some difficulties when trying to implement this approach with people with psychosis. However, Gilbert et al. (2014) suggests that there is no reason why fears of compassion cannot be approached in a similar fashion to anxiety, (e.g. exposure and building up the capacity to tolerate it).

This research suggests that people with more frequent and distressing delusions may have more fears of compassion from others. Therefore it might be useful to consider this when working with someone with more severe delusions as they may find compassion from others particularly frightening. Furthermore when implementing CFT in psychosis populations, the focus of how compassion is developed might need to be altered. It might be helpful for compassion from others to be considered further on in treatment. Despite the potential difficulties, supporting individuals to overcome fears of compassion could be very powerful as it could potentially lead to reductions in shame and even possibly effect the level of distress psychosis can cause.

Further research is still required to continue to explore the role of shame, particularly in psychosis populations. This study highlighted the potential possibility

of a model linking childhood trauma with external shame, external shame with internal shame and internal shame with delusional beliefs. This could be an area for future research to consider.

#### **2.5.9. Limitations**

This study used a cross-sectional design, which can only provide a snapshot of a particular place in time. Furthermore as a correlational study, causation cannot be determined.

The sample size was relatively small. Despite the recruitment of participants from a total of 12 teams, including early intervention, rehabilitation and community mental health teams across three NHS trusts, enlisting participants for the study was difficult. Although the minimum number of participants required was attained, the small number prevented further exploration. For example, analysis of specific sub categories of childhood abuse and further breakdown of impact of symptoms of psychosis might have been possible with a larger sample. In addition the standard deviations were quite substantial for some measures indicating a wide range of dispersion in the scores, which is a limitation that may be due to the relatively small sample size.

There is a possibility that the sample was biased, due to the non-randomised method of sampling. Individuals, who were deemed to be in crisis or considered to be at risk from taking part, were not invited to participate. Furthermore, although I

am unaware of the exact numbers, I estimate that approximately half of those selected to be invited to take part declined to participate. The feedback I received from care coordinators indicated the majority who declined considered the nature of the research (particularly childhood trauma and shame) to be too difficult. Therefore it is possible that the people with the highest feelings of shame and with the greatest potential for shame acting as a mediator may have not been included in the sample.

The participants in the current study included people who had been diagnosed with psychosis recently as well as people who have had the diagnosis for a long period of time. Although potentially representative in relation to psychosis overall, recovery expectations are complex and are likely to significantly vary (Rosen & Garety, 2005). Consequently a different relationship could potentially be identified depending on the population. However length of illness was not identified to correlate with any of the included variables. The current study also did not control for anxiety or depression. It is possible this could have influenced the findings as some researchers have found a relationship between shame, depression and social anxiety (Michail & Birchwood, 2009).

The participants were predominantly male, with only four female participants, creating another possible source of bias. Previous research (Fisher et al., 2009) has shown that females are more likely to report sexual or physical abuse even after confounding variables were controlled for. Furthermore Fisher et al., (2009) found a trend that more females had elevated rates of psychosis type experiences among

those who reported childhood sexual or physical abuse although these associations were not significant. Therefore as the current study only had a small number of females potentially this may have affected the findings.

The Experience of Shame Scale (ESS) was used in the current study to measure internal shame. It has been used by many other researchers to measure internal shame (e.g. Matos et al, 2013, Johnson et al., 2014). However, the scale has been criticised for not being a true measure of internal shame as a small number of the questions ask about how others see them, which would be more consistent with external shame. Consequently some researchers have suggested it should be used as a measure of general shame. In the present study the ESS did correlate with external shame, however internal and external shame did correlate differently with other measures, in particular the delusions scale, which suggests that they are measuring different constructs.

#### **2.5.10. Conclusions**

Although this research did not show support for shame as a mediator variable between childhood trauma and psychotic symptomology, it does however continue to highlight shame as an important emotion that is very present in the psychosis population. As research moves forward and further our understanding of emotions such as shame within psychosis, the more developed and sophisticated the treatment approaches can become.

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## **Chapter 3 – Reflective Paper**

**The challenges of conducting sensitive research with vulnerable people using quantitative methodology: A reflective account.**

Overall chapter word count: 2974 (Excluding references)

Written in preparation for submission to Reflective Practice.

(See Appendix S for author instructions).

### **3.1 Abstract**

This paper provides a reflective account of conducting sensitive quantitative research looking at shame and childhood trauma with people with people with psychosis in the NHS. The research journey from the conception of the idea through to the studies completion will be considered. Particular attention to clinicians, participants and the researchers' perspectives will be provided.

*Keywords: Reflection, Psychosis, Childhood trauma, Shame, Sensitive research, Vulnerable*

### **3.2. Introduction**

This paper provides reflection on the process of conducting sensitive research with a vulnerable client group using quantitative methodology. Research is considered to be sensitive if it poses a substantial threat to those who are involved (Lee, 1993).

My research was sensitive in nature due to the inclusion of the emotive factor shame, as well as the taboo and personal subject of childhood trauma.

Furthermore people with psychosis are a vulnerable client group and therefore ensuring their safety and wellbeing during the research process was of paramount importance. Consequently particular consideration and reflection will be given to the impact of conducting sensitive research in relation to the participants, clinicians and me, the researcher.

Within this reflective report I will explore the experience of completing a piece of research as part of a thesis in a Clinical Psychology Doctorate. I will consider how my prior experiences, thoughts and feelings came to influence my thesis and how my research affected me both personally and professionally.

### **3.3. Idea development and my relationship with the topic**

At the start of this journey when I was in the phase of developing an idea, a priority to me was creating a research study that would be meaningful and worthwhile. I was aware that conducting a research study whilst being on placement and juggling other course demands with home and family life would be a difficult process.

Therefore in order to make the experience more enjoyable, I thought that ensuring that my research would be useful clinically would make it more personally fulfilling.

I feel slightly naïve now to say that I thought my research might be able to bring to light something which had been misunderstood previously. In retrospect, using the stages of learning model (the origins of which are unclear, although its use has been promoted by US Gordon Training International organisation), I wonder if I was in a stage of unconscious incompetence, as I was unaware of what I did not know.

To develop a research idea, I drew from my experience of working with people who had experienced psychosis. Whilst working as an Assistant Psychologist prior to the Clinical Psychology Doctorate training course, I worked on a ward with people who had been considered to be unwell for a long time. Some of the people had spent years in a hospital environment, however, their progress appeared minimal and their recovery was slow. I was keen to do research in this area as I could see that for some people the treatments available were simply not as effective as one would hope.

I am aware my ideas were influenced by my involvement in a men's psychotherapy group. At this group I was privileged to hear open group discussions that appeared less restricted and more honest than I had encountered in other environments. I was intrigued by how some particular conversations in the group would cause anxiety. I also noticed how feelings of shame seemed to be intolerable for some people. I was curious by how shame seemed to act as a trigger for a dip into the psychotic world. It seemed shame often led to anxiety and somehow a greater intensity of psychotic symptomology. I was aware from the outset that these

would be sensitive areas to research, in a client group that was particularly vulnerable.

After reading many research articles I became more aware of the vast amount of literature available in psychosis, but noted how controversy and debate was around every corner. The traditional view that psychosis is an illness which needs to be treated with medication was more present than I had envisaged, although I found many sources of counter argument, for example the recently published *Understanding Psychosis and Schizophrenia* (British Psychological Society, 2015). As I tried to carve out an original research study I became slightly lost and confused about which direction to take my research. I was becoming aware of what I did not know, put in another way I was moving to the second stage of the learning theory as my incompetence was becoming more conscious.

#### **3.4. My choice of methodology**

I instinctively chose a nomothetic approach using a quantitative research design. Quantitative research can be defined as “research that concerns the quantity or measurement of some phenomenon.” (Langdrige, 2004. p.13). Prior to training and during my psychology degree, quantitative methodology had been sold to me as being more rigorous and appeared to be held in higher esteem given its perception of being more scientific. I was aware that my choice of methodology should depend on my research question. But I am equally aware that due to my own personal biases, I would have a tendency to develop a research question that lends itself to quantitative research methodology.

I am aware that quantitative research can be criticised for missing meaning and some even argue qualitative research is better based in clinical practice. For example, Hurwitz (2000) argued that effective clinical practice relies on a narrative approach that avoids reducing patients to impersonal clinical data, but instead recognises and restores patients as people. I do not disagree that qualitative research is extremely valuable but I believe it has its place alongside quantitative methodologies as they complement one another. There is undeniably still a strong drive for evidence based practice in the NHS and quantitative techniques lend themselves to this. Furthermore, in order for psychological approaches to psychosis to become more to the forefront then more research of any design is needed.

Whilst reflecting on my methodological decisions, I began to question what my drive was to justify my choices. It may have been because the majority of the trainee cohort had undertaken qualitative research. I felt uncomfortable with the idea that somehow I might be purposefully trying to distance myself from my participant's painful stories. However, this was not how I viewed my position. I was aware of how this topic area was highly emotive and I was concerned that asking vulnerable people to speak in-depth about shame and childhood trauma may be too difficult for a large number of people with psychosis. As a clinician I think most psychologists would see it is part of their role to hear someone's individual story in order to build their unique formulation which will allow the most effective treatment to be offered. However, research is different. It is not about helping

that individual but instead it is about using their information to help others.

Therefore as a clinician I saw it as my role to protect my participants. I thought that a questionnaire may create a protective barrier for the participant as they were not expected to explain themselves in any way. Furthermore quantitative methodology might provide a voice to those who would not have been able to articulate themselves or may have been considered too unwell to participate otherwise.

Gaining ethical approval for my study was a slow process, as it is for many researchers. There were no particular objections raised to the sensitive nature of the topic in relation to the methodology I was planning to use. Understandably the Research Ethics Committee were concerned about the potential vulnerability of the people being asked to participate in my research and wanted to ensure all possible safe guards were in place. On the whole it appeared they were satisfied as I had only a few relatively minor amendments to make which were mainly in relation to making my participant information sheet as transparent as possible.

### **3.5. My experiences of conducting the research with clinicians**

After gaining all required ethical approvals, I was able to begin the recruitment stage of my research. However recruiting a sufficient number of participants was very difficult, despite recruiting from three NHS trusts. Prior to commencing this journey I was aware that this might be the case, consequently I put a lot of thought into my recruitment strategies and considered alternative options. During this process my thoughts and priorities remained however with ensuring any decisions

were ethically sound. Maintaining my integrity as a clinician throughout my research was very important to me. I was also aware of not wanting to burden clinicians with lengthy procedures when the current climate in the NHS is one of structural changes and funding cut backs.

The first problems I encountered with my recruitment appeared to stem from relying upon care coordinators talking to their clients about the research in order to recruit participants for my study. This meant care coordinators were effectively gate keepers between me and potential participants. It often appeared that these gates were watched carefully, although the motivations of keeping a tight gate appeared to vary. For many it seemed to be about protecting their clients from potential upset. Answering questionnaires about childhood trauma could be unsettling for some people and I appreciated that people needed to be robust enough to cope with this. However some people's reasoning I found more frustrating. For example one clinician told me her clients do not like answering questionnaires and explained it takes her three sessions to complete just one when she has to do paperwork. Although I acknowledge taking part in research has limited direct advantages, to deny people the opportunity based on a rather subjective assumption appears to me to be unjust and unfair.

I learnt that in order for clinicians to open their gate, the relationship I held with them personally was important. Attending one team meeting did not appear to be enough. I needed to speak with individual clinicians over a number of occasions. Establishing that I would prioritise the wellbeing of their client over my research

seemed to allow clinicians to entrust their clients to me. I do not think it was a coincidence that the team I had existing relationships with was the team that I was able to recruit the most participants from. I also found being very transparent and showing clinicians' copies of the questionnaires that I would be using was particularly helpful.

Once a clinician had agreed to ask their client if they would like to take part, I was reliant on the clinician actually remembering to ask them. I found this the most frustrating part of the research as this meant I was not in control and was completely reliant upon other people. Completing the research was of utmost importance to me not least because my future career progression rested upon it. However, my research was not a priority for the clinicians that were helping me with recruitment. I also wonder if clinicians continued to be a little resistant to asking their clients due to concerns of causing harm. I was accepting and considerate of this but I found I needed to be very active in the recruitment process to compensate. I kept a spreadsheet so that I could follow-up and remind clinicians. This I found to be awkward as it felt as if I was pestering and checking up on the clinician. However my anxiety of upsetting colleagues did not turn out to be a reality as clinicians appeared comfortable with this process. It also gave them an opportunity to get to know me and feel more comfortable with the research.

### **3.6. My experiences of conducting the research with participants**

After a client had been asked if they would like to take part in my study they were then able to make a decision. Ulrich et al. (2005) wrote about respondent burden,

which they suggest is the subjective perception of a participant of the psychological, physical, and/or economic hardships associated with taking part in the research process. I was aware that there was little incentive for people to take part in the study and in fact there could be a risk that taking part would be upsetting for the participant. It was important that participants understood this and were able to make their own choice. It seemed that on average half the people asked if they would like to take part decided not to participate. Although this was concerning in terms of the effect it might play on my research my immediate reaction to this was as a clinician rather than as a researcher. I felt proud that people were able to make a choice based upon an understanding of what the research would involve.

When meeting with participants I always held in mind the need to protect participants' wellbeing. At the end of each questionnaire, I always asked each participant how they found the questions and what it was like for them. This enabled me to ascertain how the participant was finding the process of taking part in the research and to check whether they were still consenting to continue.

Occasionally this question prompted some really interesting and insightful comments relevant to my research topic. This felt a little frustrating as I was aware that the participant was providing me with additional context and meaning that the questionnaires had not captured. To some degree I was concerned that my research findings might not do justice to the participant.

Although participants' reactions to taking part were mixed, thankfully everyone taking part in the study appeared to find the experience acceptable. Some people

appeared to be relieved that taking part was less difficult than they had envisaged. Others appeared to be a little upset. All seemed to be able to manage these feelings but I was able to point out potential sources of support should they be required. I continued to feel uncomfortable with the idea of a participant putting themselves at risk in the name of research. Furthermore I was aware that if there were any negative outcomes for participants taking part in the study then support would need to come from their service, adding burden to the teams that had been kind enough to support me in my research. I noticed a sense of guilt that in my role as a researcher I was not in position to offer any form of ongoing support, which was in contrast to my role as a clinician.

I was curious of participants' reactions to the study's aims and research questions. The research's implicit message was that people's past and emotions may play a role in their current difficulties in relation to psychotic symptomology. This represented a psychological rather than medical model view of their difficulties. For some this came as no surprise, whereas for others this appeared to be something new which was either enlightening or terrifying. One person decided they did not want to participate as they were concerned that the process would bring up painful memories that they felt they were not in a position to cope with as they were unwell.

### **3.7. My own personal experiences of conducting the research**

I noticed some parallels between the questionnaires and factors which may be relevant to the current context and the relationship between me, the researcher

and the participant. One of the questionnaires in my empirical research asks the participant questions about their opinions on compassion and asks their views on expressing compassion to others. As I asked the participant whether they felt people will take advantage of them if they are seen as too compassionate, I began to wonder whether I was indeed taking advantage of the participants' kindness and willingness to take part in a research study that does not directly benefit them. This is something that I pondered over the time I was meeting with participants and my opinions oscillated during this period.

I reassured myself by thinking about the reasons participants had decided to take part. Some participants spoke of being lonely or isolated and spoke of how much they valued having someone to speak with. Others appeared to be thinking about their own recovery journey and felt that they were now in a position to help others and wanted to help improve services. Several recognised the relevance of the area of the research and could relate to its importance. However, there were some that appeared to feel obliged to help and to be a "good patient". Obviously participants are told they do not have to take part and that their participation is entirely voluntary, however some participants readily agreed without taking much deeper thought. I wondered whether this was indicative of their views of compassion.

Completing my research has been a long journey which has been interwoven with both positive and negative feelings. At times it has felt novel, interesting and gave me a sense of achievement, whereas at other times I felt frustrated, disappointed and resentful. Overall though I am proud that I was able to follow my heart and

completed my research in an area that I was passionate about despite the difficulties I needed to overcome. In revisiting the learning model I am not sure I reached the final unconscious competent stage but I feel more equipped in my understanding of carrying out research and hope in my future career as a qualified Clinical Psychologist I will be able to pursue some element of research in my role.

### **3.8. Conclusion**

The research journey has been a valuable learning experience and this piece has provided space to reflect on the processes and challenges of conducting sensitive research. Through the experience I have come to further appreciate my own personal values and how they may relate to my professional identity. Furthermore it has also created an opportunity to consider how I might integrate what I have learned to develop my professional practice.

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## Appendix A: Author guidelines for Clinical Psychology Review



### CLINICAL PSYCHOLOGY REVIEW

#### AUTHOR INFORMATION PACK

#### TABLE OF CONTENTS

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• <b>Description</b>	<b>p.1</b>
• <b>Audience</b>	<b>p.1</b>
• <b>Impact Factor</b>	<b>p.1</b>
• <b>Abstracting and Indexing</b>	<b>p.2</b>
• <b>Editorial Board</b>	<b>p.2</b>
• <b>Guide for Authors</b>	<b>p.3</b>



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**Appendix B: Data Extraction Tool**

**JBI Data Extraction Form for  
Experimental / Observational Studies**

Reviewer ..... Date .....

Author ..... Year .....

Journal ..... Record Number .....

**Study Method**

RCT  Quasi-RCT  Longitudinal

Retrospective  Observational  Other

**Participants**

Setting \_\_\_\_\_

Population \_\_\_\_\_

**Sample size**

Group A \_\_\_\_\_ Group B \_\_\_\_\_

**Interventions**

Intervention A \_\_\_\_\_

Intervention B \_\_\_\_\_

Authors Conclusions: \_\_\_\_\_

\_\_\_\_\_

Reviewers Conclusions: \_\_\_\_\_

\_\_\_\_\_

Measures \_\_\_\_\_

\_\_\_\_\_

**Study results**

**Dichotomous data**

<b>Outcome</b>	<b>Intervention ( ) number / total number</b>	<b>Intervention ( ) number / total number</b>

**Continuous data**

<b>Outcome</b>	<b>Intervention ( ) number / total number</b>	<b>Intervention ( ) number / total number</b>

**Appendix C: EPHPP: Quality Assessment Tool for Quantitative Studies**



**QUALITY ASSESSMENT TOOL FOR QUANTITATIVE STUDIES**

**COMPONENT RATINGS**

**A) SELECTION BIAS**

**(Q1) Are the individuals selected to participate in the study likely to be representative of the target population?**

- 1 Very likely
- 2 Somewhat likely
- 3 Not likely
- 4 Can't tell

**(Q2) What percentage of selected individuals agreed to participate?**

- 1 80 - 100% agreement
- 2 60 – 79% agreement
- 3 less than 60% agreement
- 4 Not applicable
- 5 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

**B) STUDY DESIGN**

**Indicate the study design**

- 1 Randomized controlled trial
- 2 Controlled clinical trial
- 3 Cohort analytic (two group pre + post)
- 4 Case-control
- 5 Cohort (one group pre + post (before and after))
- 6 Interrupted time series
- 7 Other specify \_\_\_\_\_
- 8 Can't tell

**Was the study described as randomized? If NO, go to Component C.**

No                      Yes

**If Yes, was the method of randomization described? (See dictionary)**

No                      Yes

**If Yes, was the method appropriate? (See dictionary)**

No                      Yes

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

### C) CONFOUNDERS

**(Q1) Were there important differences between groups prior to the intervention?**

- 1 Yes
- 2 No
- 3 Can't tell

**The following are examples of confounders:**

- 1 Race
- 2 Sex
- 3 Marital status/family
- 4 Age
- 5 SES (income or class)
- 6 Education
- 7 Health status
- 8 Pre-intervention score on outcome measure

**(Q2) If yes, indicate the percentage of relevant confounders that were controlled (either in the design (e.g. stratification, matching) or analysis)?**

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

### D) BLINDING

**(Q1) Was (were) the outcome assessor(s) aware of the intervention or exposure status of participants?**

- 1 Yes
- 2 No
- 3 Can't tell

**(Q2) Were the study participants aware of the research question?**

- 1 Yes
- 2 No
- 3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

### E) DATA COLLECTION METHODS

**(Q1) Were data collection tools shown to be valid?**

- 1 Yes
- 2 No
- 3 Can't tell

**(Q2) Were data collection tools shown to be reliable?**

- 1 Yes
- 2 No
- 3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

**F) WITHDRAWALS AND DROP-OUTS**

**(Q1) Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?**

- 1 Yes
- 2 No
- 3 Can't tell
- 4 Not Applicable (i.e. one time surveys or interviews)

**(Q2) Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest).**

- 1 80 -100%
- 2 60 - 79%
- 3 less than 60%
- 4 Can't tell
- 5 Not Applicable (i.e. Retrospective case-control)

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

**G) INTERVENTION INTEGRITY**

**(Q1) What percentage of participants received the allocated intervention or exposure of interest?**

- 1 80 -100%
- 2 60 - 79%
- 3 less than 60%
- 4 Can't tell

**(Q2) Was the consistency of the intervention measured?**

- 1 Yes
- 2 No
- 3 Can't tell

**(Q3) Is it likely that subjects received an unintended intervention (contamination or co-intervention) that may influence the results?**

- 4 Yes
- 5 No
- 6 Can't tell

**H) ANALYSES**

**(Q1) Indicate the unit of allocation (circle one)**

community organization/institution      practice/office      individual

**(Q2) Indicate the unit of analysis (circle one)**

community organization/institution      practice/office      individual

**(Q3) Are the statistical methods appropriate for the study design?**

- 1 Yes
- 2 No
- 3 Can't tell

**(Q4) Is the analysis performed by intervention allocation status (i.e. intention to treat) rather than the actual intervention received?**

- 1 Yes
- 2 No
- 3 Can't tell

**GLOBAL RATING**

**COMPONENT RATINGS**

Please transcribe the information from the gray boxes on pages 1-4 onto this page. See dictionary on how to rate this section.

<b>A</b>	<b>SELECTION BIAS</b>	<b>STRONG</b>	<b>MODERATE</b>	<b>WEAK</b>
		1	2	3
<b>B</b>	<b>STUDY DESIGN</b>	<b>STRONG</b>	<b>MODERATE</b>	<b>WEAK</b>
		1	2	3
<b>C</b>	<b>CONFOUNDERS</b>	<b>STRONG</b>	<b>MODERATE</b>	<b>WEAK</b>
		1	2	3
<b>D</b>	<b>BLINDING</b>	<b>STRONG</b>	<b>MODERATE</b>	<b>WEAK</b>
		1	2	3
<b>E</b>	<b>DATA COLLECTION</b>	<b>STRONG</b>	<b>MODERATE</b>	<b>WEAK</b>
		1	2	3
<b>F</b>	<b>WITHDRAWALS AND DROPOUTS</b>	<b>STRONG</b>	<b>MODERATE</b>	<b>WEAK</b>
		1	2	3
	Not Applicable			

**GLOBAL RATING FOR THIS PAPER (circle one):**

STRONG	(no WEAK ratings)
MODERA	(one WEAK rating)
WEAK	(two or more WEAK ratings)

With both reviewers discussing the ratings:

Is there a discrepancy between the two reviewers with respect to the component (A-F) ratings?

No      Yes

If yes, indicate the reason for the discrepancy

- 1      Oversight
- 2      Differences in interpretation of criteria
- 3      Differences in interpretation of study

**Final decision of both reviewers**

**STRONG**  
**MODERATE**  
**WEAK**

**Appendix D: Quality Table**

Author	Selection Bias	Study Design	Confounders	Blinding	Data Collection method	Withdrawals and Dropouts	Overall
Ragsdale et al. (1996)	Moderate	Strong	Strong	Moderate	Strong	Moderate	Strong
Minnen et al. (2000)	Moderate	Moderate	NA	Strong	Weak	Moderate	Moderate
Kubany et al. (2003)	Moderate	Strong	Strong	Moderate	Strong	Strong	Strong
Kubany et al. (2004)	Moderate	Strong	Strong	Moderate	Strong	Moderate	Strong
Cohen et al. (2006)	Strong	Strong	Strong	Moderate	Strong	Strong	Strong
Deblinger et al. (2006)	Strong	Strong	Strong	Moderate	Strong	Strong	Strong
Arntz et al. (2007)	Moderate	Strong	Strong	Moderate	Weak	Weak	Weak
Resick et al. (2008)	Weak	Strong	Strong	Moderate	Strong	Strong	Moderate
Ginzberg et al. (2009)	Weak	Strong	Strong	Moderate	Strong	Moderate	Moderate
Deblinger et al. (2011)	Moderate	Strong	Strong	Moderate	Strong	Strong	Strong

<b>Mannarino et al. (2012)</b>	Moderate	Strong	Strong	Moderate	Strong	Strong	<b>Strong</b>
<b>Harned et al. (2012)</b>	Moderate	Moderate	NA	Strong	Strong	Moderate	<b>Strong</b>
<b>Murray et al. (2013)</b>	Weak	Moderate	NA	Moderate	Strong	Moderate	<b>Moderate</b>
<b>Oktedalen et al. (2015)</b>	Moderate	Strong	Strong	Moderate	Strong	Strong	<b>Strong</b>
<b>Goldsmith et al. (2014)</b>	Weak	Moderate	NA	Moderate	Strong	Strong	<b>Moderate</b>
<b>Harned et al. (2014)</b>	Moderate	Strong	Strong	Strong	Strong	Weak	<b>Moderate</b>

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- Differentiate works by the same author and with the same publication date by adding an identifying letter to each date: (Bloom, 1987a, 1987b)
- List works by different authors in alphabetical order by last name, and use semicolons to separate the references: (Gould, 1989; Smith, 1983; Tutwiler, 1989).

All references must be complete and accurate. Where possible the [DOI](#) for the reference should be included at the end of the reference. Online citations should include date of access. If necessary, cite unpublished or personal work in the text but do not include it in the reference list. References should be listed in the following style:

### **Journal Article**

Gardikiotis, A., Martin, R., & Hewstone, M. (2004). The representation of majorities and minorities in the British press: A content analytic approach. *European Journal of Social Psychology*, *34*, 637-646. DOI: 10.1002/ejsp.221

### **Book**

Paloutzian, R. F. (1996). *Invitation to the psychology of religion* (2nd ed.). Boston: Allyn and Bacon.

### **Book with More than One Author**

Natarajan, R., & Chaturvedi, R. (1983). *Geology of the Indian Ocean*. Hartford, CT: University of Hartford Press.

Hesen, J., Carpenter, K., Moriber, H., & Milsop, A. (1983). *Computers in the business world*. Hartford, CT: Capital Press. and so on.

The abbreviation *et al.* is not used in the reference list, regardless of the number of authors, although it can be used in the text citation of material with three to five authors (after the initial citation, when all are listed) and in all parenthetical citations of material with six or more authors.

### **Web Document on University Program or Department Web Site**

Degelman, D., & Harris, M. L. (2000). *APA style essentials*. Retrieved May 18, 2000, from Vanguard University, Department of Psychology Website: [http://www.vanguard.edu/faculty/ddegelman/index.cfm?doc\\_id=796](http://www.vanguard.edu/faculty/ddegelman/index.cfm?doc_id=796)

### **Stand-alone Web Document (no date)**

Nielsen, M. E. (n.d.). *Notable people in psychology of religion*. Retrieved August 3, 2001, from <http://www.psywww.com/psyrelig/psyrelpr.htm>

### **Journal Article from Database**

Hien, D., & Honeyman, T. (2000). A closer look at the drug abuse-maternal aggression link. *Journal of Interpersonal Violence*, 15 , 503-522. Retrieved May 20, 2000, from ProQuest database.

### **Abstract from Secondary Database**

Garrity, K., & Degelman, D. (1990). Effect of server introduction on restaurant tipping. *Journal of Applied Social Psychology*, 20 , 168-172. Abstract retrieved July 23, 2001, from PsycINFO database.

### **Article or Chapter in an Edited Book**

Shea, J. D. (1992). Religion and sexual adjustment. In J. F. Schumaker (Ed.), *Religion and mental health* (pp. 70-84). New York: Oxford University Press.

\*The Digital Object Identifier (DOI) is an identification system for intellectual property in the digital environment. Developed by the International DOI Foundation on behalf of the publishing industry, its goals are to provide a framework for managing intellectual content, link customers with publishers, facilitate electronic commerce, and enable automated copyright management.

**Illustrations.** Upload each figure as a separate file in either .tiff or .eps format, the figure number and the top of the figure indicated. Compound figures e.g. 1a, b, c should be uploaded as one figure. Grey shading and tints are not acceptable. Lettering must be of a reasonable size that would still be clearly legible upon reduction, and consistent within each figure and set of figures. Where a key to symbols is required, please include this in the artwork itself, not in the figure legend. All illustrations must be supplied at the correct resolution:

- Black and white and colour photos - 300 dpi
- Graphs, drawings, etc - 800 dpi preferred; 600 dpi minimum
- Combinations of photos and drawings (black and white and colour) - 500 dpi

The cost of printing **colour** illustrations in the journal will be charged to the author. The cost is approximately £700 per page. If colour illustrations are supplied electronically in either **TIFF** or **EPS** format, they **may** be used in the PDF of the article at no cost to the author, even if this illustration was printed in black and white in the journal. The PDF will appear on the *Wiley Online Library* site.

### **POST ACCEPTANCE**

**Further information.** For accepted manuscripts the publisher will supply proofs to the corresponding author prior to publication. This stage is to be used only to correct errors that may have been introduced during the production process. Prompt return of the corrected proofs, preferably within two days of receipt, will minimise the risk of the paper being held over to a later issue. Once your article is published online no further amendments can be made. Free access to the final PDF offprint or your article will be available via author services only. Please therefore sign up for author services if you would like to access your article PDF offprint and enjoy the many other benefits the service offers

**Author Resources.** Manuscript now accepted for publication?

If so, visit out our suite of tools and services for [authors](#) and sign up for:

- Article Tracking
- E-mail Publication Alerts
- Personalization Tools

**Cite EarlyView articles.** To link to an article from the author's homepage, take the DOI (digital object identifier) and append it to "http://dx.doi.org/" as per following example:

DOI 10.1002/hep.20941, becomes <http://dx.doi.org/10.1002/hep.20941>.

**Appendix F: Demographic information sheet**

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**Demographic Information Data Collection Sheet**

**16<sup>th</sup> September 2014 Version 1.1**

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**Title of Project:** Experience of self-conscious emotion in psychosis.

**Name of Researcher:** Joanne Barratt

Identifier Code: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Length of Illness: \_\_\_\_\_ years

Age: \_\_\_\_\_ years

Gender: Male  Female

Ethnicity:

White English / Welsh / Scottish / Northern Irish / British \_\_\_\_\_  
Irish \_\_\_\_\_  
Gypsy or Irish Traveller \_\_\_\_\_  
Any other White background, please describe \_\_\_\_\_

Mixed / Multiple ethnic groups White and Black Caribbean \_\_\_\_\_  
White and Black African \_\_\_\_\_  
White and Asian \_\_\_\_\_  
Any other Mixed / Multiple ethnic background \_\_\_\_\_

Asian / Asian British Indian \_\_\_\_\_  
Pakistani \_\_\_\_\_  
Bangladeshi \_\_\_\_\_  
Chinese \_\_\_\_\_  
Any other Asian background \_\_\_\_\_

Black / African / Caribbean / Black British \_\_\_\_\_  
African \_\_\_\_\_  
Caribbean \_\_\_\_\_  
Any other Black / African / Caribbean background \_\_\_\_\_

Other ethnic group Arab \_\_\_\_\_

Any other ethnic group, \_\_\_\_\_

## **Appendix G: Childhood Trauma Questionnaire**

Questionnaire redacted due to copyright.

## **Appendix H: Psychiatric Symptoms Rating Scale**

Questionnaire redacted due to copyright.

## Appendix I: Experience of Shame Scale

Everybody at times can feel embarrassed, self-conscious or ashamed. These questions are about such feelings if they have occurred at any time in the past year. There are no “right” or “wrong” answers. Please indicate the response which applies to you by circling the number on the scale ranging from not at all to very much.

	<b>not at all</b>	<b>a little</b>	<b>moderately</b>	<b>very much</b>
1. Have you felt ashamed of any of your personal habits?	1	2	3	4
2. Have you worried about what other people think of any of your personal habits?	1	2	3	4
3. Have you tried to cover up or conceal any of your personal habits?	1	2	3	4
4. Have you felt ashamed of your manner with others?	1	2	3	4
5. Have you worried about what other people think of your manner with others?	1	2	3	4
6. Have you avoided people because of your manner?	1	2	3	4
7. Have you felt ashamed of the sort of person you are?	1	2	3	4
8. Have you worried about what other people think of the sort of person you are?	1	2	3	4
9. Have you tried to conceal from others the sort of person you are?	1	2	3	4
10. Have you felt ashamed of your ability to do things?	1	2	3	4
11. Have you worried about what other people think of your ability to do things?	1	2	3	4
12. Have you avoided people because of your inability to do things?	1	2	3	4
13. Do you feel ashamed when you do something wrong?	1	2	3	4

14. Have you worried about what other people think of you when you do something wrong?	1	2	3	4
15. Have you tried to cover up or conceal things you felt ashamed of having done?	1	2	3	4
16. Have you felt ashamed when you said something stupid?	1	2	3	4
17. Have you worried about what other people think of you when you said something stupid?	1	2	3	4
18. Have you avoided contact with anyone who knew you said something stupid?	1	2	3	4
19. Have you felt ashamed when you failed in a competition situation?	1	2	3	4
20. Have you worried about what other people think of you when you failed in a competitive situation?	1	2	3	4
21. Have you avoided people who have seen you fail?	1	2	3	4
22. Have you felt ashamed of your body or any part of it?	1	2	3	4
23. Have you worried about what other people think of your appearance?	1	2	3	4
24. Have you avoided looking at yourself in the mirror?	1	2	3	4
25. Have you wanted to hide or conceal your body or any part of it?	1	2	3	4

## Appendix J: Other as Shamer Scale

We are interested in how people think others see them. Below is a list of statements describing feelings or experiences about how you may feel other people see you.

Read each statement carefully and circle the number to the right of the item that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement. Use the scale below.

**0 = NEVER 1 = SELDOM 2 = SOMETIME 3 = FREQUENTLY 4 = ALMOST ALWAYS**

- |  |           |
|--|-----------|
| 1. I feel other people see me as not good enough.  | 0 1 2 3 4 |
| 2. I think that other people look down on me   | 0 1 2 3 4 |
| 3. Other people put me down a lot  | 0 1 2 3 4 |
| 4. I feel insecure about others opinions of me   | 0 1 2 3 4 |
| 5. Other people see me as not measuring up to the  | 0 1 2 3 4 |
| 6. Other people see me as small and insignificant  | 0 1 2 3 4 |
| 7. Other people see me as somehow defective as a person                                    | 0 1 2 3 4 |
| 8. People see me as unimportant compared to others   | 0 1 2 3 4 |
| 9. Other people look for my faults   | 0 1 2 3 4 |
| 10. People see me as striving for perfection but being unable<br>to reach my own standards | 0 1 2 3 4 |
| 11. I think others are able to see my defects  | 0 1 2 3 4 |
| 12. Others are critical or punishing when I make a mistake                                 | 0 1 2 3 4 |
| 13. People distance themselves from me when I make mistakes                                | 0 1 2 3 4 |
| 14. Other people always remember my mistakes   | 0 1 2 3 4 |
| 15. Others see me as fragile   | 0 1 2 3 4 |
| 16. Others see me as empty and unfulfilled   | 0 1 2 3 4 |
| 17. Others think there is something missing in me  | 0 1 2 3 4 |
| 18. Other people think I have lost control over my body and feelings                       | 0 1 2 3 4 |

## **SCORING**

Add up all items

## **DESCRIPTION**

### *The Other as Shamer Scale (OAS)*

The OAS was adapted from Cook's (1993) Internalised Shame Scale to measure 'external shame' (Allan, Gilbert & Goss, 1994; Goss, Gilbert & Allan, 1998). The scale consists of 18 items rated on a five-point scale according to the frequency of evaluations about how others judge the self, (0 = Never to 4 = Almost always). Items include: 'I feel other people look down on me', 'other people see me as somehow defective as a person' and 'other people always remember my mistakes'. In the original study the scale showed high internal consistency with a Cronbach's alpha of .92. The scale has been shown to have a high alpha level 0.96.

## **REFERENCE**

Allan, S., Gilbert, P. & Goss, K. (1994). An exploration of shame measures: II: Psychopathology. *Personality and Individual Differences*, 17, 719-722

Goss, K., Gilbert, P. & Allan, S. (1994) An exploration of shame measures: I: The 'other as shamer'scale. *Personality and Individual Differences*, 17, 713-717.



9. Being too compassionate makes people soft and easy to take advantage of  
0 1 2 3 4
10. For some people, I think discipline and proper punishments are more helpful than being compassionate to them  
0 1 2 3 4

**Scale 2: Responding to the expression of compassion from others**

1. Wanting others to be kind to oneself is a weakness  
0 1 2 3 4
2. I fear that when I need people to be kind and understanding they won't be  
0 1 2 3 4
3. I'm fearful of becoming dependent on the care from others because they might not always be available or willing to give it  
0 1 2 3 4
4. I often wonder whether displays of warmth and kindness from others are genuine  
0 1 2 3 4
5. Feelings of kindness from others are somehow frightening  
0 1 2 3 4
6. When people are kind and compassionate towards me I feel anxious or embarrassed  
0 1 2 3 4
7. If people are friendly and kind I worry they will find out something bad about me that will change their mind  
0 1 2 3 4
8. I worry that people are only kind and compassionate if they want something from me  
0 1 2 3 4
9. When people are kind and compassionate towards me I feel empty and sad  
0 1 2 3 4
10. If people are kind I feel they are getting too close  
0 1 2 3 4
11. Even though other people are kind to me, I have rarely felt warmth from my relationships with others  
0 1 2 3 4
12. I try to keep my distance from others even if I know they are kind  
0 1 2 3 4
13. If I think someone is being kind and caring towards me, I 'put up a barrier'  
0 1 2 3 4

### Scale 3: Expressing kindness and compassion towards yourself

1. I feel that I don't deserve to be kind and forgiving to myself  
0 1 2 3 4
2. If I really think about being kind and gentle with myself it makes me sad  
0 1 2 3 4
3. Getting on in life is about being tough rather than compassionate  
0 1 2 3 4
4. I would rather not know what being 'kind and compassionate to myself' feels like  
0 1 2 3 4
5. When I try and feel kind and warm to myself I just feel kind of empty  
0 1 2 3 4
6. I fear that if I start to feel compassion and warmth for myself, I will feel  
overcome with a sense of loss/grief  
0 1 2 3 4
7. I fear that if I become kinder and less self-critical to myself then my standards will  
drop  
0 1 2 3 4
8. I fear that if I am more self compassionate I will become a weak person  
0 1 2 3 4
9. I have never felt compassion for myself, so I would not know where to begin to  
develop these feelings  
0 1 2 3 4
10. I worry that if I start to develop compassion for myself I will become dependent  
on it  
0 1 2 3 4
11. I fear that if I become too compassionate to myself I will lose my self-criticism  
and my flaws will show  
0 1 2 3 4
12. I fear that if I develop compassion for myself, I will become someone I do not  
want to be  
0 1 2 3 4
13. I fear that if I become too compassionate to myself others will reject me  
0 1 2 3 4
14. I find it easier to be critical towards myself rather than compassionate  
0 1 2 3 4
15. I fear that if I am too compassionate towards myself, bad things will happen  
0 1 2 3 4

**Appendix L: Coventry University Ethics Committee Approval**

**TO WHOM IT MAY CONCERN**

QRS/Ethics/Sponsorlet

Wednesday, 17 September  
2014

Dear Sir/Madam

**Researcher's name: Joanne Barratt**  
**Project Reference: P9824**  
**Project Title: Self conscious emotion: An investigation into the relationship between childhood trauma, feelings of shame, voice hearing, delusions and compassion in people experiencing psychosis.**

The above named student has successfully completed the Coventry University Ethical Approval process for her project to proceed.

I should like to confirm that Coventry University is happy to act as the sole sponsor for this student and attach details of our Public Liability Insurance documentation.

With kind regards

Yours faithfully



**Professor Ian Marshall**  
**Deputy Vice-Chancellor, Academic**

Enc

## Appendix M: NHS Research Ethics Committee Approval

**NHS**  
**Health Research Authority**

**NRES Committee South West - Frenchay**

Level 3, Block B

Whitefriars

Lewins Mead,

Bristol BS1 2NT

Email: [nrescommittee.southwest-frenchay@nhs.net](mailto:nrescommittee.southwest-frenchay@nhs.net)

Telephone: 0117 342 1335

Fax: 0117 342 0445

17 December 2014

Mrs Joanne Barratt  
4 Cornflower Road  
Swindon  
SN25 1SA

Dear Mrs Barratt

**Study title:** Self-conscious emotion: An investigation into the relationship between childhood trauma, feelings of shame, voice hearing, delusions and compassion in people experiencing psychosis.  
**REC reference:** 14/SW/1111  
**IRAS project ID:** 121718

Thank you for responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager, Mrs Naazneen Nathoo, [nrescommittee.southwest-frenchay@nhs.net](mailto:nrescommittee.southwest-frenchay@nhs.net). Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

### Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

A Research Ethics Committee established by the Health Research Authority

### **Conditions of the favourable opinion**

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

*Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.*

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

*Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of approvals from host organisations*

### **Registration of Clinical Trials**

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact [hra\\_studyregistration@nhs.net](mailto:hra_studyregistration@nhs.net). The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

### **Ethical review of research sites**

#### **NHS sites**

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

A Research Ethics Committee established by the Health Research Authority

## Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Covering letter on headed paper [Re: amendment]		26 September 2014
Covering letter on headed paper [Re: amendment]		28 October 2014
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		
GP/consultant information sheets or letters	1.0	16 September 2014
IRAS Checklist XML [Checklist_26092014]		26 September 2014
IRAS Checklist XML [Checklist_29102014]		29 October 2014
IRAS Checklist XML [Checklist_02122014]		02 December 2014
IRAS Checklist XML [Checklist_12122014]		12 December 2014
Letter from sponsor		17 September 2014
Letters of invitation to participant	1.0	08 September 2014
Other		
Other [Demographic Information Data Collection Sheet]	1.1	16 September 2014
Other [Participant Reply Slip]	1.0	08 September 2014
Other [Site specific reply slip]	1.1	26 September 2014
Other [local participant information sheet (no home appointment)]	1.4	12 November 2014
Other [Debriefing Sheet]	1.2	12 December 2014
Participant consent form	1.4	12 November 2014
Participant information sheet (PIS)	1.4	12 November 2014
REC Application Form [REC_Form_23092014]		23 September 2014
Research protocol or project proposal	1.1	16 September 2014
Summary CV for Chief Investigator (CI)		18 September 2014
Summary CV for supervisor (student research)		
Validated questionnaire		
Validated questionnaire [All 4 questionnaires and 1 structured interview]	1.0	24 September 2014
Validated questionnaire [Experience of Shame Scale]		
Validated questionnaire [Other as a shamer scale]		
Validated questionnaire [Fear of Compassion Scale]		
Validated questionnaire [PSYRATS pg. 75-86 (Structured Interview)]		

## Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

A Research Ethics Committee established by the Health Research Authority

## After ethical review

### Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

### **User Feedback**

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:

<http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

### **HRA Training**

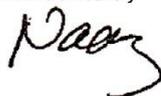
We are pleased to welcome researchers and R&D staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

**14/SW/1111**

**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely



pp. Mr Stephen Draper  
Chair

Email: [nrescommittee.southwest-frenchay@nhs.net](mailto:nrescommittee.southwest-frenchay@nhs.net)

Enclosures: "After ethical review – guidance for researchers" [SL-AR2]

Copy to: Dr Ian Marshall

*Ms Natassia Embury, West Midlands South Comprehensive Local Research Network*

A Research Ethics Committee established by the Health Research Authority



## Health Research Authority

NRES Committee South West - Frenchay

Level 3, Block B

Whitefriars

Lewins Mead,

Bristol BS1 2NT

Email: nrescommittee.southwest-frenchay@nhs.net

Tel: 0117 342 1335

Fax: 0117 342 0445

12 March 2015

Mrs Joanne Barratt  
4 Cornflower Road  
Swindon  
SN25 1SA

Dear Mrs Barratt

**Study title:** Self-conscious emotion: An investigation into the relationship between childhood trauma, feelings of shame, voice hearing, delusions and compassion in people experiencing psychosis.

**REC reference:** 14/SW/1111

**Amendment number:** 1.0

**Amendment date:** 19 February 2015

**IRAS project ID:** 121718

The above amendment was reviewed by the Sub-Committee in correspondence.

### Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

### Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Letters of invitation to participant [Participant Letter V1.1]	1.1	19 February 2015
Notice of Substantial Amendment (non-CTIMP) [AmendmentForm_snapshot[2]]	1.0	19 February 2015
Participant consent form [Consent Form v1.5]	1.5	20 February 2015
Participant information sheet (PIS) [Participantinformationsheet v1.5 submitted 09.03.2015]	1.5	19 February 2015

### Membership of the Committee

The members of the Committee who took part in the review are listed below.

A Research Ethics Committee established by the Health Research Authority

**R&D approval**

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

**Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

**14/SW/1111: Please quote this number on all correspondence**

Yours sincerely



pp. **Mr Peter Jones**  
**Chair**

E-mail: [nrescommittee.southwest-frenchay@nhs.net](mailto:nrescommittee.southwest-frenchay@nhs.net)

Copy to: *Ms Natassia Embury, West Midlands South Comprehensive Local Research Network*  
*Dr Ian Marshall*

.....  
**NRES Committee South West - Frenchay**

**Attendance at Sub-Committee of the REC meeting in correspondence**

**Committee Members:**

Name	Profession	Present	Notes
Mr Peter Jones	Retired Head teacher	Yes	
Dr Ruth Morse	Senior Lecturer in Molecular Biomedicine	Yes	

**Also in attendance:**

Name	Position (or reason for attending)
Miss Tanya Muravyeva	REC Assistant

**Appendix N: Coventry and Warwickshire Partnership NHS Trust Research and  
Development Team approval**

**Coventry and Warwickshire **  
Partnership Trust

National Institute for Health Research Clinical Research Network: West Midlands  
Fourth Floor, Rotunda (ADA40014)  
University Hospitals Coventry & Warwickshire NHS Trust  
University Hospital  
Clifford Bridge Road  
Coventry  
CV2 2DX

23<sup>rd</sup> December 2014

Mrs J Barratt  
Trainee Clinical Psychologist  
Coventry and Warwickshire Partnership NHS Trust  
St Michaels Hospital  
Warwick  
CV34 5QW

Dear Mrs Barratt

**Project Title: Self conscious emotion: An investigation into the relationship  
between childhood trauma, feelings of shame, voice hearing, delusions and  
compassion in people experiencing psychosis**  
**R&D Ref: PAR240914**  
**REC Ref: 14/SW/1111**

I am pleased to inform you that the R&D review of the above project is complete, and  
NHS permission has been granted for the study at Coventry and Warwickshire  
Partnership NHS Trust. The details of your study have now been entered onto the  
Trust's database.

The permission has been granted on the basis described in the application form,  
protocol and supporting documentation. The documents reviewed were:

Document	Version	Date
REC Favourable Opinion Letter		17.12.2014
Letter of Invitation to Participant	1.0	08.09.2014
Gp Information Sheet or Letter	1.0	16.09.2014
Other (Demographic Information Data Collection Sheet)	1.1	16.09.2014
Participant Reply Slip	1.0	08.09.2014
Site Specific Reply Slip	1.1	26.09.2014
Participant Information Sheet (no home appointment)	1.4	12.11.2014
Debriefing Sheet	1.2	12.12.2014
Participant Consent Form	1.4	12.11.2014
Participant Information Sheet	1.4	12.11.2014
Research Protocol	1.1	16.09.2014
Validated Questionnaire (All 4	1.0	24.09.2014

questionnaires and 1 structured interview)		
Validated Questionnaire (Experience of Shame Scale)		
Validated Questionnaire (Other as a shamer scale)		
Validated Questionnaire (Fear of Compassion Scale)		
Validated Questionnaire (PSYRATS Structured interview)		
R and D Form	121718/714760/14/896	17.10.2014
SSi Form	121718/674953/6/284/263061/309032	01.10.2014

All research must be managed in accordance with the requirements of the Department of Health's Research Governance Framework (RGF), to ICH-GCP standards (if applicable) and to NHS Trust policies and procedures. Permission is only granted for the activities agreed by the relevant authorities.

All amendments (including changes to the local research team and status of the project) need to be submitted to the REC and the R&D office in accordance with the guidance in IRAS. Any urgent safety measures required to protect research participants against immediate harm can be implemented immediately. You should notify the R&D Office within the same time frame as any other regulatory bodies.

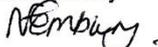
It is your responsibility to keep the R&D Office and Sponsor informed of all Serious Adverse Events. All SAEs must be reported within the timeframes detailed within ICH-GCP statutory instruments and EU directives.

In order to ensure that research is carried out to the highest governance standards, the Trust employs the services of an external monitoring organisation to provide assurance. Your study may be randomly selected for audit at any time, and you must co-operate with the auditors. Action may be taken to suspend Trust approval if the research is not run in accordance with RGF or ICH-GCP standards, or following recommendations from the auditors.

You will be sent an annual progress report which must be completed in order to ensure that the information we hold on our database remains up to date, in line with RGF requirements.

I wish you well with your project. Please do not hesitate to contact me should you need any guidance or assistance.

Yours sincerely



**Natassia Embury**  
RM&G Facilitator

**Cc:** Bernie Campbell, CWPT  
Ian Hume, Academic Supervisor, Coventry University  
Ian Marshall, Sponsor Representative, Coventry University  
Kay Wright, RD&I Manager, CWPT

## No Objection to Amendment

Research Amendments (RKB) <Research.Amendments@uhcw.nhs.uk>

Wed 08/04/2015 17:50

Inbox

To: Barratt, Jo <Joanne.Barratt@warwick.ac.uk>;

**Dear Mrs Barrett**

**R&D Reference: PAR240914**  
**Short Title: Self Conscious Emotion**  
**Amendment: Substantial Amendment 1**

Following review of substantial amendment 1 for the above study, Coventry & Warwickshire Partnership Trust confirms they can accommodate this amendment. The amendment may therefore be immediately implemented at this site under the existing NHS Permission.

The following documents were reviewed:

- Letters of invitation to participant [Participant Letter V1.1] - V1.1 - 19 February 2015
- Notice of Substantial Amendment (non-CTIMP) [Amendment Form\_snapshot[2] - V1 - 19 February 2015
- Participant consent form [Consent Form v1.5] - V1.5 - 20 February 2015
- Participant information sheet (PIS) [Participant information sheet v1.5 submitted 09.03.2015] - V1.5 - 19 February 2015
- REC Favourable Ethical Opinion Letter - 12 March 2015

**Please note:**

**You may only implement changes that were described in the amendment notice or letter.**

Thank you for keeping R&D informed.

Best wishes & kind regards

**Elizabeth Vassell**  
**Research Support Assistant**  
NIHR Clinical Research Network: West Midlands

Tel: 024 7696 7549 (internal: 27549)  
Research Amendments: [research.amendments@uhcw.nhs.uk](mailto:research.amendments@uhcw.nhs.uk)  
CSP query: [uhc-tr.wmsclrn@nhs.net](mailto:uhc-tr.wmsclrn@nhs.net)

NIHR Clinical Research Network: West Midlands | Fourth Floor Rotunda (ADA40014) | University Hospitals  
Coventry & Warwickshire NHS Trust | Clifford Bridge Road | Coventry | CV2 2DX

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[www.crn.nihr.ac.uk](http://www.crn.nihr.ac.uk)

P Please consider the environment before printing

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**Appendix O: Avon and Wiltshire Partnership NHS Trust Research and Development Team**



**Our Reference: 868AWP**

Joanne Barratt  
St Michaels Hospital  
St Michaels Road  
Warwick  
CV34 5QW

Hannah Antoniadou  
Research and Development  
Avon & Wiltshire Mental Health Partnership NHS Trust  
Blackberry Hill Hospital  
Blackberry Centre  
Manor Road  
Fishponds  
Bristol  
BS16 2EW  
0117 378 4267

Date: 28<sup>th</sup> January 2015

[hannah.antoniadou@nhs.net](mailto:hannah.antoniadou@nhs.net)

Dear Joanne,

**Title of study:** **Self-conscious emotion: An investigation into the relationship between childhood trauma, feelings of shame, voice hearing, delusions and compassion in people experiencing psychosis.**  
**Approval date:** 28<sup>th</sup> January 2015  
**End date:** 27<sup>th</sup> February 2015

Thank you very much for applying to undertake your research in AWP, we pride ourselves on a straight forward and rapid process for research governance and project management.

We are pleased to advise that we have been able to grant R&D Permission at Avon and Wiltshire Mental Health Partnership NHS Trust ("the Trust").

We now use EDGE (a Clinical Management System) to manage our research studies. As part of your approval you will be issued with an account and guide and will be expected to upload AWP recruitment figures regularly. This is a requirement from 01 April 2014 for all research recruiting in the Trust. Failure to comply with this will result in your research being suspended, so please make sure you complete this on a monthly basis.

We also require you to document any study activity on RiO for the relevant patient records.

The R&D Permission in the Trust is valid until **27<sup>th</sup> February 2015**. If you require any extension to this in the future please contact us to arrange.

The documentation listed below has been received and all the relevant governance checks have now been completed.

I am therefore happy to provide R&D Permission for the above study across all locations within the Trust parameters.

Document	Version	Date
Covering letter on headed paper [Re: amendment]		26 September 2014
Covering letter on headed paper [Re: amendment]		28 October 2014
IRAS Checklist XML [Checklist_26092014]		26 September 2014
IRAS Checklist XML [Checklist_29102014]		29 October 2014

Continued...

Chair  
Anthony Gallagher

Headquarters  
Jenner House, Langley Park, Chippenham. SN15 1GG

Chief Executive  
Iain Tulley

IRAS Checklist XML [Checklist_02122014]		02 December 2014
IRAS Checklist XML [Checklist_12122014]		12 December 2014
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		
Letter from sponsor		17 September 2014
Letters of invitation to participant	1.0	08 September 2014
GP/consultant information sheets or letters	1.0	16 September 2014
Other		
Other [Demographic Information Data Collection Sheet]	1.1	16 September 2014
Other [Participant Reply Slip]	1.0	08 September 2014
Other [Site specific reply slip]	1.1	26 September 2014
Other [local participant information sheet (no home appointment)]	1.4	12 November 2014
Other [Debriefing Sheet]	1.2	12 December 2014
Participant consent form	1.4	12 November 2014
Participant information sheet (PIS)	1.4	12 November 2014
REC Application Form [REC_Form_23092014]		23 September 2014
Research protocol or project proposal	1.1	16 September 2014
Summary CV for Chief Investigator (CI)		18 September 2014
Summary CV for supervisor (student research)		
Validated questionnaire		
Validated questionnaire [All 4 questionnaires and 1 structured interview]	1.0	24 September 2014
Validated questionnaire [Experience of Shame Scale]		
Validated questionnaire [Other as a shamer scale]		
Validated questionnaire [Fear of Compassion Scale]		
Validated questionnaire [PSYRATS pg. 75-86 (Structured Interview)]		

**Please be aware that if there are any amendments to the above documents they must be sent to Hannah Antoniadis, Research and Development Operations Manager for permission prior to use within the Trust.**

You are reminded that you must report any adverse event or incident whether or not you feel it is serious, quoting the study reference number. This requirement is in addition to informing the Chairman of the relevant Research Ethics Committee. You are also required to submit to the Research and Development Operations Manager (Hannah Antoniadis) a final outcome report on completion of your study, and if necessary to provide interim annual reports on progress. Should publications arise, please also send copies to Hannah Antoniadis for inclusion in the study's site file.

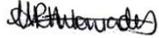
You must also abide by the research and information governance requirements for any research conducted within the NHS:

- Work must be carried out in line with the Research Governance Framework which details the responsibilities of everyone involved in research.
- You must comply with the Data Protection Act 1998 and where required, have up to date Data Protection Registration with the Information Commissioners Office. Where staff are employed, this includes having robust contracts of employment in place and ensuring that staff are made aware of their obligations through training and similar initiatives.
- You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice:  
([http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4069253](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069253))
- You must have appropriate policies and procedures in place covering the security, storage, transfer and disposal of information both personal and sensitive, or corporate sensitive information. Any information security breach must be reported immediately to the Trust.

- Where access is granted to sensitive corporate information, this must not be further disclosed without the explicit consent of the Trust unless there is an override required by law. Where disclosure is required under the Freedom of Information Act 2000, the Trust will assist you in processing the request.

Please note that, as a public authority, the Trust is obligated to comply with the provisions of the Freedom of Information Act 2000, including the potential disclosure of information held by the Trust in connection with this study. Where a request for potential disclosure of personal, corporate sensitive, or contract information is made under the Freedom of Information Act 2000, due regard shall be made to any duty of confidentiality or commercial interest.

Yours sincerely



**Hannah Antoniadou**  
**Research & Development Operations Manager**  
**Avon and Wiltshire Mental Health Partnership NHS Trust**

**Our Ref: 868AWP**

Joanne Barratt  
St Michaels Hospital  
St Michaels Road  
Warwick  
CV34 5QW

18<sup>th</sup> March 2015

Hannah Antoniadou  
Research and Development  
Avon & Wiltshire Mental Health Partnership NHS Trust  
Blackberry Hill Hospital  
Blackberry Centre  
Manor Road  
Fishponds  
Bristol  
BS16 2EW  
0117 378 4267  
[hannah.antoniadou@awp.nhs.uk](mailto:hannah.antoniadou@awp.nhs.uk)

Dear Joanne,

**Title of study:** Self-conscious emotion: An investigation into the relationship between childhood trauma, feelings of shame, voice hearing, delusions and compassion in people experiencing psychosis  
**NREC ref:** 14/SW/1111  
**Amendment no:** 1.0  
**Approval date:** 18<sup>th</sup> March 2015  
**End date:** 30<sup>th</sup> April 2015

I am pleased to advise you that I have reviewed the amended documents (listed below) for the above study, and am happy for Avon and Wiltshire Mental Health Partnership NHS Trust to continue to be a site for this project.

I can confirm that we have received the Research Ethics Committee favourable opinion dated 12<sup>th</sup> March 2015 with the amendment approval request.

Document	Version	Date
Letters of invitation to participant [Participant Letter V1.1]	1.1	19 February 2015
Notice of Substantial Amendment (non-CTIMP) [AmendmentForm_snapshot[2]]	1.0	20 February 2015
Participant consent form [Consent Form v1.5]	1.5	19 February 2015
Participant information sheet (PIS) [Participantinformationsheet v1.5 submitted 09.03.2015]	1.5	19 February 2015

Yours sincerely,



**Hannah Antoniadou**  
Research & Development Operations Manager  
Avon and Wiltshire Mental Health Partnership NHS Trust

Chair  
Anthony Gallagher

Headquarters  
Jenner House, Langley Park, Chippenham. SN15 1GG

Chief Executive  
Iain Tulley

**Appendix P: Worcestershire Health and Care NHS Trust Research and Development Team**

Worcestershire Health and Care   
NHS Trust

Research & Development  
Worcestershire Health and Care NHS Trust  
Isaac Maddox House  
Shrub Hill Road  
Worcester  
WR4 9RW

Tel: 01905 681514

Samantha.Whitby@hacw.nhs.uk  
www.hacw.nhs.uk

**Mrs Joanne Barratt**  
Worcestershire Health & Care NHS Trust

Our Ref: 15\_138\_NP

27 February 2015

Dear Jo,

Thank you for your research application entitled **Self-conscious emotion: An investigation into the relationship between childhood trauma, feelings of shame, voice hearing, delusions and compassion in people experiencing psychosis.**

I take great pleasure in informing you that your application has been granted approval by the Research and Development Group, on behalf of Worcestershire Health and Care NHS Trust on 27 February 2015.

Please accept this letter as official confirmation of local Trust Approval.

I should like to take this opportunity to wish you well with your research, and look forward to seeing your final report and recommendations.

If I can be of further assistance please do not hesitate to contact me.

Yours sincerely,



Yours sincerely

**Sam Whitby**  
Audit, Research & Clinical Effectiveness Manager

Chairman: Chris Burdon  
Chief Executive: Sarah Dugan

Research & Development  
Worcestershire Health and Care NHS Trust  
Isaac Maddox House  
Shrub Hill Road  
Worcester  
WR4 9RW

Tel: 01905 681514

Samantha.Whitby@hacw.nhs.uk  
www.hacw.nhs.uk

**Mrs Joanne Barratt**  
Worcestershire Health & Care NHS Trust

Our Ref: 15\_138\_NP

2 April 2015

Dear Jo,

Thank you for submitting your amendment to the study entitled **Self-conscious emotion: An investigation into the relationship between childhood trauma, feelings of shame, voice hearing, delusions and compassion in people experiencing psychosis.**

Please accept this letter as official confirmation of approval.

I should like to take this opportunity to wish you well with your research, and look forward to seeing your final report and recommendations.

If I can be of further assistance please do not hesitate to contact me.

Yours sincerely,



Yours sincerely

**Sam Whitby**  
Audit, Research & Clinical Effectiveness Manager

Chairman: Chris Burdon  
Chief Executive: Sarah Dugan

## Appendix Q: Participant Information Sheet

Coventry University  
Priory Street, Coventry CV1 5FB  
Telephone 024 7688 8328  
Fax 024 7688 8702

Programme Director  
Doctorate Course in Clinical Psychology  
Dr Eve Knight  
BSc Clin.Psy.D. CPsychol

THE UNIVERSITY OF  
WARWICK



Coventry and Warwickshire Partnership 

NHS Trust

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### PARTICIPANT INFORMATION SHEET - (Version 1.5, 19<sup>th</sup> February 2015)

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Title of Project: Experience of self-conscious emotion in psychosis.

---

I would like to invite you to take part in a research study. Before you decide if you would like to take part, it is important you understand why the research is being done and what it would involve for you. Please read this information sheet, which explains the research fully. If you have any questions, or would like more information, feel free to talk to me or a member of your care team about the research.

#### What is this study about?

This research study focuses on people who have a diagnosis of psychosis and hopes to look at the following important areas.

- 1) To look at peoples emotional experiences of shame.
- 2) To see if there is a relationship between shame and difficult childhood experiences.
- 3) To see if there is a relationship between shame and the symptoms experienced.
- 4) To understand how expressions of kindness, warmth and compassion are experienced.

#### Why have I been invited to take part?

You have been invited to take part as you have experienced a psychosis and have reported experiencing symptoms in the past year.

#### Do I have to take part?

No, you do not have to take part. It is up to you to decide if you want to take part in the research. You can change your mind at any time and withdraw from the study. Identifiable data already collected with consent would be retained and used in the study. No further data would be collected or any other research procedures carried out on or in relation to the participant. You can change your mind, without giving a reason. Withdrawing from the study will not affect the care you receive in any way.

#### If I decide to take part, what do I need to do?

The researcher will contact you to arrange a time and place to meet with you. You will usually meet with the researcher at a local NHS building or if this is not convenient for you it might be possible to arrange to meet with the researcher at

your home. First you will look through this information sheet together and any questions you might have will be answered. If you agree to take part, you will then be asked to sign a consent form.

You will then be asked to complete a number of short questionnaires. The researcher will explain each questionnaire to you and will help you to complete the forms. Each questionnaire normally takes between five and ten minutes to complete, but there will be no pressure to finish quickly and extra time can be arranged if you would like. The researcher will also ask you some questions about your voice hearing symptom and beliefs. It is expected that the entire meeting should last between 1 and 1 ½ hours in total.

There will be four questionnaires in total. They include; two questionnaires asking you about your experiences of shame; one questionnaire asking you how often you experienced particular difficulties in your childhood and one questionnaire asking you to rate how you experience kindness and warmth from others, to others and to yourself. Everyone who takes part in the research will be asked the same questions.

#### **What are the possible benefits of taking part?**

There are no personal benefits or rewards from taking part in the research. However it is hoped that the research will be of benefit in improving understanding of psychosis and treatment options, although this cannot be guaranteed.

#### **What are the possible disadvantages and risks of taking part?**

You will need to give up between 1 and 1 1/2 hours of your free time to participate in the research. In all circumstances the utmost will be done to meet with you at a time and place that is most convenient for you, however this may not always be possible. Unfortunately there are no funds available for reimbursement of any expenses.

There is a potential risk you may find answering the questions particularly in relation to your experiences of shame, difficult childhood experiences and symptoms of psychosis upsetting. If you think the research may have a bad impact on your wellbeing, you may not wish to take part. If you are not sure how it might affect you, you might like to discuss this with your care coordinator. If you decide to take part but then become upset you can decide you do not want to continue. If you were to find taking part upsetting you can access support from your care team.

#### **What will happen to my information?**

All the information you provide is confidential and will be kept in a locked cabinet. Your name will not be kept on any of the questionnaires so no one will be able to link them to you. The anonymous information will only be shown to people involved in the research. The results of the study as a whole will be shared with local NHS Services so they can understand how their services might be improved. The results will also be shared more widely by being put forward for publication in psychology journals. You will also have the opportunity to receive information about the findings of the research. Your information remains anonymous in all these reports. They will not contain any information that would mean you could be identified. At no time will the researcher have any access to your medical files.

Your care coordinator will be informed that you have decided to take part, but the information you provide will not be passed on. The only time information you give will be shared is if you say; that you are going to hurt yourself; somebody else; or are involved in any criminal activity. This is a rule you are probably familiar with

and all research follows this same procedure. If the researcher needs to share information with your care team because of this rule, then they will let you know.

**Further details about the research**

This study has been organised and funded by Coventry and Warwick Universities. Your care team are independent of the research and receive no financial gain from you taking part. All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity, this research has been granted their ethical approval.

Thank you for taking the time to read this information sheet and for thinking about taking part.

If you have any questions about the study, please feel free to contact either:

**Joanne Barratt (Chief Investigator and Trainee Clinical Psychologist)**

Address: Coventry University Clinical Psychology Doctorate, James Starley Building, Coventry University, Priory Street, Coventry, CV1 5FB  
Telephone: 02476887806 (Office Hours)  
Email: [barrat16@uni.coventry.ac.uk](mailto:barrat16@uni.coventry.ac.uk)

**Ian Hume (Academic Supervisor and Senior Lecturer in Clinical Psychology)**

Address: Coventry University Clinical Psychology Doctorate, James Starley Building, Coventry University, Priory Street, Coventry, CV1 5FB  
Telephone: 02476887806 (Office Hours)  
Email: [i.hume@coventry.ac.uk](mailto:i.hume@coventry.ac.uk)

**Imogen Reid (Clinical Supervisor and Clinical Psychologist)**

Address: Swindon Psychological Therapies Service, Chatsworth House, Bath Road, Swindon, SN1 4BP  
Telephone: 01793 715000 (Office Hours)

## Appendix R: Consent Form

Coventry University  
Priory Street, Coventry CV1 5FB  
Telephone 024 7688 8328  
Fax 024 7688 8702

Programme Director  
Doctorate Course in Clinical Psychology  
Dr Eve Knight  
BSc Clin.Psy.D. CPsychol

THE UNIVERSITY OF  
WARWICK



Coventry and Warwickshire Partnership   
NHS Trust

Centre Number:

Unique Identification Code:

---

### CONSENT FORM (Version 1.5, 20<sup>th</sup> February 2015)

---

Title of Project: **Experience of self-conscious emotion in psychosis.**

Name of Researcher: **Joanne Barratt**

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated 19<sup>th</sup> February 2015 (version 1.5) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw without giving any reason, without my medical care, services I receive or legal rights being affected. I am aware I can change my mind and withdraw from the study. Identifiable data already collected with consent would be retained and used in the study. No further data would be collected or any other research procedures carried out on or in relation to the participant.
3. I agree to take part in the above study.
4. I am happy for the researcher to contact my care coordinator in order to inform them that I am taking part in the study.

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

## Appendix S: Debrief Sheet

Coventry University  
Priory Street, Coventry CV1 5FB  
Telephone 024 7688 8328  
Fax 024 7688 8702

Programme Director  
Doctorate Course in Clinical Psychology  
Dr Eve Knight  
BSc Clin.Psy.D. CPsychol

THE UNIVERSITY OF  
WARWICK



Coventry and Warwickshire Partnership 

NHS Trust

---

### DEBRIEFING SHEET (Version 1.2, 12<sup>th</sup> October 2014)

Title of Project: Experience of self-conscious emotion in psychosis.

Name of Researcher: Joanne Barratt

---

Thank you for taking part in this research. The focus of this research was to learn if people with psychosis who had difficult experiences in their childhood would be more likely to experience more feelings of shame. Furthermore, to understand if having more feelings of shame means people experience more severe symptoms of psychosis. Finally the research study sought to explore how people with psychosis experience expressions of kindness and warmth and to see if this was frightening for some people.

I would like to remind you the information you have provided is confidential. The results of the study as a whole will be shared with local NHS Services so they can understand how their services might be improved. The results will also be shared more widely by being put forward for publication in psychology journals. Your information remains anonymous in all these reports and will not contain any information that would mean you could be identified.

If you have requested a copy of the final report of this study, this will be forwarded to you to the agreed address within two months of the study's completion. If you have requested to meet with the researcher to discuss the findings the researcher will be in touch with you within two months of the study's completion.

If for whatever reason, you decide that you no longer want to be part of this study then please contact me. Identifiable data already collected with consent would be retained and used in the study. No further data would be collected or any other research procedures carried out. Withdrawing from the study will not affect the care you receive in any way.

Finally I would like to remind you that if following taking part in the research, you feel upset or distressed, please contact your care co-ordinator or a member of your clinical team for support.

**CONTACT**

If you have *any* questions regarding this study, its purpose or procedures, please feel free to contact the Chief Investigator

Joanne Barratt (Trainee Clinical Psychologist) at [barrat16@uni.coventry.ac.uk](mailto:barrat16@uni.coventry.ac.uk) or call 02476887806.

I will be available for contact for up to 6 months after you have participated in the research.

## Appendix T: Author guidelines for the Reflective Practice

### SCHOLARONE MANUSCRIPTS™

This journal uses ScholarOne Manuscripts (previously Manuscript Central) to peer review manuscript submissions. Please read the [guide for ScholarOne authors](#) before making a submission. Complete guidelines for preparing and submitting your manuscript to this journal are provided below.

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## Contents List

### [Manuscript preparation](#)

1. [General guidelines](#)
2. [Style guidelines](#)
3. [Figures](#)
4. [Publication charges](#)
  - [Submission fee](#)
  - [Page charges](#)
  - [Colour charges](#)
5. [Reproduction of copyright material](#)
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# Manuscript preparation

## 1. General guidelines

- Manuscripts are accepted in English. British English spelling and punctuation are preferred. Please use single quotation marks, except where ‘a quotation is “within” a quotation’. Long quotations of 40 words or more should be indented with quotation marks. No Article types required
- A typical manuscript will not exceed 6000 words including tables, references, captions, footnotes and endnotes. Manuscripts that greatly exceed this will be critically reviewed with respect to length. Authors should include a word count with their manuscript.
- Manuscripts should be compiled in the following order: title page (including Acknowledgements as well as Funding and grant-awarding bodies); abstract; keywords; main text; acknowledgements; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figure caption(s) (as a list).
- [Abstracts](#) of words are required for all manuscripts submitted.
- Each manuscript should have 3 to 6 [keywords](#).
- Search engine optimization (SEO) is a means of making your article more visible to anyone who might be looking for it. Please consult our guidance [here](#).
- Section headings should be concise.
- All authors of a manuscript should include their full names, affiliations, postal addresses, telephone numbers and email addresses on the cover page of the manuscript. One author should be identified as the corresponding author. Please give the affiliation where the research was conducted. If any of the named co-authors moves affiliation during the peer review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after the manuscript is accepted. Please note that the email address of the corresponding author will normally be displayed in the article PDF (depending on the journal style) and the online article.
- All persons who have a reasonable claim to authorship must be named in the manuscript as co-authors; the corresponding author must be authorized by all co-authors to act as an agent on their behalf in all matters pertaining to publication of the manuscript, and the order of names should be agreed by all authors.
- Please supply a short biographical note for each author.
- Please supply all details required by any funding and grant-awarding bodies as an Acknowledgement on the title page of the manuscript, in a separate paragraph, as follows:

- *For single agency grants:* "This work was supported by the [Funding Agency] under Grant [number xxxx]."
- *For multiple agency grants:* "This work was supported by the [Funding Agency 1] under Grant [number xxxx]; [Funding Agency 2] under Grant [number xxxx]; and [Funding Agency 3] under Grant [number xxxx]."
- Authors must also incorporate a [Disclosure Statement](#) which will acknowledge any financial interest or benefit they have arising from the direct applications of their research.
- For all manuscripts non-discriminatory language is mandatory. Sexist or racist terms must not be used.
- Authors must adhere to [SI units](#). Units are not italicised.
- When using a word which is or is asserted to be a proprietary term or trade mark, authors must use the symbol ® or TM.
- Authors must not embed [equations](#) or image files within their manuscript

## 2. Style guidelines

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