The Development of a New Measure of Shame for Adolescents

By

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Volume I

Submitted for the degree of Doctor of Psychology (Clinical Psychology)

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July 2010

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I would first and foremost like to thank my two supervisors for all the support they have given me over the last two years. To Ms Mary John, who inspired and encouraged me throughout this project. She had enthusiasm when mine was lacking, and she was always there when I needed her most. To Dr Laura Simonds, for her statistical knowledge, her methodological advice, and her all round helpfulness and kindness. A big thank you also goes to all of the young people who took part in this project and to the schools who agreed to data collection; I really appreciate the time and effort that went in.

I would like to thank my tutor team who have supported me throughout training; Dr Kate Danvers, Ms Louise Deacon, Professor Arlene Vetere, and Dr Fiona Warren. Thank you everyone for sharing your knowledge and wisdom, and for reminding me to stay passionate about the job I love.

Finally, my thanks go to my fabulous family and friends. To my parents for their unconditional love, to my best friends, for their ability to keep me grounded in everything other than PsychD, and to Richard, my soul mate. Without him, none of this would have been possible. He believed in me right from the start and I will be forever grateful for everything.
STATEMENT OF ANONYMITY

Throughout this portfolio, all names and places have been replaced by pseudonyms and identifying information has been altered or omitted to preserve confidentiality and anonymity.
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Adult Mental Health Essay-Approaches to Psychological Distress

December 2007

Year 1
INTRODUCTION

This essay will critically evaluate the contribution of attachment theory to the formulation and treatment of anorexia nervosa. I am drawn to this particular essay question, firstly because my knowledge on attachment theory is limited. Secondly, this topic is particularly relevant for my current clinical placement in adult mental health where I am working from a psychodynamic perspective with most of my clients. I am aware that the contribution of attachment theory is highly relevant when working within a psychodynamic framework, and therefore have acknowledged that I need to have a greater understanding of this topic. I have decided to focus on anorexia nervosa because again I have limited theoretical knowledge of this disorder. On a professional level, I have never worked with anyone suffering from anorexia nervosa but do envisage that I probably will in the future. I am interested in how relevant attachment theory is when working with someone with anorexia nervosa. I am not looking at bulimia nervosa because I want this essay to be focussed and thorough. I feel that there would be too much to cover if I looked at both eating disorders.

I am going to start this essay by describing anorexia nervosa to you, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth edition-Text Revised (DSM-IV-TR; American Psychiatric Association, 2000). I will then focus on the formulation of anorexia nervosa. I will start with an overview of the different theoretical perspectives, but then focus specifically on a psychodynamic formulation. A brief history of attachment theory will follow. This description is necessary; however I would like to point out now that this essay will not include a critical evaluation of attachment theory (that would be a whole other essay in itself). I will then use this description of attachment theory and depict how this theory is seen to have relevance when working within the psychodynamic framework, and when formulating from this perspective. This will lead me on to evaluate some of the pertinent literature investigating the contribution of attachment theory to anorexia nervosa. Using this literature and combining it with my thoughts as a trainee clinical psychologist, I will illustrate how attachment theory contributes to formulation when working with someone with anorexia nervosa.
I will then move on from formulation and look at treatment. Most of this section will focus on how attachment theory is seen as an important contributing factor in regards to seeing the therapist as an attachment figure for the patient. I will also look at the contribution of attachment theory in interpersonal psychotherapy. I will comment on how relevant this ‘contribution of attachment theory’ that we found when thinking about formulation, is actually considered when treating someone with anorexia nervosa. I will convey my beliefs that there is currently a gap in the literature. Finally I will summarise my findings and thoughts and conclude that I believe attachment theory has a very important contribution in the formulation and treatment of anorexia nervosa.

ANOREXIA NERVOSA

Anorexia nervosa falls under the category of eating disorders. It is one of the two major eating disorders, the other being bulimia nervosa. As stated in the introduction this essay will focus only on anorexia nervosa. The diagnostic criteria for anorexia nervosa from DSM-IV-TR (APA, 2000) is as follows:

a. Refusal to maintain body weight over a normal weight for age and height.

b. Intense fear of gaining weight or becoming fat, even though underweight

c. Disturbance in the way in which one’s body weight, size, or shape is experienced, undue influence of body weight on self-evaluation, or denial of the seriousness of the current low body weight.

d. In postmenarcheal females, amenorrhoea, i.e., the absence of at least three consecutive menstrual cycles.

According to specific criteria patients are then classified into one of two mutually exclusive types, the Restricting Type, or the Binge-Eating/Purging type.

It has been reported that the average age of onset for anorexia nervosa is 17 years (DSM-IV-TR). It is more common in women than men and a recent study by Woodside et al. (2001) report a ratio of 4.2:1.0.
FORMULATION

Formulation of anorexia nervosa

When a clinical psychologist starts working with someone who has been diagnosed with anorexia nervosa (and the assessment process is complete), the next step would be for him or her to begin formulating that client's difficulties. I see formulation as one of the key roles of a clinical psychologist, but first let's clarify what I understand formulation to be. The Division of Clinical Psychology (2001) state that 'Formulation is the summation and integration of the knowledge that is acquired by the assessment process. This will draw on psychological theory and data to provide a framework for describing a problem, how it developed, and how it is being maintained' (p3).

Clinical psychologists have the skills and knowledge to be able formulate from different theoretical perspectives, thus focussing their framework on a particular psychological theory or model. In view of that, if we think about anorexia nervosa this can also be looked at from a variety of theoretical perspectives. For example, one may formulate from a cognitive behavioural perspective and address the interplay between thoughts, feelings, and behaviours of the individual with anorexia nervosa (Garner et al., 1997). One may formulate from a systemic perspective and look at how the family contribute to the anorexia nervosa (Dare & Eisler, 1997), or formulate from an integrative perspective, taking into account the biological, psychological, and systemic factors that may be involved in the anorexia nervosa (Weerasekera, 1996). Finally formulation could be from the psychodynamic perspective, and as mentioned in the introduction this is the model I am going to use throughout this essay. I have decided to do this, not because I think the other psychological perspectives are irrelevant, less important, or less effective, but because I feel that the quality of the essay will be better and the arguments that are put forward will be more thorough and detailed if I only focus on one model.
Psychodynamic formulation of anorexia nervosa

When thinking about the purpose of formulation Johnstone & Dallos (2006) describe one of the key features being to help select and guide the interventions. Thus, formulation not only helps us think about where the problem came from, and how it is being maintained, but also facilitates in deciding what interventions to use. So, if we think about that in psychodynamic terms, what does it mean?

Well, as there is no single psychodynamic theory there is therefore no single way of constructing a psychodynamic formulation (Leiper, 2006). ‘Psychodynamic’ is an umbrella term that refers to all models of the mind that are primarily concerned with unconscious processes (Howard, 2006). There are some core features of a psychodynamic approach and these features are what therapists can use to organise the information that needs to be integrated to be able to arrive at a useful formulation. Psychodynamic therapy is about getting in touch with thoughts and feelings which were previously ‘warded off’, kept hidden from the conscious mind because they seemed to be too much to deal with (Leiper, 2006). It is about looking at the nature of the client’s problem in terms of repeated maladaptive patterns occurring in relationships or in terms of making inferences as to how the problem relates to the client’s internal world (Howard, 2006).

Exploring anorexia nervosa from a psychodynamic perspective there are some key themes and ideas that can be brought into formulation. Obviously every client is unique and therefore the formulation will be specific to that individual client and what they bring to the therapy sessions. However, if we take a look at the history of the psychodynamic conceptualisation of anorexia nervosa, you can observe how it has changed and developed over time, paralleling the development of psychoanalytic thought (Swift & Stern, 1982).

Anorexia was understood in the 1940’s as a defensive adaptation to highly instinctual unconscious fantasies (based on Freud’s drive-conflict model, as cited in Goodsitt, 1997). Theorists of this model felt that for the anorexic, eating was
equated with the wish and fear of oral impregnation by the father. Bruch (1974) then challenged these prevailing psychodynamic views and described how many anorexic patients are so retarded in all aspects of individualism that the problem of sex is really outside their reach. She believed that the ego deficits observed in anorexic patients were consequences of long-term chronically disturbed mother-child interactions. This became known as the 'Interpersonal theory' of anorexia nervosa (Bruch, 1974). Pallazzoli and Masterson (as cited in Goodsitt, 1997) also challenged the drive-conflict theorist's views and their work extended Bruch's (1974) notions of a distorted mother-child relationship.

It seems then that when working with an individual with anorexia nervosa from a psychodynamic perspective, it is important to reflect upon these historical viewpoints. If we take a closer look into the interpersonal theories by Bruch (1974), and later on Palazzoli and Masterson (as cited in Goodsitt, 1997) a central theme in all three of these theories was that of attachment. The focus was on the interpersonal context and identified how the psychology of the individual was dominated by the way the individual experiences relationships. This made me think about the degree of importance of this concept of attachment. By further investigation I found that there has been a great deal of research carried out on the supposed contribution of attachment theory to anorexia nervosa, however before we move onto exploring some of the research I believe a brief overview of attachment theory is needed.

ATTACHMENT THEORY

History

Attachment theory originated from the work of John Bowlby (1969/1991). His interest in child separation began whilst working with maladjusted children in the 1920's. This interest continued and he went on and studied how early emotional trauma affected the development of behaviour in young thieves, he examined hospitalised children who had suffered separation from their mother, and he also looked at the ethological field research carried out by Lorenz and Harlow (as cited in
From this point forward Bowlby's research into the concept of attachment developed, and Mary Ainsworth, amongst others, became heavily involved. Bowlby (1969/1991) wanted to convince people that human beings possess a biologically based attachment system that is activated as soon as external or internal danger appears. He describes how young children develop this powerful emotional relationship with a 'attachment figure' (usually the child's mother), and how this can be observed by looking for certain 'attachment behaviours' (such as crying when the attachment figure leaves the room). These attachment behaviours can be seen in children as young as six-months-old, and as the child gets older the attachment to this figure gets stronger and more consolidated (Bowlby, 1969/1991).

### Attachment types

Bowlby (1969/1991) believed however, that this concept of 'attachment to another figure' was much too simple to be useful. He decided that the different behaviours displayed by the child to the attachment figure needed to be observed and analysed. Ainsworth and colleagues did exactly that. They developed a test like procedure called the "Strange Situation" which assessed individual differences in the organisation of attachment behaviour in infants of twelve months. During the test an infant would be playing in a room with their mother (attachment figure), the mother would then leave the room and the infants' behaviour would be observed. It was from this that three different types of attachment quality were classified (Ainsworth et al. 1978, as cited in Bowlby, 1969/1991).

1. Secure Attachment:
2. Insecure-Avoidant Attachment:
3. Insecure-Ambivalent Attachment:

Main and Solomon (1990) have since added a fourth attachment quality. This was as a result of some infants not fitting into any of the other three types of attachment. They described these children as insecure-disorganised/disorientated.
ATTACHMENT AND ANOREXIA NERVOSA

The research

I have explained the core components of attachment theory, and I have described the different qualities of secure and insecure attachment that can be observed in infants. But I now want to investigate how this theory relates to anorexia nervosa in adults. It is thought that the attachment behaviour observed in infants becomes internalised as working models of attachment in later life (Ward et al., 2000a). However, there have been very few studies that have followed individuals from infancy to adulthood observing the attachment style and quality throughout life, meaning that attachment in adults is usually assessed using contemporary measures (Broberg et al., 2001). There are various attachment measures, tests and interviews available, most relating to Bowlby's or Ainsworth's attachment constructs. The Adult Attachment Interview (George et al., as cited in Ward et al., 2000a) is at present seen as the 'gold standard' in measuring internal representations of attachment figures.

Numerous studies have been carried out over the past 20 years using a variety of attachment measures to try and develop a formal application of attachment theory to anorexia nervosa. As mentioned previously Bruch (1974) proposed that abnormal mother-infant relationships underlie the development of anorexia nervosa, and she suggested that the mother's own difficulties were often projected onto the infant. Therefore most studies hypothesised that individuals with anorexia nervosa would show an insecure pattern of attachment.

Two important empirical reviews have explored the relations between attachment and eating disorders (O'Keamey, 1996; Ward et al., 2000a). O'Keamey (1996) found that taken together, the data reviewed gave evidence for the presence of attachment disturbances in eating-disordered populations, thus supporting the hypothesis of insecure attachment. What O'Keamey (1996) did not find was a consistent association between specific attachment patterns and the subtypes of eating disorders, which is what interests me. Looking at the studies closer, it appears that different subtypes of eating disorders were classified, but that attachment patterns did not differentiate among these different diagnostic subtypes. A separate study carried out by Ward et al. (2000b) suggested that similar
attachment difficulties may underlie both anorexia nervosa and bulimia nervosa, and that insecurity provides the template for an eating disorder, with later events colouring the precise presentation. Ward et al. (2000a) also concluded that the vast majority of studies reviewed found that attachment processes, by whatever method measured, were abnormal in eating disorder populations. However, this review did find that attachment style (dismissive/avoidant vs. preoccupied/ambivalent) in fact might be linked to diagnostic subgroup. They found that anorexic participants tended to be dismissive, whereas those with bulimic behaviours, whether anorexic or bulimic, tended to be preoccupied. It is extremely interesting that Ward et al. (2000a) review looked at the data in this way. I believe that perhaps this is why differences were not observed in previous studies or reviews. Anorexia nervosa is, as mentioned above, classified into two types (restricting and purging). Perhaps the overlap between the purging type of anorexia nervosa and bulimia nervosa is that blurred, that analysing attachment differences in the two subtypes is pointless (unless the anorexic subtype is identified). Ward et al. (2000a) also conclude in their study that in actual fact searching for tighter associations between attachment style and diagnosis may be unhelpful.

There could be additional reasons as to why this difference in diagnostic subgroup was not found in more studies. The measures used could be an important factor, for example 6 out of the 10 studies O'Kearney (1996) reviewed used the PBI (Parker et al., 1979). This does not relate to Bowlby's attachment constructs, making it very difficult indeed to define the participants as an attachment style when they were not even assessed in this way. Ward et al. (2000a) also state that it is useful to consider at what level of consciousness the instruments were measuring. I think this is extremely important, because if the measures look deep into the unconscious then they may give a truer picture of internal object relations, thus producing different results in terms of attachment patterns than those measures that only look at attachment on a more conscious level. Terminology is another factor that needs to be considered, not only the difference between the anorexic types, but also how each attachment pattern is defined. Ward et al. (2000a) comment that the word 'anxious' is used in a different sense in some studies, and this links back to the different measures used. The categories defined by the measures use different language and I find that this is extremely confusing. As I was researching I found it very difficult to grasp the different terminology used in the various studies. This may have also been the case for some of the people carrying out the research.
It is important to recognise at this point some diversity issues that came to me as I was writing. I stated earlier that anorexia nervosa is more common in women than in men, however this disorder is still present in men. Looking through the research I collected, almost all of the studies used only females as their participants. Only one study in O'Kearney's (1996) review used male participants, however the findings were then conveyed in a way that made the reader assume that the findings were related to the population as a whole (both genders). Attachment patterns, in regards to anorexia nervosa, may be very different in males, and therefore I believe further investigation is needed before inferences can be made. I also noticed how cultural and socio-economic differences are not attended too in the majority of the studies. Most of the studies in Ward et al. (2001a) were carried out on American college students and therefore their findings should not be applied to a more general population until more research is carried out about the applicability of this.

What this means for formulation

Having critically reviewed some of the available research and thinking about the historical psychodynamic perspective, I believe that there is evidence for insecure attachment in individuals with anorexia nervosa. What I am not sure about is the difference in attachment styles in anorexia nervosa. I do not feel that I can conclude that people with anorexia nervosa are more likely to have a dismissive/avoidant attachment pattern, although there is evidence to suggest this link. Taking methodological and terminological issues into consideration I do not deem the evidence to be sufficient enough. It is also important for me to note here that there seems to be a lack of studies solely focussing on the restricting type of anorexia nervosa. If these studies were carried out then perhaps a stronger association between anorexia nervosa and avoidant attachment would be found.

So, what does this mean for me in practice? In terms of psychodynamic formulation, I would certainly consider insecure attachment as a valuable concept to take into account when formulating a client's difficulties. However, this leads me to comment on something O'Keamey (1996) pointed out. He stated that 'the psychodynamic formulations (Bruch, 1974) from which much of the empirical work is derived disregard many possible causal, moderating, and mediating factors both concurrent
and subsequent to the putative attachment disruption' (p10). I think this is a very valid point. He came to these views by believing that the 'main effect model' (a model taking into account the attachment status alone), which was adopted by the majority of authors reviewed, did little to advance his understanding of how, if at all, disturbances in the development of secure attachment relate to the subsequent manifestation of the symptoms of eating disorders. O'Keamey (1996) believed that models that use information about early attachment, but also about temperament, environmental factors, contemporaneous parenting, peer relationships, and marital conflict would perhaps more accurately predict externalising behaviour problems in later life (such as anorexia nervosa). I believe that this is where I sit in regards to the literature. I am not saying that attachment theory does not contribute to the formulation of anorexia nervosa; I believe there is a huge contribution. But I am saying that in regards to formulation I would not see the main effect model of attachment as a full explanation of anorexia nervosa.

TREATMENT

Attachment theory in treatment

If attachment disturbance or insecure attachment patterns have been identified through formulation, then it would seem only natural for me to try and explore this during treatment. However, there has been controversy regarding the applicability of attachment theory to the practice of psychotherapy (Farber et al., 1995). Bowlby (1977) pointed out the importance of the therapist becoming a reliable and trustworthy figure (a secure base) to the patient, and Ainsworth (as cited in Farber et al., 1995) stated that attachment theory has generated important clinical applications. Hamilton (1987) however, perceived attachment as a theoretical framework only, and stated that from a clinical point of view it cannot be used directly. As a trainee who has just started training, I believe that this theory does have clinical application and I see it as much more than a background theory.
Some of these views have been formed from reading an article written by Farber et al. (1995). The authors explore the ways in which psychotherapists serve as attachment figures to their patients. They state that by being aware of a patient's reactions to a lack of felt security, the therapist can help the patient explore how this aspect of personality affects other relationships. They believe that by doing this, the attachment model lends itself to enriching their understanding of the patient's internal and external world, and the ways in which early attachment relationships affect their patient-therapist relationship. This made me think about how important the patient-therapist relationship is when considering the application of attachment theory to psychological treatment. Thinking back to patients in the past, when they have responded to me with anger (a nasty voicemail or cross phone call) after an expected session got disrupted, I can understand this now as possible perceived threats to our attachment bond. Or when patients have become upset when our therapy is coming to an end, I can now be aware of this as a probable reaction to the loss of the attachment relationship we had. Thinking about why patients see therapists as secure bases, it is important to remember what Bowlby (1988) said about the infant using the mother as a secure base from which to explore the environment. Farber et al. (1995) investigates the way in which the therapist serves as a secure base by providing a safe place (the office) to discuss and attempt new ways of seeing and being in the world. They believe that the sense of safety is facilitated by the therapist's constancy, availability, sensitivity, and responsiveness to the patient's distress. Thinking about the therapeutic relationship in this way, I can look back and remember when patients have perhaps used me as this 'secure base'. They had brought to the therapy feelings that they would not usually express in their external world. Expressing those feelings within therapy is like a 'trial' within a safe environment. The patient can then go and try out the new ways of functioning in the external world.

In view of all of this I do believe that the contribution of attachment theory is extremely relevant in regards to the psychodynamic treatment for anorexia nervosa, and that a key aspect of this is the therapist as an attachment figure. I would like to add that although this essay has focussed on treatment from a psychodynamic perspective, I believe (like Farber et al., 1995) that this understanding of the therapist as an attachment figure would be useful to all psychotherapists in clinical practice, whatever their theoretical orientation. To note that although I have said
that attachment theory contributes to the psychodynamic treatment of anorexia nervosa, I am also standing by my earlier viewpoint in regards to the 'main effect model'. Attachment theory is not everything, and in regards to treatment for anorexia nervosa other factors may have just as a big part to play.

Another way of looking at how attachment theory contributes to the treatment of anorexia nervosa is by exploring the use of Interpersonal psychotherapy (IPT). IPT is a brief, time-limited therapy that developed from the psychodynamic perspective. It was initially used for the treatment of depression (Klerman et al., 1984). The theoretical underpinnings of the treatment are that regardless of the etiology of the disorder, the current presentation is 'inextricably intertwined' with the patient's interpersonal relationship. Given the often-central role that interpersonal functioning has occupied in theories of anorexia nervosa (Bruch, 1974), and the success of IPT in bulimia nervosa (Fairburn et al. 1993), there is a strong rationale for applying IPT to anorexia nervosa (McIntosh et al. 2000). This is however, a very new area of research. The interpersonal therapy website (www.interpersonalpsychotherapy.org) is the only place where I could find any literature about the contribution of attachment theory to IPT for anorexia nervosa. It states there that 'In IPT the focus is arguably on the issue of attachment. It is assumed that resolution of “here and now problems” in an interpersonal and hence attachment context should result in symptom relief’. It is also thought that by the therapist forming a warm, empathetic, and collaborative relationship, this may help the patient by providing a secure base in which to explore their interpersonal circumstances and make changes necessary to achieve symptom relief (Klerman et al., 1984); thus linking it to attachment theory.

The literature that focuses on interpersonal therapy for anorexia nervosa, although extremely limited, does acknowledge that attachment has a part to play. However, I could not find any research that looks at how attachment contributes to the therapy itself, and if it does contribute, how effective the application of attachment is. This is an area, I believe, that would benefit from future research and then hopefully provide us with more of an evidence base for the clinical application of attachment theory in anorexia nervosa.
In addition to the lack of literature for IPT, I also believe that there is currently a huge gap in the literature generally about how attachment theory can be brought into the psychodynamic treatment of anorexia nervosa. There is a great deal of research available that supports that insecure attachment patterns are linked to anorexia nervosa, however there is an extremely limited amount of research that looks at how this supposed contributing factor can then be worked with in regards to therapy. In my eyes formulation guides intervention, so why find a significant contribution that is used in formulation and then ignore it during therapy? The practice implications of this lack of research are that clinicians may be aware of the importance of attachment theory, but they are unsure of how to bring it into therapy. Finally I will point out that no service user research has been carried out in this area. I think it is essential (but also very interesting) to get an opinion from the person at the centre of it all. Perhaps some single case studies could be written up? These could look, with the patient, how attachment was brought into the therapy, and how useful the person found this.

CONCLUSION

The process of writing this essay has allowed me to critically analyse how much of a contribution I believe attachment theory has in the psychodynamic formulation and treatment of anorexia nervosa. I began this essay by defining anorexia nervosa. I then described my current understanding of formulation before exploring the more specific psychodynamic formulation. I investigated the historical psychodynamic context of anorexia nervosa and I concluded at this point that the work of Bruch (1974), in terms of the interpersonal theory of anorexia nervosa, had a significant influence in the introduction of Bowlby's theory of attachment to the understanding of this disorder. This led me to examine some of the significant literature that looked at the relations between attachment and anorexia nervosa, and I concluded that there was evidence to support the claim that insecure attachment is often found in individuals with anorexia nervosa. I added at this point that, although I see
attachment theory as an important concept to consider when formulating, I do believe that there are other things that need to be considered as well.

I then moved onto looking at treatment, and focussed my writing on the contribution of attachment theory in regards to the therapist as an attachment figure during therapy. I related some of the ideas put forward to my own clinical practice. In addition to this I briefly looked at IPT for anorexia nervosa and commented on how relevant the contribution of attachment theory is in this treatment method but that there is currently a gap in the literature. I finished this essay by concluding that I believe attachment theory contributes significantly in the psychodynamic treatment of anorexia nervosa, however I again acknowledge that other factors should also be considered. I also identified that there is currently a gap in the clinical literature regarding attachment theory and how it is used in the treatment of anorexia nervosa.

Writing this essay has been a very rewarding but tough exercise. Because of the psychodynamic historical aspect of this essay a lot of the early writings were only found in books, therefore some references had to be secondary citations that I would of preferred not to use. I found it difficult not to 'skim' over things too much, but I was aware that there was so much literature to cover. I also had to try hard to leave enough words to critic the literature after describing it. However, I found writing in first person really valuable, and actually enjoyed writing this way. I have learnt so much as a result of this essay, and I believe I have definitely gained that greater insight into attachment theory that I aimed to at the beginning of the essay. What I will take into my clinical practice as a result of this essay is that when I am working with someone with anorexia nervosa in the future I will consider attachment theory in both the formulation and the treatment process.
REFERENCES


Clinical Psychologists are expected to take a clinical leadership role in Mental Health Teams. What themes and approaches might inform our understanding of a clinical leadership position and its usefulness to others?

Professional Issues Essay
January 2009
Year 2
INTRODUCTION

In Britain today, clinical psychologists are expected to take a clinical leadership role in mental health teams. This essay will look at what themes and approaches inform clinical psychologists' understanding of a clinical leadership position. It will also consider if this position is a useful one to take and if so who it is useful for. I am drawn to this particular essay, firstly because one day I hope that I will hold a clinical leadership position. Secondly, as already stated, clinical psychologists are now expected to take leadership roles within teams, and therefore I feel that I need to increase my knowledge and awareness of this topic. I consider myself to have very little theoretical understanding of leadership, in the context of both business and health care settings. I hope this essay will teach me more about the theory but also enable me to make links between this theory and my own clinical practice.

I will start this essay by exploring what leadership is and how it is viewed specifically in today's National Health Service (NHS). I then aim to look at how leadership and clinical psychology fit together, and the current policies behind the drive to encourage psychologists to take leadership roles. I will then look particularly at a few theories of leadership. I will examine how clinical leadership seems to be occurring in current practice, using my own experiences as examples but also using clinical research. I hope to look at some good examples of clinical leadership and observe how this role can be useful to others. However, I will also take a critical viewpoint and look at how this clinical leadership role might in fact impede upon our practice. As a second year trainee this essay is written from the perspective of someone who has had no direct leadership experience herself, and because of this lack of personal experience I do feel like I am coming from a somewhat naïve position. Therefore as I prepare to write and read more about this topic, I am very open to the fact that I have a great deal to learn.
Leadership vs. management

One of the first things that came to my mind when I initially started reading for this essay was what is the difference between leadership and management? This is an important question to answer, as I believe both in the business world and in health care settings the two roles can cause some confusion. Walton (1997) describes management as doing things appropriately and properly (making things happen), compared to leadership which he describes as mobilizing those around you, or creating a momentum for desired change. Stewart (1996) talks about leadership as discovering the route ahead and encouraging others to follow, compared to management, which she describes as a set of techniques and approaches that can be learnt. Traditionally leadership was viewed only as a subset of management, and some still hold this opinion. For example the military believe that leadership is a definable skill, a science that can be learned (Shriberg, Shriberg & Kumari, 2005). However, others view leadership and management as separate and distinct, that they share some characteristics but that there are parts of leadership that cannot be considered as management (Kotter, 1996, as cited in, Shriberg, Shriberg & Kumari, 2005).

There is much debate about these two terms and I could continue comparing people’s views on this for a long time. However, as I was reading the literature I began to develop ideas of my own about what I think the difference between the two is. I decided that this quote encapsulates where I stand:

‘A job title alone does not make a person a leader. Only a person’s behaviour determines if he or she occupies a leadership position. The manager is the person who brings things about—the one who accomplishes, has the responsibility, and conducts. A leader is the person who influences and guides direction, opinion, and course of action.’ (Marquis & Huston, 2009, pp.32)
Clinical leadership

So, how is the above relevant to the NHS? The NHS Plan (Department of Health, 2000) stresses the need for clinical and managerial leaders throughout the health service. It talks about how there have been too few clinicians in leadership roles and how leadership development in the NHS has been incoherent. Therefore, in recent years, there has been a drive to increase clinical leadership. One might ask why leadership is necessary in the NHS when there are managers who handle the business side of things. Clinical leadership, as I view it, is not management. I am not saying that managers cannot step into this role, but what I am saying is that you do not have to be a manager to become a clinical leader.

Millward & Bryan (2005, pp.15) describe clinical leadership as ‘facilitating evidenced-based practice and improving patient outcomes through local care’, thus making clinical leadership about the effective delivery of health care at the front line. Stewart (1996) explains how managers in the NHS are expected to do much more now than in the past. Therefore there is a need for other people to be leaders, people who can show the way and help others adapt successfully to the changing work environment. Anyone can, in principle, be a leader, and it is often the best person for the task that takes on this role within a team (Kogler Hill, 2004). There are however, people that are employed within the NHS that are assigned to be clinical leaders. Service managers, consultants, team managers, and practice managers of GP surgeries are all employed to take some sort of a clinical lead, and this leads me to question where psychologists stand in regards to clinical leadership?

Leadership and clinical psychology

Over the past ten years there has been increased investment in mental health services (Sainsbury Centre for Mental Health, 2003). As a result of this the delivery of psychological therapies in the NHS has changed, and continues to do so (Mental Health Choice, 2007; Layard, 2005). This means that in every mental health service someone has to ensure that effective psychological therapy is being delivered. New ways of working for applied psychologists in health and social care – Organising, managing, and leading psychological services (British Psychological Society (BPS),
2007) proposes that applied psychologists (including clinical psychologists) are the right people for this job. The report highlights the need for strong leadership from psychologists, and this is in order to ‘help staff deliver increasingly sophisticated psychological services in a complex and perpetually changing environment’ (pp.9). The report also considers the competition that might take place for these leadership roles from other professions, such as psychotherapy and nursing. It emphasises that applied psychologists have doctoral level academic and practice-based training so they should be strong contenders for these positions. In addition to this, the New Ways of Working for Psychiatrists report (Department of Health, 2005) also advocates a stronger clinical leadership position for applied psychologists, so it is not just psychologists that are driving this movement forward.

THEORIES OF LEADERSHIP

What makes a good leader

So, now I understand the role of leadership in the NHS, what I need to establish is what makes a good leader. What stands out from the literature to me is that there seems to be two main ways of looking at how someone becomes a good leader. One of these ways focuses on personal qualities and traits, the other focuses much more on the process and development of a good leader. In regards to the trait theory, Northouse (2004) defines the five major leadership traits as intelligence, self-confidence, determination, integrity, and sociability. This theory, in its most purist form, suggests that only people with certain personal characteristics (such as those listed above) can become leaders, and it is in that person’s nature for them to become a leader. This is where the saying “born to be a leader” comes from. The process theory however, suggests that leadership is available to everyone. It is something that can be learned and it is the context in which people are placed that makes them leaders (Northouse, 2004).

Now, the point of this essay is not to prove which theory of leadership holds the most weight, it is for me to consider which theories and approaches inform my understanding of clinical psychologists as leaders. I believe that there is a subtler way of thinking about the trait theory, and it is this way that guides some my understanding. That it is not only a person’s traits that make that person a leader,
but that those traits and characteristics do contribute towards the success of that person as a leader. This is also where many of the participants of ‘The Leadership Project’ (Coak, 2006, as cited in BPS, 2007) stood in regards to their view on leadership. Psychologists and major stakeholders in psychology services were given the chance to say what they thought about the ‘person as a leader’ and they too felt that certain individual characteristics were important in leaders. These included characteristics such as self-awareness, enthusiasm, inspiring others, creativity, being energetic, reflective, approachable, confident, honest, and genuine. In addition to this, the NHS have published the ‘NHS Leadership Qualities Framework’ (Department of Health, 2004), and at the core of this framework are five personal qualities believed to enable NHS leaders through the demands of their job. These qualities are self-belief, self-awareness, self-management, drive for improvement, and personal integrity. Therefore, I believe that personal qualities and characteristics are critical to the success of clinical leaders.

In regards to the process or development theory of leadership, it is thought that prospective leaders can be taught skills that will make them into good leaders (Northouse, 2004). In my view this is also true. I still hold onto the opinion that individual characteristics matter, but the person must also have good leadership skills, and it is these skills that I think can be developed. Again, if we look at the views of the participants from the leadership project (Coak, 2006, as cited in BPS, 2007), they reported examples of the range of skills that they felt were associated with effective leadership. Political awareness, strategic thinking, and the ability to disseminate information to others in a careful, timely, sensitive manner were viewed as essential skills in general leadership. Excellent interpersonal and communication skills were also viewed as important, alongside the ability to form and maintain relationships with a wide range of people. In terms of more psychology specific leadership some of the skills reported were psychologists’ ability to bring people together, their knowledge of human behaviour, relationships and groups, and psychologists’ tendency to be good listeners and empathetic.

If we take a look at those skills, some of them are much easier to learn than others. I think learning about the politics behind a team or business, or learning how to communicate better with certain people or in certain environments, are skills that can be taught. I would have to say though that being empathic or having good interpersonal skills, are things which are much harder to teach people to do. There
is very good reason therefore as to why applied psychologists are thought to make good leaders. A lot of the skills mentioned above are things that psychologists already posses, skills that have already been tuned into during a person’s training to become a qualified psychologist. Coak (2006), as cited in BPS (2007), also points out that many psychologists already possess characteristics associated with effective leadership, and therefore many psychologists have leadership potential. In addition to this, I see the core skills of a clinical psychologist (assessment, formulation, intervention, and evaluation) as a key to good leadership. These skills, like so many that have already been mentioned, are ones that psychologists are trained to be competent in (BPS, 2006). The introduction of new policy, difficult situations occurring in teams, and service related changes, are all things that clinical leaders would have to deal with. If one has the appropriate skills to assess these difficult situations, formulate to refame, intervene to find solutions to these problems, and evaluate the success of the intervention, then I would say that this person would be a fine candidate for the job as clinical leader.

Another way of looking at good leadership is in the style or approach that a leader may take. Again, there are so many theories of leadership that could be related to the position of a clinical leader that I have chosen to focus on only two approaches; transformational leadership (Bass, 1990) and authentic leadership (George, 2004).

Transformational leadership

Transformational leadership refers to the process whereby an individual inspires others with a shared view for the future. That person creates a connection that raises the level of motivation and morality in the followers. They also try and help followers reach their full potential (Northouse, 2004). This type of leadership attends to the needs and motives of followers, inspires through optimism, and encourages follower creativity. The leader themselves are a role model who provides a sense of direction and leads by valuing, visioning, coaching, empowering, team building, and promoting quality (Bass, 1990).
Authentic leadership

This type of leadership is somewhat different to other forms of leadership as it not about adopting certain characteristics or developing certain skills, it is more about being yourself. George (2004) describes authentic leaders as people who use their natural skills and abilities rather than try and change themselves into a conformed image of a leader. Authentic leaders recognise their shortcomings and try to overcome these, compared to other forms of leadership where people are so eager to win the approval of others they try and cover up their shortcomings. Authentic leadership is also about practising solid values, establishing connected relationships, and demonstrating self discipline (George, 2004).

LINKING THEORY TO PRACTICE

My own experience of clinical leadership

Before I started training I worked in a learning disability team as an assistant psychologist. It was in this job that I observed and worked with a clinical psychologist who I perceived to hold the role of a clinical leader. She was not a manager and had only been qualified two years. I was already working in the team when she started so I saw the changes that she made first hand. The team was integrated with social services and therefore the criteria for accessing the service were quite rigid. Only clients with an official IQ of below 70 were allowed to access the service, whether or not other professionals felt that the client’s needs would be best met from that team. This psychologist totally disagreed with the way the team was working, and felt that it was not a client-led service and that many vulnerable people were going without a service because of this. To share this view with others she had to start off in quite a subtle way. First speaking with members of the health team, and then once relationships and trust had been built with social services staff she started sharing this view with them. In actual fact many of the team agreed with her and it was then that changes started happening. She held teaching sessions for team members on why basing a service on an IQ score was not a helpful way of working and also helped staff try and understand some of the difficulties and disadvantages of carrying out the Wechsler Adult Intelligence Scale (WAIS-III) (Wechsler, 1997) on people with a learning disability.
When I think back to how this psychologist worked, there were many things that she did that can be related to theories of leadership. She pointed out the way, which Stewart (1996) describes as a leader's first task. She inspired others and created pride within the team, both of which are clear leadership attributes. Stewart (1996) also talks about an essential role for a leader being to symbolize the meaning and values of an organisation. Our learning disability team was there to provide a service to the people that needed it, and what this psychologist did was to share her passion and drive about what she cared about with the rest of the team. This then meant through her leading the way, the organisations meaning and values had been restored. The way this psychologist worked can also be linked to authentic leadership (George, 2004) in that she did not take on a false persona to lead the team. Instead she used her own values and beliefs to achieve success and to make positive changes within the team.

Another experience I have of working with psychologists who I perceived to be holding clinical leadership positions was during my first year placement in an adult primary care mental health team. The clinical psychologists were managing and supervising a number of Graduate Primary Care Mental Health Workers (GPCMHW's), which is a role that came out of The NHS Plan (DOH, 2000). The psychologists' role also included consultation to other health professionals in the primary care team and helping implement 'Improving Access to Psychological Therapies' (Mental Health Choice, 2007). What resulted from this was a very psychologically minded service, with psychology being at the forefront of formulation and treatment. By training and educating GP's on the effectiveness of cognitive behaviour therapy the team were able to set and up and maintain a very clear referral pathway for all primary care depression and anxiety referrals. This meant that every person coming into the service was screened and assessed by psychology before any medication was prescribed. A launch night was held and there was an open forum available for people to question how and why this pathway was going to work.

I realise now that the introduction of this referral pathway was not a particularly radical piece of work, in actual fact NICE guidelines state that this is how people coming into primary care with depression or anxiety should be treated (National Institute for Health and Clinical Excellence, 2004 and 2007). It was how this referral pathway had been implemented and maintained that stands out for me. Psychology
were clearly leading the way, and by consultation and training other professionals (mainly GP's), everyone involved in the project started to believe in what was happening. Stewart (1996) explains that to be a strong leader you must have a belief and vision of what needs doing. She describes how this vision needs to be conveyed to others with enthusiasm and there must be a viable personal commitment to its accomplishment. This is exactly what these psychologists did. I think that if I were to define a leadership approach that fits with this example, it is a good illustration of transformation leadership (Bass, 1990). The clinical psychologists inspired the rest of the team, in particular the GPCMHW's, and they also spent a lot of time communicating with others and delegating responsibility. They truly believed in what they were doing and they provided a very clear sense of direction.

Another example I am going to use is not one that I was there for physically but it is something that impacts the work I am currently doing on my learning disability placement. Over the last 20 years many long stay institutions for people with learning disabilities have being closed down. The idea behind this was to move as many people out of these hospitals and into the community (Collins, 1992; Emerson & Hatton, 1994). If you look at the history of this movement, there was a huge psychology element involved in this. The purpose of the move was to improve quality of life, give service users much more freedom in their day-to-day lives, and to reduce the stigma associated with people with learning disabilities (Emerson & Hatton, 1994). I think that psychologists were perhaps not given the credit they deserved in regards to their involvement in this, and I wonder if this was related to the fact that there were probably very few psychologists who actually managed those services at that time. Health professionals who often play a huge role in the way changes occur or have a big influence in how services are ran, may not in fact be the managers of those services, but this does not mean that big things cannot still happen. I feel that vision and inspiration are much more important attributes, and it is these attributes that are imperative to the role as clinical leader.

Is the Clinical Leader a Useful Role?

In regards to the examples already given, and in relation to how mental health teams work today, what I now need to think about is if the clinical leader position is a
useful one? I need to think about whom it is useful for and who receives the most benefit from it? In the learning disability examples I gave, it was clear that the clients themselves were affected most by the changes the clinical leaders made. People received better services as a result of the work of the clinical leaders, and hopefully this improved the psychological well being and quality of life for these people. Not only did people receive better services, I think that service users might have also felt empowered to know that clinicians were standing up for them and advocating on their behalf. People's lives were changed because of the actions of the leaders, in fact it was not only their lives but family members and carer's lives were affected too. I clearly remember one mother who had been fighting for a long time for her son to be seen by the learning disability service but because he had been previously defined as having a borderline learning disability he had been denied this service. Because of the changes made, the team felt that as he was a vulnerable adult who needed support, they should in fact offer him a service. The mother was extremely grateful and thanked the team for the help with her son but also for the help and support the family received.

In regards to the primary care mental health team example I gave, there were various different people that benefitted from the changes made by the clinical leaders. First of all service users themselves were affected by the introduction of a new referral pathway. All patients referred were assessed by a mental health practitioner and some sort of psychological intervention was offered to everyone that wished to receive it. Some could argue that this was in fact not improving things for service users as it meant that few people received face to face therapy. But compared to receiving no psychology input, or waiting an extremely long time on a waiting list, the new pathway did open the therapy doors for a number of people. Secondly, team members and other professionals from the wider system also benefitted from the clinical leader role. I think team morale and motivation improved and working more closely with GP's meant that the leaders were able to share their vision with more people, which meant that over time there were more followers.

There are a couple of research studies that have been carried out in recent years that look at the different leadership styles used within mental health teams. These studies do not investigate the role of a psychologist as a clinical leader, but the results are still very useful to us as a profession. Corrigan, Lickey, Campion & Rashid (2000) explored the relationship between the style of leadership, and service
user satisfaction and quality of life. The study was based in America so differences in service provision do need to be considered. The researchers reported that satisfaction and quality of life of service users was positively associated with both transformational and transactional leadership styles from the leaders of their mental health teams. The study also found that leaders who rated themselves as inspirational, and team members who rated their leaders as charismatic and considerate of others, were more likely to work in programs that service users found satisfying. Corrigan & Garman (1999) also explored transformational and transactional leadership, but this time looked at it from the teams' perspective. They found that leaders using transformational skills helped team members view their work from different perspectives and helped team members develop innovative ways to deal with work related problems. These two studies therefore illustrate that using transformational leadership in mental health teams can not only be of benefit to the consumers of that service, but it can also benefit members of the team in regards to their work.

What I have been able to demonstrate above is that there is evidence to suggest that the clinical leadership role is a useful role. It can lead to service user and employee satisfaction and improvements in service delivery. I now need to consider if there is any evidence of this role not being so useful. The style a leader takes might in fact negatively impact on team morale and service user satisfaction (Corrigan, Lickey, Campion & Rashid, 2000; Corrigan & Garman, 1999) and another thing that comes to my mind when thinking about this is, can we as psychologists be leaders and therapists? Some might argue that we would find it hard to juggle both roles at the same time, that as psychologists the service has employed us to provide therapy. But as already stated the job of a clinical leader in the eyes of the BPS is to facilitate evidenced-based practice and improve patient outcomes, so this not only involves providing therapy. Supervising others and consulting to the rest of the team would also be classed as facilitating evidence based practice, and I would hope that our inspiration and enthusiasm would also filter down into the rest of the team (just like in the examples I provided).

I am not suggesting that this would be an easy role to take, especially in teams where service delivery and recovery is based on the medical model, and there may be times where the rest of the team disagrees with the way that you are doing things. Then it would most certainly be impossible to be the 'leader'. As
psychologists we are very used to taking time to think and reflect on our client work, even if this means spending time challenging the literature or thinking outside the box, but other professionals have not been trained in the same way. This might cause confusion and conflict, especially if we are challenging the way things have been done in teams for a long time. The last thing a leader needs is no followers, so clinical leaders have the difficult task of keeping team moral and enthusiasm high without compromising on their own values and beliefs. Finally, a further point to raise is one related to gender differences. Perhaps as a clinical leader, you might have to work with team members that are resistant to females taking a lead, especially if those people are confused and unsure about the differences between a manager and a leader.

The Future

So it is clear from looking at current policy that clinical psychologists are expected to take clinical leadership roles in mental health teams. As a second year trainee what I am now hoping is that I will be equipped to become a leader when I finish training. I am aware that I will be provided with teaching and clinical support in regards to this role, but I wonder if this happens in all universities. As already discussed I think personality has a part to play, but some of the leadership skills could be taught and developed through training. I think courses need to think about providing teaching and training from the business sector, perhaps thinking more about how we can sell and market ourselves as the ones for the job. I think if we have more understanding of other professional’s views on leadership then we can hopefully put some of this skills training into practice. In addition to this, I think that if as trainees we were provided with good examples of psychologists taking the position of clinical leader (in teaching and on placement), then this might give us the motivation and inspiration to follow in those leaders’ footsteps. What we need is passion and self believe that we can make changes, and we need to believe and see for ourselves that the clinical leadership position is a useful one to hold.
CONCLUSION

As I reflect on this essay I am wondering if I got the best out of the policies and research I used. I feel that I spend so much time getting my head around what a clinical leader is that there was not enough time to think and explore further some of the ideas I only briefly mentioned. I am left wondering what the future will hold for clinical psychology in regards to leadership and I would love to look back at this essay in ten years time to see if any of the predicted changes occur, and also see where I am on the leadership ladder! What I have established from this essay is that I do think that a clinical leadership role is a useful one and I think that clinical psychologists are ideal candidates for the job. As a profession we have so many transferable skills and hopefully these skills, characteristics, and natural abilities will be of benefit to service users, carers, and other team members as more of us begin to take on the role of clinical leader. Finally, the last thing I wish to do is to think about what sort of leader I would like to be. From the theories and approaches that we have read, I feel that authentic leadership fits well with my own theoretical stance but also with my own values. I believe that if we are to be leaders of the future, we should be leading from an honest and genuine position. Not from one that is based on someone else’s style or beliefs.
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The Relationship to Change

Problem Based Learning Reflective Account I

March 2008

Year 1
The first day

I remember the 17th September 2007 well. It was the start of a new chapter in my life, one that filled me with excitement and happiness, but also fear and nerves. I had left my life in the North of England the previous week, and moved to London with my boyfriend to start clinical training. It had been a week of change.

The first day of training was long. There were so many names to learn, university campus seemed like a rabbit warren, and by 5pm my head was spinning. However, for seven of us the day was not over yet. We had opted in for the Monday night Case Discussion Group, and it was there where we were presented with the Problem Based Learning (PBL) exercise.

The task

At the beginning of the first session the facilitator introduced herself and described her role as facilitator to us (Wood, 2003). Time had then been allocated for us to get to know each other a bit more. This consisted of brief introductions about who we were and where we had come from, and also about how we were feeling after the first day of training. Conversation quickly led to the task itself, thus leading the facilitator to introduce the exercise. The title of the task was ‘The relationship to change’ and we were informed that we were to present to the rest of the cohort in six weeks time. We were told very little, as it was up to us as a group to do what we wanted with the title. Immediately I sensed confusion and ambiguity amongst some of the group members. As we discussed the task in more detail I was aware that people were beginning to panic. Thinking back I think people felt lost. There was no direction and no list of ‘things to do’. I believe that perhaps people felt annoyed and frustrated that the first piece of academic work was something so vague. However, looking back I remember feeling ok about the task. I am not somebody who needs to be told what to do, and have since realised that perhaps my best performance comes when I am left to be creative. I felt confident that the task would be achievable.

Thinking back to this session and the way some of the group members reacted, reminds me of a client I worked with in the past. I was asking the client to complete
some homework and he suddenly got very annoyed and irritated with me. I explored this with him and it came about that the client was annoyed with me for asking him to explore his thoughts and feelings himself. He had come to therapy with the expectation that I would tell him his thoughts and feelings, and that I would tell him what to do for him to feel better. Perhaps this is how some of the group members felt. They wanted the facilitator to tell us what to do, and had come with the expectation that they would have direction in this task. Thinking back I believe that these observations were really significant and now play importance in my clinical work. I think that clients often come to therapy believing that the therapist will ‘fix them’ and tell them what to do to feel better. In actual fact therapy is much more collaborative and often involves the clients doing a great deal of thinking and application themselves. Because my understanding of this is much clearer I now have greater awareness of this in my own clinical practice, especially when using the cognitive behavioural model. I discuss with clients at the beginning about their role in the therapy and how the process is going to be collaborative.

The process

During session two we decided that our presentation would focus on the PBL task itself. We decided we would talk about change in terms of the change that occurs in the group over the six CDG sessions, and the change that happens as we produce the presentation. We would then link this to theoretical models of change. We discussed various models but in the end decided to map our group experience onto the Transition cycle (Hopson & Adams, 1976) and the Plan Do Study Act (PDSA) model (Langley et al, 1996).

During the subsequent three sessions we planned our presentation, and this process taught me a great deal about different people’s learning styles. For example; some group members felt quite strongly about having interactive teaching aids and believed that a PowerPoint presentation would be boring. Others felt that PowerPoint slides were essential in a presentation. On reflection I think these thoughts related to our own learning styles, and how useful we find PowerPoint slides as teaching aids ourselves. It is important for us to not only consider what we find useful, but to consider the viewpoints of others. In relation to clinical practice this is something I now consider with all of my clients. What is their learning style?
And how best will they learn? This is particularly relevant when working in groups. All group members may have different learning styles so it is important to explore this with each individual group member.

During the process of designing our presentation, there were times when I was unhappy with some of the decisions made. I sometimes expressed these thoughts and opinions, but on other occasions I kept quiet. Thinking about why I did this I think it is related to my desire to please others. I know that expressing some opinions within the group may have caused other people to feel upset or disappointed that their suggestions had been questioned, and I think that I would find this difficult to deal with. I do not like seeing people upset, or in despair, and because of this perhaps I think it is easier to not say anything. Since this task I have become much more aware of my desire to please others and not wanting to let people down. I have noticed personally that I find it hard to say no if it is going to cause disappointment. In practice I have noticed that with some clients I find it difficult to end the session if the client is feeling distressed, upset, or wants to talk to me for longer. I know that boundaries in therapy are important and since this task I have become more aware of what I do and why I do it thus making it easier to stick to these boundaries and say to a client when their session is over. Personally I am trying to be more assertive in life.

The group

During the first session we were asked by the facilitator to allocate two roles: a chair and a scribe (Wood, 2003). We decided to rotate these roles each week so that everyone would have a chance at taking on a different role. I felt that this was a good idea, as I was happy to do either role for the group. However, I feel that maybe we forgot to consider the possibility that some people may have not felt comfortable being chair or scribe, and that this could have caused unnecessary anxiety for these people. One group member did check with everyone that they were happy with the allocation of roles, but looking back I believe that even if someone was not happy with this decision it would have been unlikely that they would have voiced this opinion. It was the first time we had met each other, and we would be studying and working together for the next three years, therefore it was unlikely that someone would have had the confidence to speak out about the
decision. On reflection perhaps we could have decided to think about the allocation of these roles, instead of rushing into making a decision.

Another thing that comes to my mind when I think about my group is how diverse we are. Within the group there are different genders, different ages, different backgrounds, different cultures, and different personality traits. I think that diversity like this within a group can be a good thing as it increases the amount of skills, knowledge, and experience in the group. However, Shaw & Barrett-Power (1998) state that diversity can also inhibit creativity and cause conflict and on reflection I think this is also true. During one of our sessions the group went through a storming phase (Tuckman, 1965) where group members disagreed about how to present the information to our audience. Thinking back I think this disagreement was due to differing learning styles (as mentioned above) but it could have also been as a result of the diverse characteristics of the group members. This is something I have thought about a great deal in regards to future PBL tasks but also in relation to a clinical group I am going to be facilitating in the near future. I hope that having a greater awareness of how diversity can cause conflict will encourage me to talk about this issue within future groups, which may prevent the conflict occurring.

The presentation

As part of the presentation we mapped our experience as a group of the task onto the Transition cycle (Hopson & Adams, 1976). Whilst writing this account I have thought about how my own experience of the task mapped onto this cycle. My own experience is actually quite different to the group experience and this made me think a great deal about how people can go through exactly the same changes, but the experience is something very different for everyone. If we think about the change that the entire group experienced at the same time, becoming a trainee clinical psychologist, then we will have all experienced something different. Reflecting on this clinically I think this is also very true. Clients can experience similar changes in life (e.g. illness, bereavement, marriage, divorce) but these changes will have a different impact on each client. I realise that it is important that I remember this in my own practice. Something else I have related this too is the impact client change may have on carers or family members of my clients. Again, each carer or family member may experience the same change but each will experience it differently.
think that this understanding will be really helpful in future work with families or couples.

What else have I learnt?

I think the main thing the PBL task taught me is that the experience of change is different for everyone. I have therefore learnt to be much more mindful of this within my case discussion group, within social situations, and also within a clinical setting. The task also taught me to reflect on myself within my group, and this led me to think about my role within the group and how I 'fit in'. I have concluded that although I am happy to be chair and do enjoy this role; I feel that I need to practise being more assertive within the group when I am not chair. Whilst writing this account and thinking about myself, I was shocked by how passive I can be sometimes. I think if people were asked if they thought I was assertive then they would say that I was. However, when thinking about different situations there are many times when I say yes to things just to please others. I am therefore going to try and be more truthful to myself.

Finally, I think the PBL task itself would not have taught me as much as it did if I was not required to write this reflective account at the end of it. I feel that being able to reflect in writing was a really useful task, as it has allowed me to think about my thinking in an in depth way. I have also learnt how imperative reflection is, for me personally and for my clinical practice.
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Working with People in Later Life, their Families, and the Professional Network

Problem Based Learning Reflective Account II
March 2009
Year 2
The Task

We were given a description of this problem based learning (PBL) exercise at a briefing run by the academic tutors. What was described to us was a problem situation about a 69 year old gentleman called Mr Nikolas, who had been referred to psychology for assessment of his short term memory. Mr Nikolas was in the midst of a complex family system, where divorce and a current court of protection order were only a few of his problems. Other family members were also causing disputes and disagreements. We were provided with handouts, which included a detailed description of the case and prompt questions that could be used to fuel discussion.

When I was first made aware of the title of this task (working with people in later life, their families, and the professional network) I remember feeling quite apprehensive. I think this apprehension came from the fact that I have never worked with older adults before and it is the client group that I feel I know the least about. I was fully aware that as a group none of us had been on our older adult placement yet so we would all be coming from a similar position, but this did not prevent my feelings of trepidation. Because of this I think I approached the task with less enthusiasm compared to previous PBL exercises. As I reflected on this after the first meeting, I was led to question this. The second PBL exercise had been carried out with dietetic students (which was a subject I knew nothing about), but I did not experience the same feelings then. After spending some time thinking, I was able to identify that my feelings were due to my own anxieties about working with older adults. As I write about this now, I feel very grateful that I have been given the opportunity to really explore these feelings well in advance of my older adult placement.

The Group

My group was made up of two female third years, one male third year, and three female trainees from my year group, and I remember feeling quite excited about the prospect of this being a joint piece of work with another cohort. As a trainee, peer support and friendships are extremely important to me and I have always valued opportunities to meet up with peers and colleagues. Therefore, I saw it as a real
opportunity to get to know different people but also as a chance to learn from colleagues who had already experienced the second year of training.

After initially being introduced to the topic, our group scheduled a couple of meetings together. What became apparent as our meetings progressed was that the male group member began to take a chair type role within the group. He would make notes of our meetings and then email them to us in what I felt was quite a directive manner, suggesting what and by whom should be done next. As I reflect on this, I wonder why this made me feel so uncomfortable. Perhaps it was related to feeling like I was being bossed around. I am quite an assertive person and I guess I am often the person who takes the lead in small group tasks. From the start of this task it felt like someone else was telling me what to do, and the manner in which I was being told made me feel somewhat like a child. Maybe that was it—that I was being told what to do and not asked what to do. Relating this to our role in clinical practice, we often encourage clients to do things for therapy i.e. homework tasks. However, I wonder how clients actually feel when we are asking them to do these things. I wonder if they also feel like they are being told what to do and not asked or advised. This has really reminded me how important it is to see the client as the expert, to encourage the nature of a collaborative working relationship, and to be hyper vigilant to the power differentials in the room and how they might impact the therapy.

I also wonder if the fact that the group member who was taking the lead was the only male impacted on the way I was feeling. Perhaps his gender was a factor, and maybe as the only male he felt like he had to conform to society’s view on the role of a male as leader (Lindsey, 2005). However, clinical psychology is a female dominated profession and therefore male psychologists are often outnumbered, so I am not sure this was the case. This leads me to question why else I felt uncomfortable. I think maybe it was due to my own feelings of not being able to have a say. This was probably not how it was in reality, and I am sure if I had spoken up and expressed my thoughts and opinions then they would have been listened to. Other group members were quite vocal about their ideas and thinking, but something stopped me. Maybe the females also conformed to society and allowed the only male member to act in a directive manner, while we stepped back
and held a more passive position (Lindsey, 2005). Or maybe I just did not like feeling someone else was taking control of the situation and therefore just stayed quiet and let him be the leader.

Aside from gender, I wonder what other reasons there might be for this group member to take on this role. Perhaps it was just his personality? Anderson and Kilduff (2009) explored why dominant personalities consistently attain high levels of influences in groups, and found that it is due to people with dominant personalities behaving in ways that make them appear more competent. Maybe his dominant personality was the reason for everyone else in the group to step back, or maybe we believed that he was the more competent trainee and that he knew what he was talking about. However, Anderson and Kilduff (2009) concluded in their study that just because someone might appear to have competence does not mean they are actually competent, and I wonder if this is also what occurred in my group.

This has made me reflect on my usual role within groups. Because I can be quite a dominant person, I wonder if people assume that I am competent in what I am talking about. As a result of this thinking I am now going to be much more aware of what the people who are not talking have to say. Those people probably have some really valuable ideas to share and because they are not acting in a dominant way, people are not listening to them. Again, I will also try and be aware of this in therapy group settings. I must remind myself that the people who are being quiet might have some very useful thoughts to add and they too should be given a chance to talk.

The Process

Writing about gender in relation to the group members has also made me think about if the gender differential affected the decision making in our group. I have often been present in all-female psychology meetings where decisions are not made they are just talked about for a long time, and if I think to how my cohort (mainly female) makes decisions then I would have to say that we are pretty poor at it! In a study comparing gender with team decision quality, Rogelberg & Rumery (1996)
discovered that as the number of males in the groups increased so did team decision quality. However, they also found that all-female teams outperformed all-male teams. I wonder then in my group if the male member inhibited decision quality or added to it?

Our meetings certainly did not lack creativity, and by the end of our third meeting we had a number of brilliant hypotheses and formulations about Mr Nikolas. But what was lacking was an idea in relation to the actual presentation. Up to that point we had failed to really think about how our thoughts would become a presentation. Perhaps as a whole group we had got so caught up in thinking of clever theories that we forgot the main purpose of the task? As I write this now, I feel frustrated at myself that again I did not speak up about how I was feeling. Perhaps one reason for this was that as a second year I had hoped that a third year trainee would step forward and take the lead. French and Raven (1959) describe legitimate power as coming from the belief that a person has the right to make demands and expect compliance and obedience from others. Perhaps unconsciously I wanted a third year to use their legitimate power to make the decision. Or maybe I hoped that the already self declared leader/chair would just decide what we should do. In actual fact, the group member who did remind us about the purpose of the task was a second year trainee. I remember feeling like this was a turning point for us as a group, as it was from here onwards that a presentation was developed. And thinking back to the literature on dominant personalities (Anderson & Kilduff, 2009), the person who moved the task forward was someone who had not being particularly dominant up to that point.

The Presentation

Once the discussions turned into actions, we were able to start planning the presentation. We decided to present from two different perspectives (systemic and psychodynamic) as we felt we had too many ideas to go with one perspective. We were able to work together as a team and we tried to incorporate everyone's ideas into the presentation. For me it felt like the group dynamics had changed. There did not appear to be a dominant leader anymore, and I remember feeling quite different,
definitely more accepting, towards the member who had once made me feel quite small and insignificant. The actual presentation went well, and if the audience had of been asked who they felt the leader of the group was, I think they would have struggled to pick out one person. We all had equal roles and I think presenting from two theoretical perspectives demonstrated the creative nature of our group. I think this also represented what sort of group we had become in the end – a sharing and co-operative group.

**Final Thoughts**

This exercise has helped me realise that despite any feelings of apprehension I may have about working with older adults, I do posses many skills that are transferable to any client group. My reading around legitimate power (French and Raven, 1959) has also made me think about how this is related to multi-disciplinary teams within the NHS. I wonder if most people in the NHS assume that qualification and power automatically results in a leadership role. Whereas clinical leadership should not be about hierarchy, but about the different skills, knowledge, and personality people bring (Millward & Bryan, 2005). Relating this to psychologists, especially in light of New Ways of Working (British Psychological Society, 2007), we are now expected to take much more of a leadership role. But we might not be at the top of the hierarchy, or even in a position of management. I think by doing this exercise it has opened my eyes to how tricky this might actually be. Will other team members only expect leadership from managers, and how will they respond and act if the leadership comes from someone else lower down the hierarchy? Finally, this exercise has helped me think much more about my role and personality within group settings. I hope that as a result of this exercise I will be more accepting of the person who takes on the role of the leader, and I hope that I will make more of a conscious effort to listen to ideas from less dominant group members.
REFERENCES


How do we know if IAPT is Working?

Problem Based Learning Reflective Account II

March 2010

Year 3
This account is based on my final problem based learning (PBL) exercise as a trainee clinical psychologist and I hope to give an overview of my experience of this PBL task. I will reflect on the impact of group roles on the process of the task. I will also reflect on how my groups’ opinions changed over the course of the task, and I map these changes onto Prochaska and Diclemente’s (1983) stages of change model.

The problem

The PBL task was based on the Improving Access to Psychological Therapies (IAPT) programme, which is a government initiative that was commissioned in response to the economic arguments of Lord Layard (Department of Health, 2008). We were asked in groups to prepare a consultancy report on how the effectiveness of IAPT can be assessed, and then present our findings. This piece of work seemed completely relevant to my career in clinical psychology, especially at this current time as I will shortly be applying for jobs.

Compared to previous PBL tasks, this one differed as it was more research orientated and was not based around a clinical vignette. I was pleasantly surprised to find this out. However, I also remember feeling apprehensive about my lack of knowledge in regards to IAPT. I thought that I should perhaps know more about it at this stage in my training and I was curious to find out if others had more extensive knowledge of the programme. Despite this feeling of apprehension I was enthusiastic to learn and was keen to get started.

Initial meeting as a group

My group decided to meet immediately after the task had been given to us. After initial introductions, group members started to discuss their feelings about the task and the chosen topic. This led to a very energetic group conversation and each group member expressed their views and opinions. I remember feeling that everyone wanted to get their voice heard. Everyone wanted to say something and it appeared that people felt quite passionate; I include myself in that. I wanted to express an annoyance about the IAPT programme assumingly missing out children,
families, and people with learning disabilities in its original form, and I expressed views about the lack of systemic thinking in its current format. As discussions evolved it became apparent that there were various types of opinion coming across. Some of the group felt decidedly positive about the task and IAPT, some felt positive about the task at hand but more negative about IAPT, and some felt negative about the task and about IAPT. Due to time constraints the meeting ended mid discussion and as a result no decisions were made about the presentation. To me it also felt like there was some animosity and tension between group members. I thought that the difference in opinion about IAPT had been the main contributing factor to this animosity.

This initial meeting reminded me of multi-disciplinary team meetings I experienced on a previous placement. Opinions and views were always shared and people often spoke about how they were feeling. However I think this resulted in very few decisions ever been made, and it felt like meetings were used only as an opportunity to rant. In those MDT situations I wanted to step in and try to encourage people to find solutions to the problems. Likewise in this PBL meeting I felt like I wanted to bring some sort of collectiveness to the group to enable us to move forward in our decision making. But for some reason I did not do this. Perhaps this was because it was the first meeting and because energy levels were so high it felt right that people should have the chance to express opinion. However, I left the meeting feeling similar to those times after the MDT meetings. I felt annoyed that no decisions had been made but also annoyed that I had not initiated the decision making process.

As a result of these experiences I now make a conscious effort to try and encourage decision making in meetings as I believe people then leave feeling like something has been achieved. I think I would have felt much happier after our initial PBL meeting if something had been decided about the task or presentation. This is something I have learnt about myself over the last three years; that I like decisions to be made and I like to have action points following meetings. I see this as one of my strengths and as a key role in leadership, something that is encouraged in clinical psychologists (British Psychological Society, 2007).
Further reflection also led me to feel surprised at my level of annoyance about the family and systemic issues. Up until that point I would have said I felt quite neutral about IAPT, but what came across was a passion for the people that IAPT does not account for. Perhaps I felt this way because I had recently completed a year of placements that had enabled me to think more systemically about clinical practice and service issues. And perhaps the people from the second year cohort found it easier to accept the individual nature of IAPT. They had just completed a year in an adult mental health setting where in my experience systemic practice is less common. Until this year I would not have said I worked in a particularly systemic way but this PBL encouraged me to see where my values and beliefs lie, and how these values impact my clinical work.

The group process

In total we met as a group five times and overall I would say we worked extremely well together. The feelings of tension I noted earlier were discussed openly during our second meeting. Instead of thinking about the difference in opinion as ‘wrong’, we reflected on the passion people had about IAPT as a subject matter. We therefore decided to try and capture this passion and difference in opinion in our presentation. We wrote a quiz show focussing on how IAPT is currently been evaluated and who this method of evaluation is effective for. Different stakeholders i.e. managers, training course members, service users, MDT members, and IAPT trainees were represented with the aim being for each stakeholder to get the opportunity to share their story about the method of evaluation.

When I think about times in therapy sessions where family members have got caught up in problem saturated stories (White & Epston, 1990), I am reminded of how useful it can be to use positive connotations (Selvini Palazzoli et al., 1978) and re-authoring (White, 1990) to enable family members to create alternative stories. This then helps them live out new self-images and new possibilities for the future (Freedman & Combs, 1996). This is also what I observed in my PBL group. Instead of focussing on the problem stories, the alternative stories allowed us to create a presentation that was rich and diverse in ideas.
Reflecting on our meetings I am aware that we worked well as a team and we functioned without disagreement or conflict. This led me to think about the different roles each group member took, and if it was these roles that enabled us to work so well together. Belbin (1993) has developed a theory about team roles and describes nine roles that fit into three categories: action-orientated roles, people-orientated roles, and thought-orientated roles. When I think about my group I think we were fortunate to have a good balance, which is something Belbin (1993) suggests for a team to work to their strengths and actively manage their weaknesses. When I think about my role in relation to these ideas I viewed myself as either a thought orientated monitor; someone who saw the bigger picture, or as a people orientated investigator; someone who explores ideas with energy and networks within the team. One of our weaknesses as a group however, could have been that these roles were never discussed and maybe other group members did not feel the same way as I did. We could have had a discussion about what each of us thought our role in the group was.

As I reflect on the whole group process it is apparent how much things changed from the initial meeting. Everyone was more accepting of other people’s view points and the tension that I witnessed during our first meeting had diminished. As mentioned, perhaps it was the right balance of different roles that facilitated us to move through the change. If we map our change onto the stages of change model (Prochaska & DiClemente, 1983) it is clear to see how we moved through the different stages. People were very much in the pre-contemplation stage during the initial meeting and then gradually as a group we moved through to action and then maintenance. I often hold this theory in mind with clients when the focus is on behaviour or personal change. For change to occur a person moves through the stages with one of the most important factors being a readiness to attempt change. In my PBL group I think once we all became ready to think differently and be more accepting of other people’s ideas, we were able to move forward.

The presentation day

I really enjoyed our presentation despite some last minute changes. Two people in my group were unfortunately on sick leave and therefore alterations were required.
This did not cause a problem and the remaining group members met early to decide what to do. It was still a success in my eyes and I think this was as a result of a close knit team who had worked openly together during preparations. The absences did not disrupt the equilibrium and this demonstrated a positive working alliance.

As I think back to the day of presentations I remember being quite struck by how much I learnt from everyone else. I remember feeling like I came away full of new knowledge and with a totally different mindset about IAPT. I no longer associated IAPT with money and time wasting, and I was more accepting of its place in mental health services in the UK today. On reflection I think this shift was mainly due to two things: an increased knowledge base and a change in attitude. This has led me to think about how clinical psychology and IAPT can work together now and in the future. It has challenged my thinking massively and has made me wonder about how many more professionals might have a shift in thinking if they too got the opportunity to find out more about the programme.

These views were also shared by other members in my group. We had an email conversation about how the presentation had gone and what we had each taken away from the experience. People commented that they had been reminded to stay curious, in spite of initial emotional reactions. People had also been reminded not to rush into tasks with preconceived ideas. Both of these group learning points resonate with me and it was really helpful to be reminded about them from others. In therapy I see these things as extremely important and I hope to remember them throughout my career as a clinical psychologist.

**Final reflections**

This PBL task had a significant effect on me. It taught me about the success of good team work and the importance of different team roles. It also provided me with an opportunity to experience a change in attitude and opinion in myself, something that as therapists we require our clients to do all of the time. It reminded me that change is possible. The task also left me with a certain amount of optimism in regards to IAPT and helped me realise that the success of the programme is not about what
we as professionals think. It is much more important to get it right for the people who are using the service, and if they are benefitting then surely there is a need for it.
REFERENCES


Case Discussion Group Process Account Summaries
Case Discussion Group Process Account Summary

Process Account I
September 2008
Year 1
This piece of writing is a reflective account of my experience of the case discussion group (CDG) during the first year of clinical training. I begin by thinking about the function of the CDG and relate this to my previous experiences of reflective practice groups. My initial expectations of what I thought the group would be like are compared to other group member's expectations, and to the realisation of what the CDG was actually like. I write about how my CDG developed over the year and I also explore how the members of my CDG contributed to this development and to the group as a whole. For me, the CDG felt like a place away from placement and teaching, it acted as a supporting environment, where I felt safe, secure and contained. As a group, I think we used our CDG as a source of comfort, support, and safety in times of need, and as a secure base for exploration and growth. I finish the account by reflecting on my own personal development throughout the year in regards to the CDG, as well as reflecting on how I developed professionally. I also think about what I learnt over the year and what I hope others learnt from me.
Case Discussion Group Process Account Summary

Process Account II

July 2009

Year 2
This process account tells the story of my case discussion group (CDG) during the second-year of clinical training. I use Gibbs' model of reflection (Gibbs, 1988) as a framework for the piece of work. This was due to feeling that I wanted to use a structure, as I had a number of things to say but was struggling to format my thinking in a meaningful way. I start by describing what happened in my CDG over the year and I write about the content of the sessions. I then move on and write about my feelings and thoughts, focusing both on my feelings during the group sessions and my feelings as I write the account. I evaluate the experience, exploring the positive and negative aspects of my CDG and I then try and make sense of some of the things that happened in my group. I think about what I and others could have done differently throughout the year, and I think ahead to next year’s CDG and what I would like to gain from my third year experience. During the account I explore my role within the group, other peoples’ roles within the group, and how the group has developed over the year. I also think about the impact of the CDG on my clinical practice and on my development as a trainee clinical psychologist.

Reference

Overview of Clinical Placement Experience

October 2007-September 2010

Years 1, 2 and 3
Placement: Adult Mental Health placement
Dates: October 2007-September 2008
Setting: Outpatient Psychoanalytic Psychotherapy Department and Primary Care Psychology Service

This placement was split between two different services. I spent half of my time in primary care across three GP surgeries, delivering individual psychodynamic therapy, individual cognitive behavioural therapy (CBT), and group CBT to adults between the ages or 18-65 years. The remainder of my time was spent in a tertiary service delivering weekly psychoanalytic psychotherapy to one client for 11 months. Across both areas I saw adults with mild and moderate mental health difficulties and severe and enduring difficulties. Presenting difficulties included anxiety disorders, depression, bereavement and loss, specific phobias, personality disorder, psychosis, anger issues, and difficulties in relationships. I also saw a number of clients who self harmed and were at times suicidal. In addition to this, I spent time on an inpatient ward for adults who were under the care of the mental health system.

The main psychological models used were CBT and psychoanalytic psychotherapy. As well as the direct client work I also attended team meetings, worked jointly with other professionals, and carried out CBT teaching sessions for Graduate Primary Care Mental Health Workers (GPCMHWs). A service related research project was completed during this placement, and I explored the GPCMHWs role across five boroughs in South West London.

Placement: Learning Disabilities placement
Dates: October 2008-March 2009
Setting: Community Learning Disability Team for Adults (CLDT)

This placement was based in a CLDT for adults, although the service also saw clients who were classed as ‘transitional’ (aged 16-18 years), who were in the process of moving from a child LD service to an adult one. Throughout my time on this placement I saw clients with significant, severe, and profound learning disabilities, including clients with additional physical and sensory difficulties, health
problems, and clients with no formal language. Presenting difficulties included anxiety, depression, challenging behaviour, social and relationship problems, issues resulting from physical and sexual abuse, and difficulties with anger. The main psychological models used were CBT (adapted for clients with a learning disability), behavioural and systemic. In addition to individual client work, I carried out a 'Relationships' group and a group that focussed on life skills and stress management. I also did a significant amount of staff training on dementia, anxiety management, and anger management. Another aspect of this role was completing dementia screening assessments for people with Downs Syndrome and neuropsychological assessments.

Placement: Children and Young People placement

Dates: April 2009-September 2009

Setting: Looked After Children (LAC) Service and Child and Adolescent Mental Health (CAMHS) Team

This placement was split between a LAC service based in Social Services and a CAMHS team based in the community. I saw children and adolescents aged between 2-18 years, presenting with emotional difficulties (attachment issues, anxiety, phobias, anger issues, self-harm, mood disorders and school refusal), developmental difficulties (Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD), and difficulties within the family system. The main models used were CBT and systemic, and in LAC there was an emphasis on attachment theory. The clients I saw within the LAC service were often struggling to adjust to psycho-social problems and the work often involved working indirectly with carers and social services, as opposed to direct individual work. My supervisor and I also offered regular consultation both to social workers and teams. I ran a parenting group for foster carers and took part in a number of training sessions for social workers. IN CAMHS I attended team meetings and worked jointly with other health professionals on a number of cases. In addition, I carried out a number of school observations and completed neuropsychological assessments for ADHD, specific learning difficulties, and ASD.
Placement: Advanced Competencies placement  
Dates: October 2009-March 2010 
Setting: Paediatric Psychology Service

I chose to complete my advanced competencies placement in the speciality of paediatric psychology. I was based in an inner city hospital and provided services to children and adolescents aged 0-18, both inpatients and outpatients. My supervisor's main interest was paediatric oncology so I saw a number of cases within this speciality. Other presenting difficulties included diabetes, infectious diseases, constipation, pain, psychosomatic disorders, and patients who were due to or had experienced surgical procedures. The main psychological models used were systemic, solution focussed and CBT. I attended weekly psychology meetings and psycho-social ward rounds. I was also required to work closely with medical staff and this enabled me to bring psychological thinking and formulation into a predominantly medicalised place of work. In addition, close communication with schools and families was essential for most patients.

Placement: Older People placement  
Dates: April 2010-September 2010 
Setting: Community Mental Health Team for Older People

For my last placement I was based in an integrated health and social care team for adults over the age of 65. I worked with adults with moderate to severe mental health difficulties and presenting problems included anxiety, depression, difficulties associated with physical health problems, dementia, stroke and issues arising from loss and bereavement. I carried out direct work with individuals, with couples and with families. I also carried out a weekly memory support group for people with dementia. The main model used was integrative. In addition to the therapeutic work, I completed a number of neuropsychological assessments. These were for people suffering with memory loss and other cognitive impairments.
Clinical Case Report Summaries and Oral Presentation of Clinical Activity Summary
A Cognitive-Behavioural Assessment, Formulation and Intervention of a 26-year-old Man Presenting with Emetophobia

Adult Mental Health Case Report I Summary
April 2008
Year 1
Joshua, a 26-year-old male was referred by his GP to the primary care psychology service with a specific phobia of vomiting (emetophobia). This phobia was precipitated by a horrible experience of smoking cannabis as a teenager, where he was violently sick a number of times. After this experience Joshua became hyper-vigilant towards other situations that might make him vomit (i.e. eating undercooked meat, contracting food poisoning in restaurants, and travel sickness) and as a result began to avoid a lot of potentially vomit inducing situations. At the time of referral Joshua would rarely travel on public transport, would not eat out in restaurants, and would not allow other people, including his girlfriend, to cook for him. A cognitive behavioural assessment and formulation guided the work and psychological intervention included exposure to feared stimulus, behaviour experiments, thought recording and thought challenging. After 12 individual sessions Joshua was able to travel on buses and trains, eat out in restaurants, and go to friend’s houses for dinner. His score on General Health Questionnaire-12 had fallen from 5/12 to 0/12 at the end of the sessions. To help remind Joshua of the specific techniques we had used in therapy, he was provided with a relapse prevention pack. This included information on his formulation, guidance of thought challenging, and instructions on various coping strategies that he had used throughout the process.
Psychodynamic Psychotherapy with a 44-year-old Woman
Focussing on Abandonment and Rejection

Adult Mental Health Case Report II Summary
September 2008
Year 1
Miss Moore, a 44-year-old female was referred to the specialist psychoanalytic psychotherapy department by a clinical psychologist from her local CMHT. The psychologist had assessed Miss Moore and recommended that she receive therapy within the psychodynamic framework. She presented with depression, self-harming behaviour and a history of suicidal ideation. She also had a diagnosis of emotionally unstable personality disorder and had extreme difficulties in relationships, past and current. Miss Moore’s score on the Clinical Outcomes in Routine Evaluation assessment was 93/136, which was classed as severe. She was seen for 38 sessions of psychotherapy. The formulation and intervention drew heavily on the ideas of The British Independent School. It was broadly informed by Object Relations theory, which emphasised real early relationships and how these had been internalised and were affecting present relationships, and Attachment theory, which focused on the clinical implications of attachment including the idea of the therapist as an attachment figure. Therapy sessions started out by allowing Miss Moore to tell her story. As the therapeutic relationship developed, reconstructive interpretations were made, as well as transference interpretations. Miss Moore engaged well with the therapy. Her self-harming behaviour significantly reduced and she stated that the therapy had helped her understand herself and her relationship patterns. Towards the end of therapy Miss Moore had also improved her interaction with the social and interpersonal world.
An Extended Psychometric Assessment of a 30-year-old Male with Learning Disabilities to determine if he has Autistic Spectrum Disorder

Learning Disabilities Case Report Summary
April 2009
Year 2
This case report was based on the work carried out with a 30-year-old male with learning disabilities. He was referred to the psychology department (within a Community Learning Disabilities Team) for a cognitive assessment. He had been diagnosed with semantic-pragmatic disorder at the age of six and he and his mother wanted to find out if this diagnosis was still appropriate. He was also experiencing some problems in his employment at a supermarket. After an initial assessment it was decided that a detailed extended assessment for autistic spectrum disorder should be carried out. A developmental history was collected, a cognitive assessment was carried out, and information was taken in regards to his current functioning. The Wechsler Adult Intelligence Scale-Third Edition (WAIS-III), British Picture Vocabulary Scale-Second Edition (BPVS-II), Adaptive Behaviour Scale-Residential and Community-Second Edition (ABS-RC:2), Childhood Autism Rating Scale (CARS) and theory of mind tests were carried out with the client. Using the results of the assessments, the information collected, and literature on the similarities between high functioning autism and semantic-pragmatic disorder it was concluded that this gentleman did have a disorder on the autistic spectrum. Recommendations were made for the client, his family, and the people that support him in his daily life.
A Behavioural Intervention for a 4-year-old Boy Presenting with
Severe Constipation and Toileting Difficulties

Advanced Competencies Case Report Summary
April 2010
Year 3
This case report was based a piece of work carried out within a paediatric psychology team. The patient, a four-year-old boy, presented with severe constipation and toileting difficulties after he was referred from a continence nurse. These difficulties included not being able to open his bowels unless wearing a nappy. An initial assessment with the family indicated that they were feeling quite stressed about the situation. Initial formulation was based on the behavioural model and it was hypothesised that the young boys' difficulties were as a result of behavioural factors, particularly the lack of positive reinforcement and the association of pain leading to avoidance. Intervention included developing a stepped behavioural programme to encourage the use of the toilet and psycho-educational support for management of the constipation. Over the course of therapy it became apparent that the constipation had worsened and therefore a reward system was set up for medication compliance. The patient and family responded well to this, and as the constipation was managed more effectively this had a positive impact on the toileting difficulties overall. The family were engaged throughout and part of the re-formulation included some systemic factors such as empowerment and a family belief that they could cope. Despite the boy still wearing nappies at times, the family stated that they felt less worried and stressed about the situation. Engaging the child was also a large element of the work as he had initially being too scared to talk to me through fear of being hurt.
Using Systemic Formulation when Working Individually with a 12-year-old Girl in Foster Care

Children and Young People Oral Case Presentation of Clinical Activity Summary

September 2009

Year 2
Josie, a 12-year-old girl, was referred to the psychology team within the Looked After Children (LAC) service because of concerns about her mood and anger. At the time of referral, Josie was living in kinship care with her maternal aunt under an interim care order. Her aunt had three children of her own and Josie’s younger sister also lived in the same placement. Josie had another younger sister and an older brother, and they were currently placed with a different maternal aunt. All four children were removed from the family home and placed in police protection following an incident of domestic violence between their mother and father. The parents were bailed and the children were allowed back in their care. Over the subsequent six months social services were heavily involved and following reports of neglect, further domestic violence incidents, alcohol and drug abuse by both parents, and the children witnessing their father cutting his own wrists, a court ordered that the children be removed. Josie’s mother and father had a long history of mental health problems.

A social worker referred Josie because of concerns that she did not have anyone to talk to about what she had experienced over the previous year. Josie’s aunt had made numerous complaints about her being rude, disrespectful and angry, and she had stated on numerous occasions that she thought Josie had mental health problems like her mother. The social worker therefore requested an assessment of Josie’s mental health, and thought that Josie would benefit from being able to talk to someone about her current living situation and her anger. She had recently lost weight and was very confused about her feelings towards her mother. The social worker was also concerned about Josie being scapegoated in the family, as she was always blamed for arguments between her sister and cousins.

It was decided that Josie would be seen for twelve sessions of psychological support, with one aim being an assessment of her mental health. Self-report measures were completed and these demonstrated that Josie was not suffering at that time with low mood, anger issues, anxiety, or post-traumatic stress disorder. These results were feedback to Josie as it was felt important for her to hear that she was ‘not mad’. As the therapy progressed, it became apparent that Josie was not the ‘problem’ despite a number of people involved in her care attributing blame on her. Sessions were therefore conducted with Josie’s aunt and the social services network, for them to hear the results of the assessment. Systemic formulation included family discourses being held onto and family patterns being maintained, as
well as entrenched behaviours and patterns of interactions. The sessions with the
wider system allowed members to openly discuss their anxieties and fears about Josie and her recent behaviour, and over time her behaviour was reconstructed as a normal reaction to a very difficult situation. Josie reported that she thought her aunt understood her more as a result of the therapy.
Service Related Research Project
An Investigation into the Role of a Graduate Primary Care Mental Health Worker: Is the role what they expected?

Service Related Research Project
Supervisors: Dr Fiona Warren and Dr Vicky Vidalaki
July 2008
Year 1
ACKNOWLEDGEMENTS

I would like to thank everyone who helped make this project happen. A special thanks goes to the participants of this study, the GPCMHWs themselves. I am aware they had to take time out of their busy schedules to attend the focus group, so thank you. I would also like to thank my research tutor Dr Fiona Warren and my clinical supervisor Dr Vicky Vidalaki, your support and encouragement has been greatly appreciated. And finally I must thank Richard, your help and support means so much to me.
ABSTRACT

Title: An investigation into the role of a Graduate Primary Care Mental Health Worker: Is the role what they expected?

Objectives: To investigate the views of ten GPCMHWs in relation to their job role and to explore whether the role is what the GPCMHWs expected it to be, and if not how the role differs.

Method: Ten GPCMHWs from one mental health trust were invited to attend a focus group. Eight GPCMHWs took part in the focus group, which was videotaped and then transcribed verbatim. The transcript was analysed using thematic analysis (Braun & Clarke, 2006).

Results: The analysis of the data revealed 3 themes: The impact of the role on self, the role is developing, and role confusion and what this does. Within the current paper all three of these themes are discussed briefly. Quotations are used to illustrate and support each of the themes.

Conclusions: Some of the findings of this study are in line with other research studies looking at the role of the GPCMHW. Role confusion and ambiguity (Bower, Jerrim, & Gask, 2004) and role developments (Farrand, Duncan, & Byng, 2007) are themes that have been highlighted before. However, the impact of the role on self is something that previous studies have not explored. Service recommendations include increased communication with GP’s and other professionals, a clear referral pathway being developed in some of the boroughs, and supervision needs being prioritised. The limitations of this project and ideas for future research are also discussed.
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Volume I – Research Dossier 93
INTRODUCTION

The World Health Organisation estimate that major depression will be the world's second most debilitating disease by 2020 (WHO, as cited in Department of Health, 2003). It is also believed that a quarter of all GP consultations are for people with mental health problems, and that depression is the third most common reason for consultation in the UK (Goldberg, as cited in Lucock et al, 2004). Taking this evidence into consideration in 1999 the NHS believed that access to psychological therapies in primary care needed to be expanded (National Health Service, 1999). Access remained problematic and a limited number of specialist mental health staff meant that demand usually outweighed supply (Priest et al, 1996). As a result of this the Graduate Primary Care Mental Health Worker (GPCMHW) was introduced in 'The NHS Plan' (Department of Health, 2000). It was proposed that the GPCMHW would be trained in brief therapy techniques of proven effectiveness, and employed to help GP's manage and treat common mental health problems (Department of Health, 2000). The GPCMHW Best Practice Guidance (Department of Health, 2003) attempts to outline the roles in which the workers would be involved and it was proposed that the focus would be within three areas:

*Direct client work* - support the delivery of brief, evidence-based effective interventions and self-help for people with common mental disorders.

*Practice teamwork* - providing resources that will help improve communication and information within primary care, or helping audit primary care mental health services.

*Wider network skills* - developing local service maps or databases of local mental health services or taking a more active role in liaising with charitable and voluntary sector services.

However, since the implementation of this new role there have been studies that show an amount of confusion about the role. Bower, Jerrim, & Gask (2004) interviewed managers and clinicians and found that the respondents had far wider role expectations of the new GPCMHWs. There was disagreement and ambiguity as to the nature of the role and the authors highlighted the potential for role conflict. O'Connor (2006) wrote a reflective narrative about the struggle for identity of
GPCMHWs, and she stated that although the workers have already made a significant contribution to primary care services she acknowledged that it would take years to establish a recognisable identity. And Farrand, Duncan, & Byng (2007) carried out a qualitative study exploring the impact of GPCMHWs upon primary care mental health. This study highlighted four themes: access to primary care mental health, inappropriate referrals, GMHW characteristics, and role developments, and within these themes concerns and problems with the role were explored. However, the study did conclude that the role was having a significant impact upon primary care mental health.

The majority of the studies investigating this topic so far have been carried out with other clinicians and managers. As far as aware, there is not a published study that has explored the role solely from the GPCMHWs point of view or examined if the role once they start working is what they expected it to be. It will be valuable to investigate if the GPCMHWs themselves understand their role fully or if they too are confused or feel ambiguous about what the role entails. This study is also interested to see if any of the themes that have been highlighted from the previous research transpire in this study. The results of this study will be useful to the service, as findings can be disseminated across this Trust and to other NHS Trusts.

Objectives

- To investigate the views of ten GPCMHWs in relation to their job role.
- To explore whether the role is what the GPCMHWs expected it to be, and if not how the role differs.
METHOD

Participants

Participants for this study were recruited by approaching the manager of a ‘Psychological Therapies in Primary Care’ department of one Mental Health Trust. Details of the ten GPCMHWs that were employed by the trust were given to the researcher with permission to contact them. The ten GPCMHWs were invited via email to take part in the study (See Appendix 1 for email) and eight of the ten GPCMHWs agreed to take part. All eight of the participants were female and ages ranged from 23 to 34 years with a mean age of 27.75 years, and they represented three of the four boroughs within the Trust’s locality. Ethnic backgrounds were also collected and participants were White British (n=5), White Irish (n=1), White Other (n=1), and British Asian (n=1). The researcher had confidence that the GPCMHWs would agree to take part because the study would allow them to discuss their own feelings about their role and it would also give them the opportunity to give information that would be fed back to their manager on their behalf.

Data collection

A focus group was set up for the GPCMHWs to attend. The group lasted for approximately 90 minutes and took place at a time and venue that was convenient for the GPCMHWs. Participants were given an information sheet that explained the aims and nature of the focus group (See Appendix 2) and consent to take part in the study was collected by means of a signed declaration (See Appendix 3). Participants were made aware that they would remain anonymous throughout the write up of the study.

It was deemed that a focus group would be the best way to collect the information as group processes have been found to help people explore and clarify their views in ways that would be less easily accessible in a one to one interview (Kitzinger, 1995). In addition focus groups can provide a setting that is less artificial than a one-to-one interview, which means that the data generated is likely to have high(er) ecological validity (Willig, 2001). The strength of a focus group lies in its ability to
mobilise participants to respond to and comment on one another’s contributions and this can generate rich data (Willig, 2001). A focus group schedule was produced (See Appendix 4) and this was based on a topic guide rather than a questioning route (Krueger, 1994). The focus group was audio and video taped to enable the researcher to pay full attention to participants’ accounts, the tapes were then transcribed verbatim (See Appendix 5 for a sample of transcript).

Analysis

The data that was collected from the focus group was analysed using thematic analysis. Thematic analysis is a qualitative method for identifying, analysing, and reporting patterns (themes) within data. The method provides a flexible and useful research tool, which can provide a rich and detailed, yet complex, account of data (Braun & Clarke, 2006). Thematic analysis was chosen because it is not wedded to any pre-existing theoretical framework, which is in contrast to IPA and grounded theory (Braun & Clark, 2006). The researcher wanted to report experiences, meanings and the reality of participants and thematic analysis can be used in this essentialist or realist way. An inductive (‘bottom up’) approach was taken which meant that the themes identified strongly with the data itself (Patton, 1990, as cited in Braun & Clark, 2006).

Due to the difficulties of assessing qualitative research on traditional frameworks of validity and reliability, the broad principles for assessing the quality of qualitative research outlined by Yardley (2000) were taken into consideration when evaluating this piece of research. These principles ensured the analysis reflected the data, with the influence of any pre-existing ideas held by the researcher minimised.

The researcher of this study used the guidelines set out by Braun & Clark (2006) to carry out the analysis. Firstly the researcher familiarised themselves with the data (reading and noting down initial ideas). Initial codes were then generated (See Appendix 6) and these codes were then collated into potential themes. These themes were then checked to see if they worked in relation to the data and a thematic ‘map’ of the analysis was created (See Appendix 7). Finally ongoing analysis refined the themes and the names for the themes and illustrative quotations were chosen.
RESULTS

The analysis of the data using thematic analysis revealed three final themes:

- The impact of the role on self
- The role is developing
- Role confusion and what this does.

These themes and the sub themes that are classified within the themes are demonstrated in Table 1 below. They can be seen along with illustrative quotations in the appendices (See Appendix 8). It is important to acknowledge that the themes and sub themes should not be viewed in isolation but should be seen as part of an integrated system.

Table 1. Themes and Sub Themes

<table>
<thead>
<tr>
<th>The impact of the role on self</th>
<th>The role is developing</th>
<th>Role confusion and what this does</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of support</td>
<td>Pioneers</td>
<td>Other professional's confusion</td>
</tr>
<tr>
<td>Pressure</td>
<td>Differences across boroughs</td>
<td>Team confusion</td>
</tr>
<tr>
<td>Demanding</td>
<td>Type of work carried out</td>
<td>Our own uncertainty</td>
</tr>
<tr>
<td>Anxiety and Stress</td>
<td>Role restrictions</td>
<td>Training</td>
</tr>
<tr>
<td>Fear</td>
<td>Service developments</td>
<td>Inappropriate referrals</td>
</tr>
<tr>
<td>Enjoyment</td>
<td>Supervision</td>
<td>Psychologists feel threatened</td>
</tr>
<tr>
<td>Not feel part of team</td>
<td>Valuable aspects of role</td>
<td>Job title</td>
</tr>
<tr>
<td>Role is as expected</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Role is different to expectations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please consult the quotation table (Appendix 8) to broaden your understanding of the themes.
The impact of the role on self

What emerged from this theme was that the role of a GPCMHW has definitely had an impact on the workers themselves. Throughout the transcript participants describe the role as demanding with a lot of pressure and responsibility. The participants related how this had caused anxiety and stress, and how they felt that they did not have enough time to do everything.

"It's like a conveyer belt of people coming in, and we feel we have less time to learn, we just have to stick to our targets and see as many people as possible."

What was also captured in comments was a sense that the GPCMHWs felt that there was a lack of support in the role. This was in regards to many different aspects of the role, but one thing that participants expressed throughout was how supervision was something they found important but at times they felt they lacked support even with supervision. Some of the GPCMHWs also felt that support differed across boroughs. What came across was that two of the boroughs had a very different experience compared to the other borough. These comparisons may have influenced how much impact the role had on different participants.

Some of the participants also felt that their role produced a feeling of fear. This was in relation to being GPCMHWs with the view to one day becoming clinical psychologists. The fear of doing anything wrong, or not complaining about something that was a problem, was reflected in some comments.

"I would feel fearful that I would lose my job. So I am in a sense prepared to put up with some things."

Finally what was reflected was how the role of a GPCMHW was in practice compared to their expectations of the role. Some participants felt that the role was actually as they had expected. This was particularly in relation to the clinical aspects of the role. However some participants felt that the role was not like they had expected at all. The participants felt they were doing more than they expected. There was also a sense that they felt lost and uncertain, and this was different to how they had expected to feel.
The role is developing

What emerged from this theme was that the role of the GPCMHW is still developing. Throughout the transcript participants talk about service developments and how they feel that the role is constantly changing.

"Its like one day you'll be doing one thing, and then the next day it'll be something else, or a different thing..."

They talk about being pioneers, and about feeling like everything they do is trial and error. What is also captured is a feeling that the role itself has certain restrictions. The GPCMHWs talk about how guided self-help and group work is not appropriate for all clients, but the role restricts what they can do about this. It was also reflected throughout that there are huge differences across the boroughs in terms of the work carried out, with some participants feeling that they were not actually doing the role of a GPCMHW at times. For some they felt that their role, and what they did was dependent on the team they were working for.

"But our service is quite psychodynamic and psychoanalytical, and some people think that triage is not a very good way of working with clients."

What was portrayed throughout was a sense that the role is not yet developed properly and that the role is evolving to meet the service needs.

Role confusion and what this does

What came out of this theme was that there is a great deal of confusion about the role of a GPCMHW. This confusion and uncertainty was from the workers themselves, from other professionals, and from their teams as a whole. There was a sense that the confusion was affecting their role, and the biggest thing to come from this was the amount of inappropriate referrals some of the GPCMHWs were receiving. However, it was felt that this was not happening for any other reason than confusion about what the GPCMHWs actually did.
"But they are not doing it on purpose or to annoy us or anything, they are only doing it because they think we are appropriate."

What also emerged was a sense of a lack of identity and this was captured from comments about people not knowing what to call the GPCMHWs. There was also a sense that some participants' felt that other psychologists and counsellors' felt threatened by the role.

"...they may feel that they are not in control of what is happening in their surgery anymore, and I think there is a lot of anxiety around that."

These feelings from other professionals may be down to the role being quite new, but also could be due to feelings of being pushed out, with a fear that the GPCMHWs are going to take over.
DISCUSSION

The findings of this study are similar to previous research studies on this topic (Bower, Jerrim, & Gask, 2004, and Farrand, Duncan, & Byng, 2007). Role confusion, role development and inappropriate referrals were themes that have been highlighted before. However, in terms of role expectations this study found that although some participants felt that the role of a GPCMHW was not as expected, it was actually in regards to the role being more demanding with participants feeling that the role gave them more than they expected. This is in contrast to the findings of Bower, Jerrim, & Gask (2004) as they found that managers and clinicians had far wider role expectations of the GPCMHWs, compared to what was happening in practice. What also stood out from this analysis was that no matter if the role had met expectations or not, it was having a huge impact on all of the GPCMHWs in some way.

The analysis also highlighted that the role is still developing, and that confusion about the role influences decision-making and how the role works. It was apparent that other professionals were still confused about the role. This impacts referrals, supervision and service provision and this is in line with Farrand, Duncan, & Byng’s (2007) findings. In regards to the specific roles of a GPCMHW, as set out in The GPCMHW Best Practice Guidance (Department of Health, 2003), the GPCMHWs in this study were undertaking all three areas of work. However, discussions were had about the limited amount of practice teamwork that was taking place.

Finally what emerged was that although participants portrayed a negative view of the role, the analysis also captured comments that reflected enjoyment and pleasure about the role. In terms of future research this study could be extended to look at other professional’s view of the role, and the impact the role is having on service provision.

Study limitations

Firstly, this project only evaluated the GPCMHWs within one mental health trust and therefore thoughts and views may be different elsewhere. Secondly this trust has four boroughs and only three boroughs were represented at the focus group. In
addition to this participants from one of the boroughs left half way through the focus group. This affected what was discussed in the group, as the borough that left is the one borough that has a clear referral pathway in place, thus limiting discussion on this. It is also hard to assume that all themes and sub themes relate to all boroughs. The three boroughs represented had different thoughts and did different things in their job. Perhaps on reflection it would have been better to run smaller groups separately, for each borough, instead of one large focus group.

It could be suggested that the GPCMHWs might not have been totally honest because they were aware that the information was going to be fed back to their manager. In actual fact the GPCMHWs gave verbal feedback to the researcher that they welcomed the opportunity talk in a safe, contained environment. However, perhaps individual interviews would have given a fairer opportunity for everyone to have their say. It may have also made it more convenient for the GPCMHWs in terms of finding time to attend. Finally perhaps feeding back the themes of the analysis to the GPCMHWs before writing up would have checked validity and reliability further.

**Service related recommendations**

A date has been arranged for the researcher to feedback the results of the study (9th September 2008). The service related recommendations that are going to be presented can be seen in Appendix 9.

**Conclusions**

To conclude I believe this study met the objectives set out at the beginning. The study highlights the importance of evaluating a role from the workers perspectives and I hope the information in this report assists the service that requested the evaluation and affects future practice of GPCMHWs within this trust.

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1 See Appendix 10
2 Conclusions to be written in 1st person
REFERENCES


Appendix 1: Initial email to GPCMHWs

Initial Email

My name is ... and I am a Trainee Clinical Psychologist from the University of Surrey. I am currently on placement with this trust, working in the Psychology Department and in Primary Care. As part of my placement I am required to carry out a piece of service-related research. My supervisors thought it would be great if I could evaluate some aspect of the role of GPCMHWs within the trust, and therefore I have decided to focus my project on the role expectations of GPCMHWs. This project is not only a piece of academic work; it will also have service-related implications. The department wants to find out if the role of a GPCMHW is what you expected it to be and to find out if it is working. In addition to my work another trainee will be examining the outcome measures that the GPCMHWs carry out (ie. GHQ, CORE, HADS etc). I wanted to explore the role from your point of view, as I am aware that there is a vast body of research that shows confusion and ambiguity about the role of a GPCMHW, and as a department we would like to know how you feel about your role.

I am planning on collecting my data by carrying out a focus group and I am hoping to run this in March or April 2008. All I need now are your ideas on times and venue? I know that Friday afternoons are hard for some workers so how about the morning? The group will last for 1 1/2 - 2 hrs. Would ... be the best place to run the group? Is that accessible for you all?

If this day is no good for any of you then we will try and get something else sorted. Fridays are really the only day where I have any free time, but if this proves to be impossible then perhaps I could try and switch some things round, or we could suggest an evening? I realise that this is taking time out of your busy working day, but myself and the department would really appreciate if as many of you as possible could attend. We really want to find out if this role has turned out to be what you expected, and if not why not. I believe that it is important for you to be able to express your thoughts about your role, and this will hopefully be made easier if someone else is feeding back on your behalf. I also hope that the results of this study will have a direct impact on the role of a GPCMHW across this trust and others.

Finally, I would like to add that consent will be taken from you to participate in the focus group, and if at any time you decide you want your participation to be withdrawn then this will not be a problem. The group will be video-taped and then transcribed, however I will add that I will be doing all of the transcribing so your thoughts and opinions will not be identifiable once the data has been written up.

Thank you in advance for your time and I look forward to hearing from you soon,

Best wishes
Appendix 2: Information sheet

Study title: An Investigation into the Role of a Graduate Primary Care Mental Health Worker.

I would like to invite you to take part in a service related research project. Before you decide, you need to know what taking part would involve. Please take the time to read this information, and ask any questions you might have about the project.

The Topic

This project will look at the role of 9 Graduate Primary Care Mental Health Workers. There is a vast body of research that shows confusion and ambiguity about the role of a GPCMHW, and therefore the Trust and I thought it would be of interest to find out how you feel about your role.

What will taking part involve?

You will be contacted by the researcher, who will arrange a time and date for a focus group in which all of the GPCMHWs from ....... will be invited to attend. The focus group will last approximately 90 minutes and will be held at a local CMHT base. I will be asking you your views on the role of the GPCMHW and your thoughts and feelings relating to your job. I would like your permission to video record and transcribe the focus group. The recordings will be stored safely and destroyed following transcription.

Writing up the research

The focus group will be written up as part of a service related research project and I will anonymise all of the data so that you will not be identifiable. The transcripts of the focus group (which will not be identifiable) and the final project will be seen by research tutors at the University, and as it is a marked piece of work an external moderator may read the final project. The results will also be presented to some of the Trust's staff as I hope that the results of this study will have a direct impact on the role of a GPCMHW across this Trust and others. However, as I said before all data will be anonymised and you will not be identifiable.
Your rights as a participant

After you have given consent to participate, you have the right to withdraw from this project at any time, without explanation. If you have any concerns or complaints about your participation in this study, please contact Mary John, Course Director of PsychD in Clinical Psychology on 01483 689 441.
Appendix 3: Consent form

- I understand that........(Trainee clinical psychologist) would like my permission to take part in a focus group. The information collected from this group (video tape) will then be transcribed and used to write up a research project.

- I have been given an information sheet, which I understand.

- I understand that the work will not contain any information that would reveal my personal identity.

- I understand that the only person that will watch the video tape will be the researcher. Once identifiers have been removed the Trainee and her Research supervisors at the University of Surrey will look at the work together. The results of the project will also be shared with some Trust staff; however all of the information will be unidentifiable.

- I understand that the project (and material relating to it) are kept in securely locked premises and are not kept in the University library. Assignments are destroyed by the University three years after the trainee has successfully completed the training course. If the trainee keeps copies of the assignments he/she must keep them securely in accordance with the British Psychological Society’s Professional Practice Guidelines and the Data Protection Act.

- I understand that I do not have to allow information about me to be used in this way. I can change my mind and refuse my consent at any stage and request for my data to be destroyed.

Participant name

Participant’s signature:

Date:
Appendix 4: Focus group schedule

Focus Group Schedule

Initial expectations of role
- When offered job
- After training
- When first started role

How you feel now
- Clarify length of time in role
- Explore the feelings of the all of the workers/different boroughs

Specific roles
- Direct clinical work
- Practice team work
- Wider network skills
- Any other roles?

Role conflict
- Among other professionals/psychologists
- GP’s
- Within the GPCMHWs

Identity
- Is this established?
- What do other professionals think of your role?
- Ethical and professional issues
Appendix 5: Sample of transcript

F1: So there are no set guidelines?
D- No. As our supervisor says, its an evolving service, so she doesn’t really know either...
J- She does not impose strict guidelines on us, she just wants us to see the clients and get on with it so that is what we are trying to do. But I have found it difficult because sometimes we offer, sometimes we see clients you need a different intervention and we can only offer them guided self help, um, that’s just completely inappropriate I think. The depression groups and the anxiety groups would not fit everyone. We also have clients who come with relationship difficulties, and I mean we will sometimes continue to see these clients. We are then offering them more psychotherapeutic work, based on four sessions. So its just that just seems like the wrong thing. I mean after a while we can step the clients up and then, but then after that we have to discharge unless they have suicidal thoughts or something or..
D- But we can refer these people onto the stress management course as well, we have that. But sometimes we have had to not see clients because of the way they present. Some people we see cannot concentrate on a book. I mean I had a client over the last few weeks who said that she is not able to do homework. She just wanted someone to listen to her and not be given guided self-help. So I have been giving her that time just listening to her and not doing the self-help.
F1- So if you think about that example and the work you are doing with that client, is that what you thought the job would be like thinking back?
D- No, its very different.
J- Yeah it is different. We can also refer clients on, women on to a counselling service in ..... and we do that too. We can refer to WPF but it is not always possible so what ends up happening is we just continue seeing them, um and another difficulty is that we do not have the time to discuss each client individually in supervision so I continue seeing them. And we need that time to
talk about them individually as some of them have severe presentations. It's just not organised yet...

D- We find in supervision that it's just like quickly, quickly going through each client and finding that there is not enough time to discuss them as much as I would like to really. You know um, you want to discuss them properly and then when you can't that results in you feeling stressed out. So supervision does cause stress.

J- Recently we have been like supervision is not like that, so let's just get on with it. We can talk to another clinician if there is one around. I guess of we actually thought someone was going to jump off a bridge then there would be someone we could talk to but the decision is left to us. We have to um use our own clinical judgement.

D- Yeah.

B- I think what I am getting from this is that when really this is the stage when we should be learning, we should be able to take the time and say well this is what I thought about this client...

Lots of agreeing

F1- Because I would say that this is the type of job where you are learning lots and you are given lots of learning opportunities, do you think that is happening?

B- Well we would like it to happen, we would like more time to learn, and take the time to learn.

H- We can say that is echoed now in our supervision or triage, if we each take six cases, and hour and a half supervision is not going to cover everything. We are knackered by that time anyway and it's not reflective, and it's not joint problem solving, it's structured and instructive. That's fine to get through numbers, and if my supervisor tells me what to do with a client then that's great at least I know what I am doing, but it is not helping me learn.

B- Yeah that's exactly it.

C- Yeah but saying that, I mean you do learn from the cases and stuff, but it is quite difficult to still make decisions.
J- I think another difficulty is that the supervisors, this role is new so their supervision of us is new, so get confused about what they should be doing. For us also, our supervisors are more psychodynamic and the work we are supposed to be doing is CBT based, so that um the supervisors I think need more training in what we do and in how to supervise this role. They are not very CBT minded, so with a limited time anyway in supervision, it is hard to get the best out of it.

F1- So do you think their confusion about your role adds confusion to the supervision?

J- Yeah definitely. Not many people in our service know what we are supposed to be doing.

H- And that makes it really hard.

Agreement from others.

F1- If we can look briefly at the document from the government which outlines your role. Um, that’s quite clear about the three areas of work a GPCMHW should be doing. I am sure you are very aware but they are direct clinical work, practice team work, and wider network skills. And um you all sound like you are doing quite a lot of direct clinical work, but what about the other two things? Practice team work would involve things like audits for GP practices.....

H- Well lately we have been trying to put something together and that would fit under that category I think. There are hundreds and hundreds of clients and we don’t know what’s going on with them, so we have all been asked to do this kind of audit and cleansing of the database on a massive spreadsheet, to find out what is going on with all of these clients. But that is the first time that that has happened since we started, and actually we have been pulled out of that now to focus on clinical work.

G- And that causes conflict doesn’t it. Because we were doing that, and then we meant to be doing clinical work, and two people couldn’t agree about what they wanted us to do. We got caught in the middle.

H- Yeah the service manager was telling us we needed to do the spreadsheet so we could find out what was happening to all of
the clients, but the clinical manager was saying triage is your priority, so we had to do that in the end. In the end we just wanted them to tell us what to do and agree about it.

F2- Would you to spend more time on that type of work?

G- Um, not really. I had a job like that before. And although this job is so stressful, I do love it. The people contact is amazing, my old job was so boring, that is why I left.

A- Yeah but if are all thinking about going into clinical training we will need to be able to talk about audit and research and the things we have done in that area, so it should be part of our job really.

G- I suppose if you could pick about what you wanted to do it would make it more interesting, but you mostly get forced to do something.

B- It would be helpful to have a picture of what is going on as a whole service with numbers and referrals and things. At the moment we are all running at 100 miles an hour, and some people at 200 miles an hour, it means that we do not have time to go 'how many people have we seen, and how many people need a service', and 'the people at that practice, why are they not turning up, or what are they receiving'.....

H- Yeah. We are starting to use that spreadsheet now, so now if a referral comes in or we see someone then there scores and how long they have been waiting is out onto it, so in 6 months or so we should have some really good figures for that.

A- And in our borough we have done something similar, we worked together for some of it. We set up an initial spreadsheet and then depending on what each area needed its been altered accordingly, and um in our team we have done a fair bit of collecting data, like client scores, but it is not far down the line enough to do any analysis.

J- And we are giving client satisfaction surveys to all of our clients when they are closed. We are supposed to use the database of the results of those and do some statistics on them, but I think like you we need to wait some more time, to get a bit further down the line.
F1- Ok, and what about any wider network skills? Do any of you think that that is part of your job role?
B- Well we have done some, but that was more in the beginning. We did a fair bit of finding out about other local services and linking up with them. But what we did do was really valuable, although we found that sometimes things needed more tailoring, like into different languages.
A- Yeah, but it was useful what we did do. We use services still now.
C- The agencies I visited when I first started this job, I visited about 40, and I promised them all that we would come back and find out more about what they did and tell them what we do, but after that part of my job got scrapped I don’t know how many clients would get signposted to them now. I mean I still have the list. It was nice in the beginning, and I know all of us did the same in our different areas didn’t we?
H- Yeah, we all set up a directory when we started. I mean I had never worked in .......... before, so I needed to familiarise myself as well. We all created a directory, so we had all of the leaflets and things, and then what I did with the main ones, the ones people had been signposted to before, was to ring them up. I found out their prices, parking, transport links etc....information that is useful to clients when you signpost them to other agencies. It would have been nice to keep up contacts, and visit them further down the line, but that has not been possible. So it hasn’t been updated recently, which is a shame.
F1- So is that a part of your role that you would like to do more of?
H- Yeah
E- Yeah that is so important and we have not done any of that since January.
H- Yeah I think it’s really important. Like you can ring them up and they know who you are and what you do so you can have a meaningful conversation. And also so you refer appropriate clients to them. We want to know exactly what interventions they do and what clients they take and then also they do not get...
annoyed at us as a service for referring the wrong type of client or something. Definitely.

J- So its really important to keep those links and contacts there.

H- Um, I was just thinking that two of us have to go shortly so is there anything that would be really useful to find out?

F1- I think the information in past research about conflict and confusion with other health professionals is really interesting and I was wondering if you feel that you have found any of this? How is your working relationship with other health professionals in terms of your role?

E- I have found that in terms of my role and appropriate referrals. Even though I have explicitly said what guided self-help is, I still receive referrals for guided self-help that are inappropriate. I think some of our team think we offer support for anything, and that our time is spent offering support. Which we don’t have time for, we don’t just ring people up and ask them how they are doing, its more than that and I think some other health professionals don’t understand that.

E- And I think that is why we still get inappropriate referrals, because people don’t understand our role. And at the beginning we were taking referrals that probably were not suitable because we ourselves did not understand our role fully.

H- If people were told that we are the GMHW’s, this is what they do, this is who you refer, then maybe that wouldn’t have happened. And even now, for example we may get a referral for a lady who wants support because she has a son with a learning disability. I mean that would be great if we could offer that sort of support, but we don’t have time to do that. The person who referred them could have done that, they would have just had to look on the internet, instead of asking us to do it.

G- And the thing is we used to have time to do things like that, which is maybe why people think we can still offer that sort of support. But now we can’t. But they are not doing it on purpose or to annoy us or anything, they only do it because they think we are appropriate.
H- They think that that is what we do, so it is not their fault. And like you said at the beginning we did have more time to follow up things for them.

G- Yeah so in a way we have set ourselves up to fail (everyone laughs)

E- And you also feel bad saying that this is completely inappropriate.

H- It was hard to say no at the start.

F1- Do you feel that you are able to do that now?
Appendix 6: Initial coding

Initial Coding

JT – Job title
TC – Team confusion
TYW – Type of work
TR – Training
OU – Our own uncertainty
DEX – Different to expectations
L - Learning
DB – Differences in boroughs
T&E – Trial and error
OP – Other professionals
IR – Inappropriate referrals
ANX – Causes anxiety
SW – Service level work
SDEV – Service development
SRES – Service restrictions
CHR – Changing aspects of role
P - Pressure
SUP - Supervision
LS – Lack of support
TNR – Tasks that are not part of role
REX – Role is as expected
PI - Pioneers
DEM - Demanding
VAL – Valuable aspects
NEG – Negative aspects
OO – A lot on own
TDIS – Team disagreeing
STR - Stressful
ENJ - Enjoyment
CON – Conflict with others
NPT – Not feel part of team
F - Fear
# Appendix 8: Final themes with illustrative quotations

| Impact of the role on self | Lack of support | "I don’t think there is enough support generally"
| | | "I don’t think we get the support or the money to be running round doing that" (running groups alone) |
| Pressure | "And with us we felt under pressure to get the waiting list down. We felt we had to jump straight in there to get that down" |
| Demanding | "So we do have a lot of responsibility"
| | "...here we are just constantly bombarded"
| Anxiety and stress | "We just feel like we are doing a lot on our own, so it’s worrying at times"
| | "Burn out is one of their worries for us"
| Fear | "...so we all think that we dare not put a foot wrong"
| Enjoyment | "But I love my job, I love what I do, I love the work I do with clients..."
| Not feel part of team | "There sometimes feels like there is no one around so it’s difficult to feel like part of a team, we just do our job on our own"
| Role is as expected | "I think in terms of clinical work, my job is very close to what I expected it to be"
| Role is different to expectations | "...I didn’t expect to work with the amount of people I do"
| | "...I didn’t think that would be such a big part of our role" (system based work) |

## The role is developing

| Pioneers | "And I think the new GPCMHWs are going to have a fantastic time because we will just tell them everything"
| Differences across boroughs | "Yeah because we have not had that, a proper triage system"
| | "In our borough we do things differently from the other two"
| Type of work carried out | "Yeah we do a lot of counselling work, it is very different to the other GPCMHWs"
| Role restrictions | "The depression and the anxiety groups will not fit everyone"
| | "Some people we see can not concentrate on a book"
| Service developments | "The system is changing so quickly"
| | "With all of the areas of growth, it is sort of like you have to learn"
| Role confusion and what this does |  |
|-------------------------------|  |
| Supervision                   | "But that is all changing and we are going to group supervision" |
| Valuable aspects of role      | "We have found that we are using signposting so much, so it is really valuable making those links" |
| Other professionals confusion | "And I think other clinician's not knowing our role is a huge thing" |
| Team confusion                | "They do have an idea about what we do, but not exactly. It's just like we have our books and we are in our room" |
| Our own uncertainty           | "And at the beginning we were taking referrals that probably were not suitable because we ourselves did not understand our role fully" |
| Training                      | "And also there was a lot of confusion amongst some of the people that did the training about what our job role actually was" |
| Inappropriate referrals       | "And I think that is why we still get inappropriate referrals, because people don't understand our role" |
| Psychologists feel threatened | "I think that's a big part of it, the psychologists expectations of what we are and who we are and how that threatens their role" |
| Job title                     | "...but we also get called the graduates, the workers, mental health workers..." |
Appendix 9: Service related recommendations

Recommendations

- It is important that other professionals ask questions if they do not understand the role or the referral system. It is better they ask beforehand, rather than waste time with an inappropriate referral that could have been prevented.
- GPCMHWs could create a leaflet that would be distributed to all professions and surrounding services so that everyone has a clearer idea of what the role entails.
- Perhaps the other boroughs could follow in the footsteps of the borough that has implemented a clear pathway for referrals. This could cut down on the number of inappropriate referrals received.
- GP’s especially need to be kept in the loop of communication. A study looking at their views of the role and the impact they have had in their practices would be beneficial.
- When the new GPCMHWs start it is important that the current GPCMHWs disseminate all of their knowledge and skills so that the new workers do not make similar mistakes or have to learn things that could have been passed on.
- Supervision needs to be prioritised as lack of support and burnout was highlighted throughout the transcript.
- In terms of role development it would be helpful if the GPCMHWs and other professionals are kept up to date with service changes and new ideas. That way there may be less speculation and discussion about where the role is heading and what that will mean for all professionals involved. In conjunction with that managers should agree together what they want the GPCMHWs to focus on, thus reducing disagreement about the type of work carried out.
- The GPCMHWs in this study expressed a wish to keep on top of wider network skills (signposting etc) as they felt that this was a really valuable part of their role. They also highlighted that the contacts made and the lists that are produced need to be kept up to date.
- The study highlighted that practice teamwork is limited. Time could be spent looking at ways of increasing this type of work.
24th September 2008

The University of Surrey
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To whom it may concern,

I am writing to inform you that Susie Chester (Trainee Clinical Psychologist) presented the results of her Service Related Research Project on 16th September 2008. The results were presented at the Team business meeting. The recommendations Susie made were discussed during the meeting and I hope that they will have a direct impact on the work of the Graduate Primary Care Mental Health Workers within this locality.

Yours sincerely,

[Signature]

[Name]
(Clinical Psychologist and Psychotherapist, PTIPC Clinical Lead)
Major Research Project
The Development of a New Measure of Shame for Adolescents

Major Research Project

Word count = 19,196

Supervisors: Ms Mary John and Dr Laura Simonds

July 2010

Year 3
ABSTRACT

Objective: The empirical research on shame and adolescents is limited, and one of the reasons for this appears to be the lack of appropriate shame measurement tools. This study describes the development of the Shame Scale for Adolescents (SSA), a semi-idiographic questionnaire aimed to measure shame proneness and to assess the experience of shame for adolescents.

Method: Twelve young people, aged 11-15 years, were interviewed to explore their understanding of shame. The interviews were transcribed and analysed using content analysis. Items were extracted from the interviews and the initial SSA was developed. 89 young people, aged 11-16 years, completed the new measure. Principal Axis Factoring, with oblique rotation, was applied to the data to determine the most interpretable solution.

Results: The factor analysis led to a reduction of total items, culminating in a 22-item measure comprising three factors; Negative Evaluation of Self, Outward Expression, and Internalised Affect. The SSA was internally consistent, with subscale alphas ranging from 0.82 to 0.90, and a total alpha of 0.89. Validity was supported through correlations with an existing and psychometrically sound measure of shame proneness (TOSCA-A: Tangney et al., 1991) and with measures of mood, self esteem, and anger. These psychological constructs have previously been found to have a relationship with shame and therefore provided further validation of the SSA.

Conclusions: The statistical analyses suggest that the SSA could potentially be a reliable measure of adolescent shame; however more studies are required. Test-retest analyses are needed to further assess reliability in particular, and the factor structure of the SSA also needs confirming.
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1.0 INTRODUCTION

1.1 Overview

The empirical research and theoretical literature on shame has increased over the last 20 years, however it is still limited in the field of children and adolescents\(^3\). Research with adults is more developed and there are a considerable number of studies exploring the links between shame and different psychopathologies, as well as others that discuss the methodological issues of shame measurement with adults. In contrast, the literature and research on shame measurement with adolescents is much more limited. One reason for this appears to be a shortage of appropriate measurement tools. The tools that have been used in previous research with adolescents are predominantly scenario-based questionnaires. This type of questionnaire can be criticised because informants cannot complete them in relation to their own shame experiences, only ones which are pre-defined and included in the measure. The other short coming is that some researchers have developed their own methods of shame measurement which, despite being guided by theory, lack validity and reliability.

This study therefore aims to develop and validate a new questionnaire that will measure shame in 11-16 year olds. The new questionnaire will be semi-idiographic, thus enabling participants to draw on personally shaming situations instead of having to relate to prescribed scenarios, and the questionnaire items will be drawn from interviews with adolescents to ensure that the questionnaire is user-defined. It is hoped that as a result of this new measure, researchers and clinicians will be able to gain a more comprehensive understanding of the factors that influence the experience of shame for young people. A new questionnaire is important because it has been established that shame relates to different psychopathologies in adolescents, in particular depression and anger. It is therefore imperative that people working with young people have as much understanding as possible about the factors that contribute to a shaming experience.

---

\(^3\) A systematic literature review was carried out using two psychology databases (Psych Info and Psychology and Behavioural Sciences Collection) and results demonstrate this lack of literature (please refer to Appendix 1).
The first part of this introduction outlines the literature on shame as an emotion and the controversy surrounding some of the definitional issues of shame. The development of shame through infancy and adolescence is explored, with a focus on the cognitive attribution theories of shame. Some of the factors that have been found to contribute to high levels of shame proneness are also discussed. The complexity and differences between shame and guilt are then explored. Existing measures of shame are reviewed and critiqued, and this leads to the rationale for developing a new measure of shame for adolescents. The final part of the introduction focuses on how this new measure can be validated. There is research that supports a relationship between shame and depression, anger and low self-esteem in adolescents, and therefore these relationships will be examined for the purpose of validation.

1.2 Shame

1.2.1 What is shame?

Shame is described as a human emotion and is often referred to as one of the self-conscious emotions grouped with guilt, pride, and embarrassment (Tracy & Robins, 2007; Tangney & Dearing, 2002). Self-conscious emotions are those emotions that are founded in social relationships and built on reciprocal evaluation and judgement (Fischer & Tangney, 1995). People are thought to experience these emotions as a result of assuming that someone (self and/or other) is making a negative judgement about a characteristic or action of theirs (Fischer & Tangney, 1995). Self-conscious emotions differ from basic emotions because they require self-awareness and self-representations (Tracy & Robins, 2007). Shame is described as an intense, incapacitating, negative emotion with resulting feelings of inferiority and powerlessness (Wicker, Payne, & Morgan, 1983). When a person experiences shame it is thought to involve painful self-condemnation, a desire to hide or disappear and a feeling of being worthless (Lewis, 1971).

There have been a number of studies carried out which have asked adults to describe what they think shame is and the situations in which they think it occurs (Wicker et al., 1983; Tangney, 1992). The main aim of these studies has been to find out what participants think the difference between shame and guilt is, however the results can also be used to gain greater understanding of how adults define
In two separate studies, Wicker et al. (1983) asked 152 college students to recall occasions in which they had experienced shame and/or guilt. Both types of situations described (shame and guilt) were judged as painful and tense, and both resulted in self-conscious feelings and a lacking in self-confidence. Shame situations however, produced a higher “exposed” feeling and a greater tendency to feel low in power, status and control. In the second study, shame situations produced the desire to hide, increased feelings of rejection and inferiority, and an experience of a hot, flushed face (Wicker et al., 1983). Tangney (1992) carried out a similar study when she asked college students (N=146) to write down situational determinants of shame and guilt. She discovered that although situations differed in both form and content, the majority of situations appeared capable of engendering either emotion. Concern with others’ evaluations of the self however were almost exclusively only found in shame situations. She also found that guilt was more associated with moral transgressions, whereas shame was associated with non-moral situations and issues (Tangney, 1992).

With regard to children, Ferguson et al. (1991) carried out a study exploring children’s understanding of the terms guilt and shame and found that participants (aged 7-12 years) were able to express that shame resulted in avoidance behaviour, whereas guilt resulted in reparative behaviour. Differences were that younger children (7-9 year olds) associated shame with embarrassment, ridicule, blushing, and escape but older children (10-12 year olds) experienced shame as feeling stupid, being incapable of doing things right and not being able to look at others. In addition, this study showed that by the age of 10 children held similar opinions to adults about the distinction between the two emotions.

Defining shame however, is not as clear cut as it appears. There are still many differing opinions and views, and this is partly due to shame theories being rooted in different psychological schools of thought. These vary from psychoanalytic theories (Nathanson, 1987; Schore, 1991), to those that are more interested in cognitions and beliefs (H. Lewis, 1971; M. Lewis, 1992). The controversy surrounding the definition of shame is largely dependent on which school of thought one comes from. Psychoanalytic theories denote that shame can occur and be observed in very early infancy, and suggest that self reflection or abstract cognitive processes are not needed for infants to experience feelings of shame. Therefore shame in this sense would be described as a primary affect, one that occurs without self evaluation.
(Nathanson, 1987). Whereas cognitive attribution models suggest shame develops at a much later age, and children are thought only to have the capacity to experience shame secondary to some aspects of cognitive development (M. Lewis, 1992; 2000). These theories therefore suggest that shame involves cognitions and beliefs about the self, and fits with the description of shame as one of the self-conscious emotions.

Additional confusion is evident in the terms used to describe the different types of shame. Within the literature shame is described as trait shame, shame proneness, global shame and state shame. Trait shame is defined as the emotional traits or dispositions one possesses, and individuals who are sensitive to feeling shame in potentially shame provoking situations are said to have high levels of trait shame (Tangney, 1996). A shame prone person is described as someone who experiences feelings of worthlessness and inadequacy; someone whose life is pervaded by difficulties with speaking, thinking, and interacting with others (Lewis, 1971). In my opinion, trait shame and shame proneness are very similar. They are both linked to a person’s disposition to experience shame and the degree to which that person is prone to experience shame across a range of situations (Tangney & Dearing, 2002). Individuals who generally feel shame or frequently feel shame are said to experience global shame (Andrews, 1998a). The assumption is that someone who has high levels of global shame would also have high levels of shame proneness. The difference being that global shame is a generalised feeling of shame felt by the individual, independent of situational cues (Harder, Cutler et al., 1992). This can cause confusion, as this generalised feeling of shame is thought to be very similar to the generalised feeling of low self-esteem. The two are however deemed to be separate constructs, with self-esteem being seen as a stable trait but shame being viewed as an emotion - an affective state (Tangney & Dearing, 2002). Finally, state shame is referred to the experience of shame in the moment, as it is happening (Turner, 1998).

What is demonstrated is a rather confusing picture. This confusion is due to people attaching different meaning to the same terms, and people using different terms to describe the same concept. There appears to be confusion in some of the literature, for example Rosario & White (2006) describe the Test of Self-Conscious Affect-3 (Tangney et al., 2000) which is a scenario-based measure of shame proneness, as a measure of state shame. This might have been due to the authors having a
different understanding of the term state shame, but what they failed to do was make this explicit. Thus, for the purpose of clarity during this project, when trait shame and shame proneness are referred to, they are being viewed as a disposition to experience shame in a range of situations.

1.3 The development of shame

Psychoanalytic theorists were among the first to explore the concept of shame and most of the early writings about the development of shame come from this school of thought. One of the first psychoanalytic perspectives of shame can be traced back to Freud’s theory of opposition between the ego-ideal and the superego (Freud, 1905/1953). Post-Freudian theorists hypothesised that shame was thought to occur as a result of failure to live up to standards set forth by the ego-ideal, so failing to be the idealised figure the person wishes to be (Piers & Singer, 1953, as cited in Teroni & Deonna, 2008). During the 1980’s, psychoanalytic theories of shame moved away from this idea and theorists such as Nathanson (1987), Kaufman (1989) and Shore (1991) began to understand shame from the object relational perspective. The object relational school accentuates the essential nature of social relationships with main caregivers and views these relationships as a basic biological need (Spero, 1984). It is through these social relationships that shame is thought to develop; when the relational bond is disrupted in some way (Kaufman, 1989). Shame is thought to alert the individual to actions that could elicit rejection by others and therefore prevents rejection occurring (Nathanson, 1987). As indicated, these theories of shame denote that shame occurs in very early infancy, with babies as young as two and a half months believed to experience shame (Nathanson, 1987). Although different in some ways, they all concentrate on how relationships with others, including the main caregiver, contribute towards the development of shame.

During this time, some of these views were challenged, particularly the theory that very young infants can experience shame. There was a lack of research evidence supporting this theory and as a result people began to search for alternative explanations. One of the most influential psychologists at this time was Helen Lewis (1971) and she used self evaluation as the basis of her theory, as an added dimension to the relationships with others. She described that for shame to occur the person must experience negative feelings about the self, thus requiring the
person to be self aware and employ an aspect of self reflexivity. This idea was developed further by M. Lewis (1992; 2000) and is now the basis of the cognitive attribution theories of shame. These theories address the cognitive evaluative processes that elicit shame, and focus on the appraisal processes that are the stimulus for the experience of shame (Mills, 2005). Generally, cognitive models suggest shame develops at a much later age, as children are thought only to have the capacity to experience shame secondary to some aspects of cognitive development (Lewis, 1971). At about 18 months to 2 years of age, children begin to realise that there are associations between their behaviour and how other people respond (Ferguson & Stegge, 1995; Tangney & Dearing, 2002). This, along with a theory of mind, an awareness of the contingencies of approval and disapproval, and an understanding of social rules (Gilbert, 2002) are the competencies which are thought to be required for shame to develop.

Michael Lewis’s (1992; 2000) cognitive attribution model makes a distinction between emotional states (primary emotions) which can occur with little or no cognitive processes, and the experience of emotional states which are the conscious evaluations of emotional states that require cognitive processes (self-conscious emotions). Lewis (2003) denotes that for shame to develop the child has to have specific cognitions. ‘One has to know something about 1) standards, rules, and goals; 2) one’s own behaviour with regard to these standards; and 3) ones-self. Only when these cognitions develop can shame occur.’ (p1191). Figure 1 is his model of the development of shame in children (Lewis, 2000).
Figure 1. Michael Lewis's (2000) model of the development of shame

It is hypothesised that the 'exposed emotions' emerge when the child becomes conscious of himself/herself (the middle of the second year of life). The emergence of shame however, requires more than just consciousness. The first exposed emotions, such as embarrassment, are not evaluative in nature. This is what Lewis (1992; 2000; 2003) claims is needed for shame to occur; an ability to be evaluative in regard to standards, rules and goals.

It is also interesting to consider adolescence in relation to this cognitive attribution theory. Adolescents have been found to be more likely to engage in self-evaluation (Reimer, 1996), and changes in cognitive abilities such as self-reflection make adolescents vulnerable to negative self evaluation and social comparison. As negative self evaluation is a characteristic of shame, it is suggested that the adolescent becomes more prone to shame (Reimer, 1996). This is coupled with the 'normal' transition into adolescence, which can be accompanied by difficulties with
identity (Erikson, 1968), an increase in negative affect (Cole et al., 2002), and the use of more maladaptive coping strategies (Compas et al., 2001).

In addition to the contrasting psychoanalytic and cognitive theories, there is also the functionalist school of thought. Functional theories of shame are based on the theory of evolution, that emotions have an adaptive function and serve to increase the chances of survival (Barratt, 1995; Campos et al., 2004). The proposed adaptive purpose of shame is to maintain other's acceptance and preserve self-esteem. One of the main functions of shame is thought to be behaviour regulatory, by reducing exposure to evaluation by withdrawing the self (Barrett, 1995). Thus, it is suggested that shame develops through a need to protect the self. In addition, the repeated emotional experiences that occur in everyday life are thought to become the basis for affective traits (Fischer et al., 1990) and therefore it is assumed that a variety of experiences that foster a shame reaction happens in the same way (Mills, 2005). So, the more someone experiences something that makes them feel shame, the more likely they are to be shame prone.

1.4 **What contributes to shame proneness?**

1.4.1 **Early caregiver experience**

As suggested by the psychoanalytic shame theorists, children’s early caregiver experiences are thought to be influential in determining if someone is shame prone. The attachment relationship is considered to be significant, in that when the parent is consistently emotionally unavailable, support for affect regulation is lacking and therefore shame helps the child self-regulate by disengaging (Schore, 1996). There have been a few studies exploring attachment and shame (Lopez et al., 1997; Gross & Hansen, 2000) and these were carried out with undergraduate students. Both studies found shame to be inversely related to secure attachment (using adult attachment styles) and positively related to fearful and pre-occupied attachment. Neither study found shame to be related to dismissive attachment. Research is still very much lacking in investigating the quality of parental attachment and proneness to shame in children, but the few adult studies carried out suggest that it is an important factor (Lopez et al., 1997; Gross & Hansen, 2000).
1.4.2 Parenting

Just as young children may think that failure implies they are “bad” (Burhans & Dweck, 1995) the use of harsh parenting may give children the message that they are “bad” (Bennett et al., 2005). Lewis’s (1992) theory that global, negative self beliefs are primary elicitors of shame, would suggest that criticised children, who are likely to have these negative self beliefs, are going to be more shame prone than children brought up in less critical and harsh environment. Stuewig & McCloskey (2005) carried out a longitudinal study following children for 8 years to observe how different forms of maltreatment influenced shame and guilt in adolescence. Results showed that harsh parenting in childhood was related to shame proneness in adolescents, and that youth with rejecting parents were more shame prone and less guilt prone than other youth. Rosenberg (1998) found that shame prone children reported their parents were likely to express disgust, tease them about things, and use love withdrawal techniques. Gilbert et al. (1996), in a retrospective study with university students, found that frequent exposure to hurtful parental messages during childhood was associated with shame proneness. Participants recalled experiences of being “put-down” and “made to feel inadequate”. Thus, there is evidence to suggest that negative parenting experiences can influence a child’s development of shame proneness.

1.4.3 Abuse

Childhood abuse, physical and sexual, has been found to be significant in the development of shame in a number of studies (Alessandri & Lewis, 1996; Feiring et al., 1998; Deblinger & Runyon, 2005). Maltreated girls showed more shame in responses to failure in achievement situations, when compared to nonmaltreated girls (Alessandri & Lewis, 1996) and children aged 8 to 15 years of age were found to report more feelings of shame with the more abusive events they had been exposed to (Feiring et al., 1998). More recently, feelings of shame have been found to be an important mediating factor in influencing a child’s recovery from abuse (Deblinger & Runyon, 2005). The authors of these studies highlight that children who have been abused may be vulnerable to feelings of shame because when the abuse occurred their views of themselves were still forming (Deblinger & Runyon, 2005). In the context of Lewis’s (1992) model of cognitive attribution, it is clear how ones negative self evaluation is effected through abusive experiences. If one has
experienced abuse, the likelihood of that person feeling bad about themselves is very high (Andrews, 1998a)

1.4.4 Summary of contributing factors

There appears to be a number of different contributing factors for shame proneness. What is central to them all is how a child appraises a situation and the attributions the child then makes about the self as a result of the situation. In addition, the emotional responses children receive from caregivers also appear to play a big part in the development of shame proneness. A longitudinal study by Tangney and colleagues has shown that if you are shame prone in childhood it is likely that this will stay through to adulthood (Tangney & Dearing, 2002). This supports the theory that early childhood experiences are important, and provides an explanation as to why children who experience shaming experiences at a young age are also found to have high levels of shame proneness as adults. What are lacking are more longitudinal studies like Stuewig & McCloskey's (2005), exploring other potential sources of shame, such as previous shaming experiences, family environment, parent-child interaction, parent's socialisation to emotions, parental over control, and discussion of emotions within families (Mills, 2005) In addition, it is also hypothesised that once shame becomes a disposition or schema, it facilitates the encoding, storage, and retrieval of schema consistent information (Ferguson et al., 2000). Therefore, in any potentially shaming situation, if one has a shaming schema they are more likely to experience shame compared to someone who does not have a schema that is shame based.

1.5 The complexity of shame and guilt

A significant amount of the literature on shame over the last 30 years focuses on distinguishing it from guilt (Tangney, 1992; Tangney, Miller et al., 1996; Teroni & Deonna, 2008). For many years psychologists have struggled to make a clear distinction between shame and guilt (Tangney, 1996), and this has obviously led to difficulties in the assessment of these two emotions. Freud's (1905/1953) early psychoanalytic writings have been criticised for not distinguishing between the two emotional states, as Helen Lewis (1971) argued that Freud may have labelled his patient's shame experiences guilt experiences. She described how when shame
and guilt are both evoked in the context of a moral transgression, the two states tend to fuse with each other and be labelled guilt. This might be where some of the confusion lies. It was only when Lewis (1971) was able to identify key differences between the two that empirical research in this area really began. She wrote: "The experience of shame is directly about the self, which is the focus of evaluation. In guilt, the self is not the central object of negative evaluation, but rather the thing done or undone is the focus" (Lewis, 1971, p.30).

But since this time, there have still been ongoing discussions about the differences between the two. Teroni and Deonna (2008) drew on the empirical evidence to date, and brought together four prominent suggestions as to how the two emotional states differ. The first is the idea that shame as opposed to guilt, is a social emotion only experienced in public (Fontaine et al., 2006; Wallbott & Scherer, 1995). The second is the idea Lewis (1971) proposed, that shame is related to the self where as guilt is related to the behaviour. The third is linked to Freud's theory of opposition between the ego-ideal and the superego, and Higgins (1987) self-discrepancy theory. These theories predict that shame vulnerability is a result of discrepancies between actual vs. ideal self, where as guilt vulnerability is a result of discrepancies between actual vs. should self (Morretti & Higgins, 1990). Finally, the fourth idea is based on the work of Baumeister et al. (1995) and suggests that shame is self-orientated but guilt is other-orientated. The focus of shame is the self, which motivates self-directed behaviour such as hiding and running away. In comparison, the focus of guilt is interpersonal, which motivates communal, other-directed behaviour (Baumeister et al., 1995). What Teroni and Deonna (2008) have attempted to do is present a unified theory of shame and guilt. They conclude that despite previous researchers expressing concern that the four theories conflict each other, they consider all four to be related and view them as just different dimensions of the two emotions.

Taking stock of all four theories, it is perceptible that Lewis' theory (1971) has the most empirical evidence supporting it. Tangney and colleagues (Tangney, 1992; Tangney, Miller et al., 1996) have consistently produced results that support Lewis' ideas and in addition so have other researchers (Ferguson et al., 1991; Lindsay-Hartz et al., 1995; Niedenthal et al., 1994). Fontaine et al. (2006) position themselves in a similar way to Teroni and Deonna (2008) and state that although the four existing major approaches have received empirical support, none of the approaches can explain all of the findings but all four approaches are compatible.
A central issue when carrying out empirical research in this field, concerns the difficulty people face in developing scales that distinguish specific emotions (Strongman, 1987). This is even more pertinent for shame and guilt, because of the difficulties in defining the two emotions. Because shame and guilt are both negative self-evaluative emotions it is thought that they should be positively correlated with each other (Stuewig et al., 2010). This means that it is understandably complex to develop tools that measure the separate concepts, without contamination from the other. Single construct measures have been criticised for not taking into account the difference between shame and guilt, with the result being an inaccurate assessment of two confounded emotions (Tangney & Dearing, 2002). The other side of this argument stipulates that it is possible to measure shame and guilt separately, as long as potential differences are taken into account during the design of the measure (Andrews et al., 2002). When researchers are considering measurements of shame and guilt, it is important to establish definitions and theory during the development of the tool (Andrews, 1998b). Therefore, care will be taken during the development of the new questionnaire. The researcher will be explicit in the theory and definition of shame used, and will be cautious not to contaminate the questionnaire items with guilt. This will hopefully ensure that the measurement tool is one of shame and not guilt.

1.6 Existing measures of shame proneness

Some of the existing measures of shame proneness are now to be reviewed. These measures were chosen because of their dominance in the literature. There are other shame measures that are not covered in this review, and these are less prominent in the literature with fewer studies finding validity and reliability evidence for them. For information purposes, Appendix 2 contains a list of all the shame measures found when carrying out the literature review. There are also questionnaires that explore state shame (Experiential shame scale (ESS): Turner, 1998; State Shame and Guilt Scale (SSGS): Tangney & Dearing, 2002) but as indicated, state shame is different to shame proneness. These measures examine a momentary shame reaction with respondents rating how they felt right at that moment. The aim of this research is to develop a measure of shame proneness and therefore the state shame questionnaires are left out of this review.
1.6.1 Internalised Shame Scale (ISS: Cook, 1987)

The ISS is a 30-item self report inventory designed to measure trait shame, and is composed of two subscales: a 24-item scale that produces the total shame score and a 6-item self-esteem score. Respondents rate on a four point Likert scale how often they feel in response to statements that represent shame, for example ‘I feel like I am never quite good enough’. When the ISS was first developed it was not based on any specific theory of shame, but was based on experiential descriptions of shame from adult patients being treated for alcoholism. On reflection, Cook (1994/2001) described the ISS as interpretable within the theory proposed by Nathanson (1992) that shame cognitions function to motivate an individual to maintain affect. In addition, when the initial factor analysis was carried out on the shame items of the ISS, it was proposed to have only one underlying factor. Rosario and White (2006) repeated this analysis and found the ISS to have one dominant factor, termed Inferiority, and two lesser factors, termed Fragility/Exposed and Empty/Lonely. This analysis suggests that shame is multi-factorial and that the three factors are in keeping with previous theoretical understandings of shame (Lewis, 1971) and with people’s descriptive accounts of shame (Wicker et al., 1983).

Internal consistencies of the ISS are reported to be very good (α=.95 and .96) and test-retest reliability for a 7-week interval has been reported at α=.84 (Rosario & White, 2006). Because the ISS was one of the first published measures of shame, it was not validated against any other measure of shame and this has still not occurred. This is the main weaknesses of the ISS. In addition, the authors describe this tool as a measure of “internalised shame” which is described as an enduring and chronic shame state that has become internalised (Cook, 1987). This description has been criticised for being no different to low self-esteem and in fact the measure correlates very highly with low self-esteem (−.81 and -.88) (Cook, 1989, as cited in Rybak & Brown, 1996). Therefore it could be hypothesised that the measure is not measuring shame at all but is instead measuring low self-esteem. The ISS is also proposed for use with adolescents (13 years and over) however, there is limited normative data for people under 18 years of age. Published studies could not be found but norms are available in the ISS manual (Cook, 1994/2001). This demonstrates that the ISS is not yet a well researched or validated measure of shame for adolescents.
1.6.2 The Self-Conscious Affect and Attribution Inventory (SCAAI: Tangney et al., 1988, as cited in Tangney & Dearing, 2002)

Tangney and colleagues developed the SCAAI as a result of finding a lack of suitable shame and guilt measurement tools, particularly ones that explored both shame and guilt proneness together (Tangney, 1990). After critiquing the available measures, Gioiella's Adjective Checklist (1981), as cited in Tangney and Dearing (2002), and Hoblitzelle's Revised Shame-Guilt Scale (1987), Tangney summarised that the literature offered few options to the investigator wishing to assess and differentiate between proneness to shame and proneness to guilt. The SCAAI was developed by drawing on attribution theory (Peterson et al., 1981; Weiner, 1985), Lewis's (1971) framework of shame, and phenomenological descriptions of self-conscious experiences (Lewis, 1971; Lindsay-Hartz, 1984). The measure aimed to assess characteristic affective, cognitive, and behavioural responses associated with shame and guilt in the adult population. Tangney and colleagues were explicit about shame being made up of affective, cognitive, and behavioural aspects; and this was something previous measures lacked. The SCAAI comprised 13 situations (10 negative and 3 positive), with participants having to rate their likelihood of responding in a number of alternative manners. It was different to previous measures as participants were provided with the pre-defined scenarios, as opposed to responding to statements like in the ISS (Cook, 1987). The idea behind the scenario-based design is that individuals who are shame prone are more likely to respond to any situation in a shaming way, when compared to individuals who are less shame prone. The scenarios are also designed to access the appraisals associated with shame (Tangney, 1996).

The SCAAI was found to have internal consistency, with Cronbach alpha's of between .46 and .82, across four different studies (Tangney, 1990). The majority of participants were undergraduate students. Test-retest reliability was found to be .71 and .79, over a 1-5 week period. The SCAAI was also deemed to have good validity, when compared to previous measures of shame and guilt, with moderate correlations found (Tangney, 1990).
1.6.3 Test of Self Conscious Affect (TOSCA: Tangney et al., 1989)

The SCAAI was remodelled into the TOSCA very shortly after its development (Tangney et al., 1989). The authors used a much wider pool of affective, cognitive, and behavioural responses provided by written accounts of several hundred college students and adults which resulted in an entirely new set of scenarios. Otherwise it was very similar to the SCAAI. It consisted of 15 scenarios, instead of 13, followed by four or five responses, each rated on a five-point scale. This measure was designed for adults of all ages. The TOSCA was found to be internally consistent (.76 for shame and .66 for guilt) and good test-retest reliabilities (.85 and .74 for shame and guilt respectively) (Tangney et al., 1992a). The main criticism of this measure was the focus on the negative aspects of shame. Sabini & Silver (1997) suggested that the shame scale of the TOSCA focussed too much on the maladaptive aspects of shame, and neglected any adaptive aspects of this emotion. The authors were aware of this and developed the TOSCA-2 to address this issue (Tangney et al., 1996).

1.6.4 Test of Self-Conscious Affect for Children (TOSCA-C: Tangney et al., 1990) and the Test of Self-Conscious Affect for Adolescents (TOSCA-A: Tangney et al., 1991)

At the same time as the development of the adult measures, Tangney and colleagues were also developing measures for children and adolescents (TOSCA-C: Tangney et al., 1990; TOSCA-A: Tangney et al., 1991). Both of these measures were modelled on the adult version of the TOSCA, and consisted of 15 scenarios exploring shame, guilt, pride and externalisation. They were based on the same theory as the adult measure (predominantly attribution theory (Weiner, 1980) and Lewis’s (1971) conceptualisation of shame) and similarly used pools of affective, cognitive, and behavioural responses provided by written accounts of children and adolescents (Tangney, 1992; Tangney et al., 1994, as cited in Tangney & Dearing, 2002). This resulted in sets of scenarios which the measures were then based on.

Most published studies exploring shame in children and adolescents have used these measures (Tilghman-Osborne et al., 2008; De Rebeis & Hollenstein, 2009). Both measures have found to be reliable with internal consistency (TOSCA-C; α=.78 and .83, TOSCA-A; α=.77 and .81) (Tangney, Wagner et al., 1996). As far as I am
aware, there have not been any studies carried out that explore the criterion validity of the TOSCA-C and A with other shame measures, and this is probably due to the lack of measurement tools. There have been studies that have reported convergent validity, by exploration of constructs that are predicted to relate to shame, for example depression (Tilghman-Osborne et al., 2008; Stuewig & McCloskey, 2005).

1.6.5 Personal Feelings Questionnaires (PFQ: Harder and Lewis, 1987; PFQ-2: Harder & Zalma, 1990)

These questionnaires are global measurements of shame and guilt, where participants are asked to make ratings of the frequency of different adjectives describing the self (Harder & Zelma, 1990). The PFQ is composed of 5 shame and 3 guilt items, where as the PFQ-2 is an expansion of this with 10 shame items and 6 guilt items. Items include adjectives like “remorse”, “feeling ridiculous”, and “feeling disgusting to others” and participants are asked to rate the frequency of feeling like each item. The PFQ was designed to be different to previous measures because it aimed to tap into shame and guilt which is believed to be defended against. Harder & Lewis (1987) thought that up to that point, existing measures were not able to access shame that was defended against by conscious self reports. These measures have good face validity, they look like they are measuring shame and guilt, and they are extremely easy to administer (Harder et al., 1993). They have been criticised however, for requiring participants to have advanced verbal skills. Tangney (1996) found that with her samples of educated college students, some participants were unfamiliar with some of the words on the PFQ-2. Additionally, these measures require the participants to distinguish between shame and guilt but in a rather abstract way. As a result, Tangney and Dearing (2002) believe the PFQ and PFQ-2 might in fact measure shame and guilt as one generalised negative state, not two separate constructs.

The PFQ-2 has been found to have satisfactory internal consistency (.78 for shame and .72 for guilt) and good test-retest reliability after a two-week period (0.91 for shame and .85 for guilt) (Harder & Zelma, 1990). Regarding validity of the PFQ-2, the shame scores from a group of healthy women correlated highly with shame-proneness on the TOSCA-3 (.70) (Rusch et al., 2007).
1.6.6 TOSCA-2 and 3 (TOSCA-2: Tangney et al., 1996; TOSCA-3: Tangney et al., 2000)

The TOSCA became the TOSCA-2 in 1996 (Tangney et al., 1996) and differed from the original measure because it included an additional maladaptive guilt subscale. The scenarios still aimed to capture affective, cognitive, and behavioural features associated with shame and guilt. The authors also added two new scenarios and deleted a dieting scenario, owing to concerns about gender bias. Results from the TOSCA-2 were not encouraging however, as the correlation between the new maladaptive guilt items and the existing shame items was .74 (Tangney et al., 1996). It was suggested that both sets of items were in fact measuring the same constructs. Thus, the maladaptive guilt items were removed and the measure was renamed the TOSCA-3 (Tangney et al., 2000). This is the most up to date version and includes 16 scenarios (10 negative and 5 positive) designed to measure guilt, shame, pride, externalisation, and detachment. The TOSCA-3 has been found to have good reliability in numerous studies (ranging from $\alpha=.69$ to $.91$) (Tangney et al., 1996) and has also been found to have reasonable validity when compared to the PFQ-2 (Rusch et al., 2007) and the Experience of Shame Scale (ESS: Andrews et al., 2002). In addition, there is a shorter option of the TOSCA which drops positive scenarios, thus excluding the pride scale, and this measure correlated exceptionally well with the longer version (.94 for shame and .93 for guilt) (Hanson & Tangney, 1995).

1.6.7 Experience of Shame Scale (ESS: Andrews, Qian & Valentine, 2002)

The ESS (Andrews et al., 2002) was developed as part of a research project exploring shame and depression. The authors questioned if previous research confirming shame as a predictor of depressive symptoms when using interviews and not questionnaires (Andrews, 1995), was due to the method itself. To test this theory they constructed and used a questionnaire based on the same principles of the shame interview (Andrews & Hunter, 1997) - the Experience of Shame Scale (ESS: Andrews et al., 2002). This 25 item questionnaire taps into global shame and assesses four areas of characterological shame; three areas of behavioural shame and one area of bodily shame. In addition to this, for each of the eight shame areas covered, there are three items addressing 1) the experiential component, in the form of a direct question about feeling shame, 2) a cognitive component, in the form of a
question about concern about other’s opinion, and 3) a behavioural component, in the form of a question about concealment or avoidance. Respondent’s rate how they have felt in the past year and each is item is rated on a four-point scale. The ESS is different to other measures of shame proneness as the shame scores are split into the three subscales (characterological, behavioural and bodily shame) and you can also calculate a ESS total scale score. The factor structure of the ESS supports the hypothesis that shame is multi-factorial and that there are cognitive, affective and behavioural components to shame.

This initial study (N=163) showed high internal consistency (Cronbach’s alpha = .92), and test-retest reliability over 11 weeks was $r(88) = .83$. The ESS total scale and the component subscales were all significantly and substantially correlated with the TOSCA shame scale, thus providing evidence for construct validity (Andrews et al., 2002). These measures are however, highly mood dependent and it is unclear whether they are assessing an enduring characteristic or just a negative affective state (Andrews 1998). The ESS has since been used in numerous research projects and has demonstrated the role of shame in anger in young offenders (Farmer & Andrews, 2009) and non-disclosure in eating disordered and depressed patients (Swan & Andrews 2003; Hook & Andrews, 2005).

1.7 Rationale for a new measure

Taking all of the literature into consideration, there appears to be a distinct lack of shame specific measurement tools for children and adolescents. Kronmuller et al. (2008) describe how despite treatments of shame in children happening in clinical practice, there have been few empirical studies to date. They put this down to a ‘lack of appropriate measuring instruments’ (p313). As far as I am aware, the TOSCA-C and A have been the only published validated measures of shame solely for use with children and adolescents. There is also the Adolescent Shame Measure (ASM: Reimer, 1995) but this was devised with June Tangney and is comprised of items from the TOSCA-C and A, thus making it identical in its style. In addition to the assessment tools described above, other studies have devised their own ways of measuring shame in children and adolescents. For example, Olthof et al. (2000) devised their own guilt and shame inducing situations in their study, and Sjoberg et al. (2005) developed five Likert scale questions that measured shame in their
sample of adolescents. This could suggest that these researchers could not perhaps find an appropriate tool to measure the shame in their participants.

Scenario-based measures such as the TOSCA-C and A (Tangney et al., 1990; 1991) have been utilised in a significant number of studies, resulting in an evidence base for their use. However, it could be argued that a key weakness of the TOSCA's is that informants need to imagine being in a hypothetical, specific situation and then imagine how they might feel. Essentially these measures assess anticipated shame in a number of different situations. The constraint on the range of shame inducing situations available is another significant limitation. Although the authors attempted to include a range of scenarios, it is not possible to include all types of shaming situations. To address these criticisms, a semi-idiographic approach for the new measure is proposed. This would aim to resolve the issue of using pre-defined scenarios and would also avoid the use of adjective checklists.

Given the problems with definitions of shame in measurement tools, Andrews (1998b) suggests that one solution to the problem might be for new questionnaires to be piloted that ask the respondents to rate the degree of shame felt from their own personal understanding of the term. This idea could be open to criticism but Andrews suggests that "it is likely to be no more problematic than relying on researchers definitions of shame and may offer some advantages in the long run" (p .49). When researchers define shame, they might not do it in a way which makes sense to the participants, or that fits with a specific theory. In this study, this will be addressed by carrying out interviews with a sample of adolescents. This will give participants the opportunity to talk about what they think shame is, and how they think it differs from guilt. Further theoretical support for this method comes from studies exploring children's understanding of shame (Olthof et al., 2000; Ferguson et al., 2000) as it is evident that children over 9 can understand and define shame. Thus, adolescents should be able to complete a semi-idiographic measure that requires them to rate statements in relation to personal shaming experiences.

What is also missing is an adolescent measure based on the cognitive, affective and behavioural responses that result from shame. These elements are the focus of the TOSCA-C and A, but I do not think that the authors make this explicit enough in the design of the measure. Previous factor analyses on adult measures (ESS: Andrews
et al., 2000; ISS: Rosario & White, 2006) have resulted in three factor models, with factors representing these different elements. Thus, cognitions, affect and behaviour in relation to shame have been found to be related to each other and we would expect the same from the sample in this study. Therefore it is expected that there will be more than one factor in a new questionnaire, with a suggestion of a three factor model.

One final reason for a new shame measure is the need for one that is more applicable for the clinical context. Not only is the empirical research on shame in adolescents lacking, but there is a significant void in regards to clinical research that explores shame-based treatments for adolescents. Cognitive behavioural therapy for adolescents is encouraged in the National Health Service (NHS) (National Institute for Clinical Excellence: NICE, 2005) and what has been demonstrated in the adult literature (Gilbert, 2010) is how appropriate this model of therapy is for people who experience the painful emotion of shame. In addition, the ongoing shift in emphasis towards evidence-based practice has important implications for assessment. The use of empirically validated assessment tools can facilitate the clinician’s task but they can also be used as an outcome measure of treatment, something that is actively encouraged in the NHS (Goldbeck-Wood & Fonagy, 2004). As shame has been found to be related to aspects of psychopathology in adolescents (Tilghman-Osborne et al., 2008; Stuewig & McCloskey, 2005; Aslund et al., 2007), it is important to be able to measure this construct to inform ongoing assessment and intervention, and to develop a stronger evidence and theoretical base. If there was a more readily available, clinically applicable, shame measure for adolescents, perhaps more researchers and health professionals would use it to explore the complexity of a young person’s well being, emotional distress, as well as psychopathology. It would not only then add to the growing evidence base of research in this field, but it might also contribute to the understanding of therapeutic management in children and adolescents.

1.8 Validation of the new measure

In order to validate the new measure of shame, it is important that it is compared against other psychological constructs that have been found previously to have a relationship with shame. High levels of shame have been found in recent years to be
linked to many aspects of psychopathology in adults, including depression (Harder, Cutler et al., 1992; Tangney, Wagner & Gramzow, 1992; Andrews et al., 2002), anxiety and social phobia (Gilbert et al., 1994; Gilbert, 2000), anger and aggression (Tangney, Wagner, Fletcher et al., 1992, Tangney, Wagner et al., 1996), low self-esteem (Tangney & Dearing, 2002), eating disorders (Grabhorn et al., 2006; Skarderud, 2007), obesity (Sjoberg et al., 2005), and post-traumatic stress symptoms (Andrews et al., 2000). In adolescents, shame has been found to be related to depression, anger and low self-esteem, and therefore it is these constructs that will be used as validation measures.

1.8.1 Depression

The relationship between shame and depression has long been written about in the theoretical literature and specifically in psychoanalytic writings (Nathanson, 1987), but until the early 1990’s there was a limited evidence base for these claims. It was hypothesised that there would be a relationship between the two constructs and this was partly based on the findings that depression was linked to a tendency to make internal, stable, and global attributions for negative events (Robins, 1988) in a similar way to shame (Lewis, 1992). Tangney, Wagner & Gramzow (1992) were one of the first to empirically explore the relationship between depression and shame in adults using the TOSCA (Tangney et al., 1989) and results were as expected; that shame and not guilt was positively correlated with depression as measured by the Beck Depression Inventory (BDI; Beck et al., 1988). This relationship was further evidenced by Harder et al. (1992) when they used the Personal Feeling Questionnaire-2 (PFQ-2; Harder & Zelma, 1990) in a study with undergraduate students. More recently Averill et al. (2002) used both the TOSCA and the PFQ-2, and established previously found results and Webb et al. (2007) also confirmed the relationship with a larger sample size. Results confirm that this relationship is relatively strong, but until 2002 questionnaire studies had only demonstrated correlations between shame and depressive symptoms and not shame as a predictor of depression. Andrews et al., (2002) using the ESS was able to confirm shame as a predictor of depressive symptoms in adults.

Shame and depression has also been explored in adolescents with a positive correlational relationship confirmed (Ferguson et al., 1999; Tilghman-Osborne et al., 2008; Stuewig & McCloskey, 2005; Aslund et al., 2007). De Rubeis & Hollenstein
(2009) took their research one step further and tried to understand the mechanics of
this relationship in adolescence. They reported shame-proneness as a significant
predictor of depressive symptoms and suggest that how the individual copes with
shame is important in predicting depression. Thus, there is good evidence to
suggest that shame proneness is related to low mood and/or depression in
adolescents.

1.8.2 Anger

Tangney, Wagner, Fletcher et al. (1992) were one of the first to explore the
relationship between shame and anger. They carried out two studies using the
TOSCA, and found that adults who were shame-prone were also found to exhibit
more anger and aggression. Harper & Arias (2004), among others, also found a
similar result in their study, demonstrating that like depression, anger is related to
shame but not guilt proneness in adults. This relationship has also been confirmed
in children and adolescents. Tangney, Wagner et al. (1996) used the TOSCA-C and
TOSCA-A (Tangney et al., 1990; 1991) with over 700 children and adolescents, and
found that shame proneness was clearly related to maladaptive responses to anger,
where as guilt was related to constructive means of handling anger. Hoglund &
Nicholas (1995) replicated these results in a sample of adolescents that had been
exposed to family violence. More recently, Bennett et al. (2005) found that anger
was a significant mediator of shame, behaviour problems and externalising
problems in young maltreated children, but one of the possible problems with this
study being that they did not use a questionnaire to measure the shame. Aslund et
al. (2009) and Heaven et al. (2009) also confirmed the relationship between
aggression and shame but like Bennett et al. (2005) did not use a validated measure
of shame like the TOSCA-C or A. Despite this there is clear evidence to support the
theory that shame, not guilt, is related to anger and aggression in adolescents.

1.8.3 Self-esteem

Due to the negative self evaluation and appraisal associated with shame, one would
hypothesise that people with low self esteem are more likely to be shame prone.
Tangney and Dearing (2002) discuss this and conclude that because they are
different constructs, they should be related but only at a modest level. Tangney and
Dearing (2002) report this modest relationship with correlations of \( r = -0.42 \) in adults and \( r = -0.48 \) in adolescents when using the TOSCA and TOSCA-Ar. Some of the empirical evidence however, gives a mixed picture. Cook (1989), as cited in Ryback and Brown (1996), explored the relationship between the ISS with measures of self-esteem, and found a much stronger correlational relationship \( (-.81 \text{ and } -.88) \). This can be observed in two ways: that very high shame is related to very high levels of low self-esteem or that the ISS is not actually measuring shame at all but is instead tapping into self-esteem issues (Tangney & Dearing, 2002). Gilbert (1998) highlights how low self-esteem could increase sensitivity to many social emotions such as shame, social anxiety, and shyness but states that overall the relationship between shame proneness and low self-esteem has never really been resolved. This is evident in the literature too as aside from the Tangney & Dearing’s (2002) study, which is only published in their book, there appears to be no other studies exploring the simple correlation between shame and low self-esteem in adolescents. Their study found self-esteem to be negatively correlated with shame proneness at levels of \( -.48 \) (Tangney & Dearing, 2002).

1.9 Aims of the study

1. To find out what shame means to 11-16 year olds. To explore what adolescents think shame is, when they think shame occurs, what it feels like, what it makes them think, and what it makes them do.

2. To devise a psychometrically sound, user-defined, self report semi-idiographic questionnaire that measures shame in 11-16 year olds undertaking the necessary validity and reliability checks.

3. To investigate the relationship between shame scores and mood, self esteem, and anger. These variables have been shown to have a predictable relationship to shame. Therefore a validation study would assess these and would provide validity to a new measure.
2.0 METHODOLOGY

The research was made up of two parts. Study 1 comprised the development of the Shame Scale for Adolescents (SSA) and Study 2 explored the psychometric properties of the SSA.

2.1 Study 1: The development of the SSA

2.1.1 Design

The SSA was created using a cross-sectional interview-based design and the data was collected at one point in time. Interviews were used to provide participants with a private, confidential space in which to talk about their views on shame. Participants could, if they wished, describe their own shaming experiences but disclosure of this nature was optional. Participants were from a non-clinical sample because the qualitative material needed to represent what the general population of adolescents thought about shame. The aim was to develop a measure that could be used in research, as well as in clinical populations, and therefore a clinical sample was not required. Using non-clinical participants would also maximise the chances of getting a large enough sample size.

2.1.2 Participants

2.1.2.1 Demographic characteristics

Twelve young people, six males and six females, took part in Study 1. The participants were aged between 11 and 15 years old and their mean age was 13.08 (SD 1.16). In regards to their ethnicity, the demographic breakdown was White British (N=7), Black British (N=2), British Asian (N=1), British Caribbean (N=1) and South American (N=1).

2.1.2.2 Recruitment

The twelve young people were recruited in two ways; from a co-education secondary school and through an email advert sent out to all staff from one
university. Students at the school were asked by a teacher, if they would like to take part in a research study. Interested students were provided with an information sheet to take home and read (See Appendix 3) and following this, if they decided they did want to take part in the research, consent was gained from themselves and a person with parental responsibility. The school then arranged a time for the researcher to go in and interview the young people who had consented. Additionally, an email advert was sent out to University staff asking if they had children aged 11-16 years who would be interested in taking part in a research study (See Appendix 4). If their child was interested and agreed to take part, the parent contacted the researcher via email to arrange a time for the interview.

2.1.3 Ethical approval

A favourable ethical approval was granted for this piece of research by the University of Surrey Faculty of Arts and Human Sciences Ethics Committee (See Appendix 5). Procedures of research practice were followed in accordance with principles outlined by the British Psychological Society (2009) and were in line with the Data Protection Act (1998). All participants were required to give informed assent and consent from a person with parental responsibility. Participation was voluntary and confidentiality was ensured.

2.1.4 Materials

2.1.4.1 Participant information sheet

Please refer to Appendix 3 for the information sheet given to the young people prior to them making a decision as to whether to take part.

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4 At the time of this project, the Health Professionals Council (HPC) did not regulate the clinical psychology programme.
2.1.4.2 Parent/guardian letter

A letter for the person with parental responsibility was given to all interested young people from the school. This letter was also attached to the university email advert. Please see Appendix 6 for a copy of this letter.

2.1.4.3 Consent and assent forms

Once the young people had decided to take part in the study they were provided with assent forms for themselves, and consent forms for the person with parental responsibility. See Appendix 7 for copies of these forms.

2.1.5 Procedure

2.1.5.1 Interviews

Semi-structured individual interviews were carried out with the twelve young people, lasting between 20-30 minutes each. An interview schedule was used to guide the process and this can be viewed in Appendix 8. Participants were asked to define shame, but were also asked to describe the difference between shame and guilt. This was done to ensure participants were talking about shame as opposed to guilt. If participants needed some help defining the difference between shame and guilt, definitions based on Lewis’s (1971) theory of shame were used. Participants were given the opportunity to talk about their own shaming experiences if they wished, but they were reminded that this was optional. Participants were also asked to describe any feelings associated with shame, any thoughts that might result from the feeling of shame and any types of behaviour young people might engage in if they felt shame. The interviews were audio recorded to enable the researcher to pay full attention to participants’ accounts, and the recordings were then transcribed verbatim (See Appendix 9 for a copy of one interview transcript). In case of disclosure, or any other safe guarding issue, a Special Education Needs Coordinator (SENCO) was on hand at the school during the interview process. The participants were told this prior to the interview commencing and were informed that if I became concerned or worried about them or others at any point during the interview, then I would have to go and get the SENCO. At University, Ms Mary John (supervisor for the project), was available for the same purpose.
2.1.6 Analysis

2.1.6.1 Content analysis

The aim of this analysis was to extract elements of shame reported by participants that might form items on the new questionnaire. In order to do this, content analysis (Weber, 1990; Hsieh & Shannon, 2005) was used to check for frequency and commonality of any themes that had previously been identified by past studies and theories on shame. In particular, the content analysis focussed on thoughts, feelings and behaviour associated with the shame described. This was done with a view of not contaminating the analysis with constructs of guilt.

2.1.6.2 The process

Firstly the researcher familiarised themselves with the data by reading the transcripts several times and noting down initial ideas. Initial codes were then generated, with the codes aiming to encapsulate and summarise what was being said across the twelve interviews. All of the transcripts were then re-read and subjected to content analysis (Weber, 1990; Hsieh & Shannon, 2005), where the frequency of all codes was recorded. Please refer to Appendix 10 for the initial codes and frequency counts. It became apparent that the content analysis had produced a rich and detailed list of codes, however holding the purpose of this analysis in mind (to develop a questionnaire) it was decided that not all of the codes would be needed in the next stage of analysis. Using both the frequency counts and examining the relationships between the codes, four categories were generated from the most relevant codes. These were initially labelled: shaming situations, what shame feels like, thoughts associated with shame, and what shame makes me do (See Appendix 11).

2.1.7 Item development

Using the categories that had been generated from the content analysis, initial items were drafted. As previously described, the aim of the new questionnaire was for it to be semi-idiographic to enable participants to think about their own personal shaming situations. It was therefore decided that the data collected on the different

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5 These are presented in the results section.
shaming situations described by the young people, would not be developed into questionnaire items. This data will be written up as part of a separate study.

2.1.8 Piloting

In order to pilot the SSA, the researcher invited the young people who took part in the interviews to attend a focus group. The purpose of the focus group was to present the newly developed questionnaire and to find out the young people's views on it. The young people were asked to complete the questionnaire and comment on any difficulties or misunderstandings they had. This exercise also enabled the language of the instructions to be assessed by adolescents aged between 11 and 15 years old. The participants fed back that the questionnaire was easy to understand and the instructions made sense. They did suggest however, that an example question be provided to participants to enhance understanding of the instructions, and as a result this was added.

Two young people aged 11, who had no previous involvement in the study, were also asked to complete the whole questionnaire pack to find out the length of time required for participation in Study 2. Both participants completed the pack within 25 minutes.

2.2 Study 2: Assessment of the psychometric properties of the Shame Scale for Adolescents (SSA)

Following the development of the SSA, the reliability, validity and factor structure of the new measure was examined.

2.2.1 Hypotheses

Hypothesis 1: The SSA will yield more than one factor and the factors will be related to each other.
Hypothesis 2: The SSA will have good validity when compared to a different psychometrically sound shame questionnaire (TOSCA-A; Tangney et al., 1991).

Hypothesis 3: Shame will be positively correlated with negative affect.

Hypothesis 4: Shame will be inversely correlated with self esteem.

Hypothesis 5: Shame will be positively correlated with anger.

2.2.2 Design

Validated measures were used in a cross-sectional questionnaire based design to assess the psychometric properties of the SSA in a non-clinical population.

2.2.3 Participants

2.2.3.1 Recruitment

Data was obtained from a variety of sources. Six co-education secondary schools from two areas of the United Kingdom were approached and three of these schools allowed data collection to take place. Two of the schools asked form tutors to distribute information packs to students, with interested students gaining consent from someone with parental responsibility. The other school invited the researcher to do a presentation about the project in a school assembly and asked for interested students to take an information pack away with them. An email advert was also sent to all staff from a university with a link to an online version of the study (Appendix 12).

2.2.3.2 Response rate

500 information packs were handed out to students aged 11-16 years from the three schools. Written consent was received for 71 of these students to take part in the study, which was a response rate of 14.2%. Another 20 young people completed the online version of the study via the university email. In total 91 questionnaire packs were returned but only 89 were fully completed and therefore usable.
The final sample was made up of 56 females (62.9%) and 33 males. The mean age of participants was 13.55 (SD 1.46), with a minimum age of 11 and a maximum of 16. Information regarding ethnicity was not formally collected; however the schools used for data collection represented ethnically diverse areas of the United Kingdom.

2.2.4 Ethical Approval

Ethical approval for Study 2 was gained at the same time as Study 1 (Appendix 5).

2.2.5 Materials

The 500 students were given an information sheet and a parent/guardian letter to take home in order to make an informed decision about taking part (Appendices 13 and 14). The information sheet and letter were also attached to the email advert. The assent and consent forms used were the same as Study 1 (Appendix 7). Consent for participation from the young people via the email, was in the form of the parent allowing their child access to the online web address. Once the young person had read the information and made an informed decision to take part, the parent sharing the online link with their child was deemed as consent.

2.2.5.1 Questionnaires

Participants were provided with questionnaire packs containing the following:

Test of Self-Conscious Affect for Adolescents (TOSCA-A; Tangney et al., 1991)

The TOSCA-A is a scenario based measure of shame, guilt, pride and externalisation but for the purpose of this study only the shame and guilt scales were used. Participants were provided with 15 scenarios with two items relating to each scenario (one shame response and one guilt response). Items are rated on a five-point Likert scale with 1=Not at all likely, 2=Unlikely, 3=Maybe (half and half), 4=Likely and 5=Very likely and the scale scores (shame and guilt) are the sum of responses for each relevant item. The TOSCA-A has been found to have good validity and reliability (as presented in the Introduction). Internal consistency from
the current study revealed Cronbach alphas of .82 (shame) and .85 (guilt), which are comparable to alphas reported in previous studies (Tangney, Wagner et al., 1996).

Positive and Negative Affect Schedule for Children (PANAS-C; Laurent et al., 1999)

The PANAS-C is a 27-item measure that assesses positive and negative affect in children aged 10-18 years. The items consist of single words indicating affect and are rated on a four-point scale with responses: 1=Not a lot, 2=A little, 3=Quite a lot and 4=A lot. Participants are asked to indicate to what extent they have felt like each item during the past few weeks, resulting in a total for both positive and negative affect. Reliability of the measure has been found to be good, with Cronbach alphas of 0.90 and 0.89 for positive affect and 0.94 and 0.92 for negative affect in two groups of school children (Laurent et al., 1999). The PANAS-C has also been found to demonstrate good convergent and divergent validity when compared to existing self-report measure of anxiety and depression (Laurent et al., 1999).

Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1965)

The RSE is a widely used 10-item measure of global self-esteem that is suitable for use with adolescents. The 10 items are scored on a Likert scale of 0-3 with options of Strongly Agree, Agree, Disagree and Strongly Disagree. The sum of the 10 items (5 are reversed before scoring) results in the level of self-esteem, with a higher score indicating higher self-esteem. The psychometric properties of the RSE have been assessed many times and the scale is usually found to have good reliability and validity. Examples of these include McCarthy & Hoge (1982) who reported Cronbach alphas of 0.74 and 0.77 and Hagborg (1993) who reported alpha coefficients of 0.89. When compared to other measures of self-esteem the RSE was shown to correlate highly, thus supporting the validity of the scale (Hagborg, 1993).

Anger Expression Scale for Children (AESC; Steele et al., 2009)

The AESC is a 26-item self report measure designed to examine anger expression in children aged 7-17 years old. The AESC assesses four aspects of anger: Trait

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Anger, Anger Expression, Anger Suppression and Anger Control. Each item on the AESC is scored on a four-point Likert scale of 1=Almost never, 2=Sometimes, 3=Often and 4=Almost always. All items are summed to calculate individual subscale scores and can then be transferred into mean scores for comparison. The reliability and validity of the AESC was explored by Steele et al. (2009) using both healthy children and children with chronic illnesses. Internal consistencies were found to be Trait Anger; α = .84, Anger Expression; α = .69, Anger Suppression α = .71 and Anger Control α = .79. Test-retest reliability was found to be adequate with the trait anger scale showing the greatest stability over time. Convergent validity for the AESC was investigated and the measure was found to correlate positively with both parent and child reports of aggression, anger and hostility when compared to other self-rated anger scales (Steele et al., 2009).

2.2.6 Procedure

2.2.6.1 Data collection

Once assent and consent had been gained, participants received a pack containing the questionnaires detailed above, the newly developed SSA, and a demographic details sheet (See Appendix 15 for a copy of the questionnaire pack). Participants completed the questionnaire packs in different ways with some of the young people filling the questionnaires out in school time, some taking them home to complete, and some completing the online version. The demographic sheet used in the schools required participants to record their name and form group in order to be able to trace participants if any of the answers provided were cause for concern. Online this was done by the parent providing the researcher with a contact email address.

2.2.7 Statistical analysis

All analyses were conducted using the statistical programme SPSS version 17.0.

2.2.7.1 Factor analysis

Principle Axis Factoring (PAF), a type of exploratory factor analysis, was conducted to examine the underlying relationships and constructs measured by the SSA, and
to reduce and refine the number of items on the questionnaire. Factor loadings were generated using oblique rotations of PAF in order to determine the most interpretable solution. An oblique method of rotation (direct oblimin) was used, as the psychological constructs being measured were assumed to correlate and therefore this method was favoured to an orthogonal technique (Tabachnick & Fidell, 2001).

There is often confusion surrounding the differences between Principle Component Analysis (PCA) and exploratory factor analysis. Costello & Osborne (2005) describe PCA as not actually a method of factor analysis but only a method of data reduction where components, not factors, are extracted. Factor analysis is a more stringent method because factors are estimated using a mathematical model, whereby only the shared variance is analysed and the factors are associated with theory development (Tabachnick & Fidell, 2001). This is compared to PCA where all of the variance in the variables is analysed, and therefore there is no underlying theory about which variables should be associated with which components. An exploratory factor analysis (PAF) was chosen for this analysis. Fabrigar et al. (1999) discuss the different methods of exploratory factor analysis and suggest PAF is one of the methods that will give the best results.

2.2.7.1.1 Sample size

The sample size of 89 might have once been considered to be too small for a factor analysis, however Costello & Osborne (1994) state that 'strict rules regarding sample size for exploratory factor analysis have mostly disappeared' (p4). The main principle behind sample size for factor analysis is that the more participants the better, but it is thought that if the data is strong then a small sample size can produce an adequate analysis. Strong data means uniformly high communalities without cross loadings, plus several variables loading on each factor. Using these criteria, the data from this study was classed as strong. Additionally, the participant to item ratio was almost 3:1 which is more than the minimum of 2:1 suggested by Kline (1994). All of these elements imply it was appropriate to carry out a factor analysis on the data.
2.2.7.2 Reliability

2.2.7.2.1 Internal consistency

The reliability of the SSA was examined using inter-item correlations, item-total correlations and Cronbach alpha co-efficients. Test-retest was not possible due to time constraints.

2.2.7.3 Validity

2.2.7.3.1 Content and face validity

To assess if the questions on the SSA covered the psychological domain in question, it was important the items were generated through a systematic exploration of the existing literature and consultation with young people and health professionals. Face validity was investigated by missing data and a subjective evaluation of relevance by other health professionals.

2.2.7.3.2 Criterion validity

Concurrent criterion validity was investigated by correlating the scores from the SSA with the scores from the shame subscale of the TOSCA-A. The TOSCA-A shame scale has already been validated and therefore it was seen as a relevant measure of criterion validity.

2.2.7.3.3 Convergent construct validity

Convergent validity was investigated by exploring the relationship between the scores on the SSA with the scores on the PANAS-C, the RSE and the AESC.

2.2.7.3.4 Divergent construct validity

Divergent validity was investigated by exploring the relationship between the shame scores from the SSA and the scores from the guilt subscale of the TOSCA-A.
2.3 Debriefing

All participants who took part in Study 1 and Study 2 who were recruited from the schools were able to receive information about the results of the study if they wished. The information is due to be sent to the co-ordinator from each school via email. The co-ordinator will then distribute the information to the young people who took part. The participants who were recruited from the university email were given the option to receive a summary of the results if they wished. They will also be sent the same information via email.
3.0 RESULTS

This section presents firstly the results of the content analysis, and how this contributed to the development of the Shame Scale for Adolescents (SSA). Secondly, the data regarding the psychometric properties of the SSA is presented.

3.1 Study 1: The development of the SSA

3.1.1 Extraction of items from interview analysis

The aim of Study 1 was to produce a semi-idiographic questionnaire which incorporated the data from the content analysis. It was evident that shame as a concept had meaning and had cognitive, affective and behavioural elements to it. In addition, there was an ability to distinguish between shame and guilt in the qualitative data. This was important as it was fundamental that the items chosen represented what the young people thought of shame, and not guilt.

The content analysis revealed items pertaining to these three dimensions:

- **Cognitive dimension**
  i.e. ‘I thought I wanted to be on my own’ and ‘I thought I have let myself down’

- **Affective dimension**
  i.e. ‘I felt worthless and small’ and ‘I felt disappointed’

- **Behavioural dimension**
  i.e. ‘I wanted to cry’ and ‘I wanted to shout and scream’

Using the three dimensions, 30 items were composed to form the SSA. A list of the 30 items can be viewed in Appendix 16.
3.1.2 The format of the SSA

At the beginning of the SSA participants are introduced to a statement about shame in young people: ‘It is common for young people to experience feelings of shame. However, people vary in the type of situation that makes them feel shame or ashamed. Shame can occur when you have done something or when someone else has done something to you.’ The purpose of this statement is to normalise the shaming experience for participants, and to remind them that shame can occur as a result of their actions and/or the actions of others. Participants are then provided with a couple of examples of ‘common’ shaming situations, and are asked to write down up to three of their own examples of shaming situations. This is to encourage participants to think about how they generally think and feel in situations in which they experience shame. Participants are asked to hold these personal shaming experiences in mind when answering the questionnaire items. They are instructed to ‘Complete the statements below thinking back to the times you have felt shame’. A four-point Likert scale was adopted and for each item participants are asked to rate: 1=Not at all, 2=A little bit, 3=Quite a bit and 4=A lot. This process is different to participants answering questions in relation to hypothetical shaming situations, as in the TOSCA-A. The initial version of the SSA that was used for data collection can be viewed in Appendix 15 (as part of the questionnaire pack).

3.2 Study 2: Assessment of the psychometric properties of the SSA

3.2.1 Preliminary analysis

All variables were assessed for normality before any statistical tests were carried out. Inspection of Kolmogorov-Smirnov results revealed five non-normal variables: POSAFF (Positive affect) TRAITANG (Trait anger), ANGEXP (Anger expression), ANGSUP (Anger suppression) and ANGCON (Anger control). Z-scores were calculated for all variables and these revealed scores of less than 2.58 for the POSAFF, TRAITANG, ANGSUP and ANGCON variables. Field (2005) suggests that for a sample size of <100, if z-scores are less than 2.58 this indicates that the data is close to normality and can be used for further analysis. In addition, the total mean scores and the 5% trimmed mean scores were very similar, thus providing
evidence that the extreme scores were not having a strong influence on the mean. A Transformation was carried out on the remaining one non-normal variable (ANGEXP), and normality was achieved using an inverse transformation\(^6\). In regards to using non normal variables when running statistical analyses, Clark-Carter (1997) describes that in a correlation analysis only one of the two variables needs to be normal. See Appendix 17 for a table summarising variable normality.

Inspection of box-plots and extreme values tables revealed one outlier (case 75). This participant scored at the very extreme end of the scales in both the TOSCA-A shame and guilt scales, and therefore it was decided to remove the case from further analysis. Once removed, the mean scores and the 5% trimmed mean scores were closer in value suggesting that the outlier had been influencing the mean.

3.2.2 Factor analysis

3.2.2.1 Assumptions

3.2.2.1.1 Linearity

Visual inspection of the distributions of the SSA items did not strongly suggest that any item should not enter the principle axis factor analysis.

3.2.2.1.2 Outlier

There was one further outlier in the SSA data set (case 49). This participant's scores were at the extreme end of the scale and resulted in its removal prior to running the factor analysis. The total number of participants included in all statistical analyses was therefore 87.

3.2.2.1.3 Factorability of correlation matrix

Prior to performing the factor analysis, the suitability of data was assessed. Factorability of the correlation matrix containing 30 items was found to be adequate

\(^6\) Despite transformation achieving normality, the transformed variable was not used in any of the analyses.
according to several indicators. First, inspection of the matrix revealed the presence of many coefficients that were greater than 0.3 in value and all items also had large correlations (>0.3) with at least one other item in the set. In addition the Kaiser-Meyer-Oklin value was .829, exceeding the recommended value of .6 (Kaiser, 1960) and Bartlett’s Test of Sphericity (Bartlett, 1954) reached statistical significance ([chi square] = 1584.123, p<.001) indicating high sampling adequacy.

3.2.2.1.4 Multicollinearity and singularity

The determinant of the correlation matrix was less than 0.00001 which suggested that multicollinearity (variables that were highly correlated) or singularity (variables that were perfectly correlated) was present. However, the correlation matrix indicated that there were no variables correlating very highly (r=>0.8), and the original unrotated PAF revealed that the smallest eigenvalue (the one associated with the 30th factor) was 0.091, not zero (Tabachnick & Fidell, 2001). It was therefore concluded that multicollinearity and singularity was not a threat to data integrity and the decision was taken to proceed with the factor analysis.

3.2.2.2 Factor analysis outcome

An initial exploratory factor analysis (Principle Axis Factoring with oblimin rotation) was conducted and the data revealed the presence of seven factors with eigenvalues exceeding 1, explaining 59.879% of the variance (Appendix 18). This method of factor extraction by retaining eigenvalues over 1 was then compared to the examination of the scree plot. A typical scree plot is one with few high eigenvalue factors and many low eigenvalue factors resulting in a characteristic curve. Cattell (1966) suggests that the cut-off point for selecting factors should be at the point of inflexion of this curve. Inspection of the initial scree plot indicated the extraction of three factors, not seven, and therefore this method was preferred. Preacher & MacCullum (2003) describe how the use of the scree plot is considered a more accurate determination of which factors to retain. Please refer to Figure 2.
Figure 2. Scree plot of factor loadings

Due to the decision of retaining three factors the exploratory factor analysis was re-run extracting three factors. This resulted in a three factor solution explaining a total of 53.218% of the variance, with factor 1 contributing 32.017%, factor 2 contributing 10.958% and factor 3 contributing 5.244% (Appendix 19). The rotated solution obtained three distinct dimensions based on item content, and were well marked by at least five items each. The criterion for inclusion of an item in a factor was set at 0.512 as this was in line with recommendations made by Stevens (1992) for a sample size of 100. Questions 1, 2, 5, 9, 10, 15, 17 and 23 did not load significantly (loading was <0.512) onto any of the three factors and were therefore dropped. In sum, a total of 22 items were retained in the SSA (Factor 1 = 11; Factor 2 = 6; Factor 3 = 5). Table 1 outlines the items and item statistics for each of the three factors.
Table 1. SSA items and item statistics (N=87).

<table>
<thead>
<tr>
<th>SSA item</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>25. I thought &quot;Other people must think I am nasty&quot;</td>
<td>.757</td>
<td>.140</td>
<td>-.132</td>
<td>1.78</td>
<td>.88</td>
</tr>
<tr>
<td>26. I thought &quot;I am stupid&quot;</td>
<td>.714</td>
<td>.063</td>
<td>.079</td>
<td>2.13</td>
<td>1.02</td>
</tr>
<tr>
<td>7. I thought &quot;I am a nasty person&quot;</td>
<td>.664</td>
<td>.017</td>
<td>.106</td>
<td>1.85</td>
<td>.94</td>
</tr>
<tr>
<td>21. I thought &quot;I am no good&quot;</td>
<td>.663</td>
<td>-.143</td>
<td>.242</td>
<td>2.11</td>
<td>1.02</td>
</tr>
<tr>
<td>30. I thought &quot;It is better if I am not around&quot;</td>
<td>.658</td>
<td>.165</td>
<td>.108</td>
<td>2.03</td>
<td>1.09</td>
</tr>
<tr>
<td>22. I wanted to hurt myself</td>
<td>.647</td>
<td>.268</td>
<td>-.123</td>
<td>1.69</td>
<td>1.09</td>
</tr>
<tr>
<td>4. I felt worthless and small</td>
<td>.636</td>
<td>-.134</td>
<td>.196</td>
<td>2.05</td>
<td>1.02</td>
</tr>
<tr>
<td>6. I thought &quot;Other people must think I am no good&quot;</td>
<td>.589</td>
<td>-.134</td>
<td>.311</td>
<td>2.31</td>
<td>1.02</td>
</tr>
<tr>
<td>16. I thought &quot;Other people must think I am stupid&quot;</td>
<td>.567</td>
<td>-.080</td>
<td>.124</td>
<td>2.29</td>
<td>.97</td>
</tr>
<tr>
<td>13. I thought &quot;No one likes me&quot;</td>
<td>.566</td>
<td>.187</td>
<td>.131</td>
<td>2.01</td>
<td>1.05</td>
</tr>
<tr>
<td>3. I thought &quot;I have let other people down&quot;</td>
<td>.534</td>
<td>-.363</td>
<td>.027</td>
<td>2.52</td>
<td>.95</td>
</tr>
<tr>
<td>12. I wanted to seek revenge</td>
<td>-.028</td>
<td>.776</td>
<td>-.077</td>
<td>1.87</td>
<td>1.03</td>
</tr>
<tr>
<td>11. I felt angry at other people</td>
<td>-.120</td>
<td>.704</td>
<td>.176</td>
<td>2.01</td>
<td>.95</td>
</tr>
<tr>
<td>27. I wanted to hurt someone else</td>
<td>.237</td>
<td>.690</td>
<td>-.207</td>
<td>1.60</td>
<td>.98</td>
</tr>
<tr>
<td>18. I wanted to punch walls or break things</td>
<td>.065</td>
<td>.620</td>
<td>.158</td>
<td>2.25</td>
<td>1.17</td>
</tr>
<tr>
<td>8. I wanted to scream and shout</td>
<td>.040</td>
<td>.524</td>
<td>.421</td>
<td>2.34</td>
<td>1.25</td>
</tr>
<tr>
<td>29. I wanted to destroy other people's belongings</td>
<td>.453</td>
<td>.521</td>
<td>-.284</td>
<td>1.46</td>
<td>.87</td>
</tr>
<tr>
<td>19. I felt sad</td>
<td>-.048</td>
<td>-.138</td>
<td>.731</td>
<td>2.62</td>
<td>.89</td>
</tr>
<tr>
<td>28. I felt frustrated</td>
<td>-.085</td>
<td>.257</td>
<td>.711</td>
<td>2.54</td>
<td>.90</td>
</tr>
<tr>
<td>20. I had a horrible feeling inside</td>
<td>.046</td>
<td>.049</td>
<td>.683</td>
<td>2.69</td>
<td>.94</td>
</tr>
<tr>
<td>14. I felt disappointed</td>
<td>.166</td>
<td>-.247</td>
<td>.599</td>
<td>2.66</td>
<td>.87</td>
</tr>
<tr>
<td>24. I felt embarrassed</td>
<td>.158</td>
<td>-.126</td>
<td>.565</td>
<td>2.61</td>
<td>1.00</td>
</tr>
</tbody>
</table>

Note: Unique factor loadings >.512 are in bold.
3.2.2.3 Interpretation of the factors

Examination of factor 1 revealed that all items were related to participants having a negative evaluation of the self. Most items were about the thoughts participants had about themselves when thinking back to times they felt shame, for example 'I thought I am nasty' and 'I thought I am stupid', Factor 1 was therefore entitled 'Negative Evaluation of Self'. The items that made up factor 2 were in relation to participants wanting to express something in an outward manner, for example 'I wanted to seek revenge' and 'I wanted to shout and scream' as a result of shame. Factor 2 was therefore entitled 'Outward Expression'. Factor 3 contained items that were about how participants felt when they experienced shame, for example 'I felt sad' and 'I had a horrible feeling inside'. This final factor was entitled 'Internalised Affect'.

3.2.2.4 Scoring of the SSA

Please refer to Appendix 20 for a copy of the final 22-item SSA. SSA item scores ranged from 1-4 with Likert scale anchors of 1=Not at all, 2=A little bit, 3=Quite a bit and 4=A lot. Higher scores on each of the three factors of the SSA are indicative of higher levels of shame. Table 2 shows the mean scores for the SSA subscales and total scale score.

Table 2. SSA mean scores for each factor and total (N=87)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Number of items</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative evaluation of self (1)</td>
<td>11</td>
<td>2.07</td>
<td>.24</td>
</tr>
<tr>
<td>Outward expression (2)</td>
<td>6</td>
<td>1.92</td>
<td>.35</td>
</tr>
<tr>
<td>Internalised affect (3)</td>
<td>5</td>
<td>2.62</td>
<td>.06</td>
</tr>
<tr>
<td>SSA total</td>
<td>22</td>
<td>2.16</td>
<td>.36</td>
</tr>
</tbody>
</table>

3.2.2.5 Normality of the SSA

Prior to running any further statistical analysis on the data, normality of the new 22-item questionnaire and the three factors was checked. The SSA total score variable (SSA) was found to be normally distributed; however the separate SSA factor
variables were not (Appendix 17). As stated earlier, when carrying-out correlations only one of the two variables needs to be normal (Clark-Carter, 1997), so parametric analyses would be carried out where possible. Non-parametric tests would be carried on the necessary non-normal variables, as transformations did not contribute towards normality.

3.2.2.6 Subscale inter-correlations

Correlations were calculated between the means of the individual factors of the SSA and the SSA total and these can be seen in Table 3. Pearson product-moment correlation coefficients were conducted on the normally distributed, linear data and Spearman Rho correlations were used on the non-normal data. The correlations demonstrate that all three factors were positively correlated with each other in this sample; however factor 2 was only weakly correlated with factors 1 and 3.

Table 3. Subscale inter-correlations (N=87)

<table>
<thead>
<tr>
<th>Factor</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>Total SSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative evaluation of self (1)</td>
<td>1.00</td>
<td>.29**</td>
<td>.62**</td>
<td>.91**</td>
</tr>
<tr>
<td>Outward expression (2)</td>
<td></td>
<td>1.00</td>
<td>.16</td>
<td>.60**</td>
</tr>
<tr>
<td>Internalised affect (3)</td>
<td></td>
<td></td>
<td>1.00</td>
<td>.68**</td>
</tr>
</tbody>
</table>

Note: Numbers underlined are Spearman's Rho calculations
Two-tailed significance: * is significant at 0.05 level; ** is significant at 0.01 level

3.2.3 Descriptive statistics

The means for all of the variables are shown in Table 4. The means for males and females are also shown.
Table 4. Descriptive statistics for all variables

<table>
<thead>
<tr>
<th></th>
<th>Total sample</th>
<th></th>
<th>Males</th>
<th></th>
<th>Females</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>N</td>
<td>M</td>
<td>SD</td>
<td>N</td>
</tr>
<tr>
<td>SSA Total</td>
<td>47.4</td>
<td>12.4</td>
<td>87</td>
<td>43.6</td>
<td>10.6</td>
<td>33</td>
</tr>
<tr>
<td>SSA Factor 1</td>
<td>22.8</td>
<td>8.0</td>
<td>87</td>
<td>19.5</td>
<td>6.3</td>
<td>33</td>
</tr>
<tr>
<td>SSA Factor 2</td>
<td>11.5</td>
<td>4.6</td>
<td>87</td>
<td>12.2</td>
<td>4.3</td>
<td>33</td>
</tr>
<tr>
<td>SSA Factor 3</td>
<td>13.1</td>
<td>3.5</td>
<td>87</td>
<td>11.9</td>
<td>3.5</td>
<td>33</td>
</tr>
<tr>
<td>TOSCA-A Shame</td>
<td>41.8</td>
<td>9.1</td>
<td>87</td>
<td>37.8</td>
<td>9.3</td>
<td>33</td>
</tr>
<tr>
<td>TOSCA-A Guilt</td>
<td>57.3</td>
<td>8.2</td>
<td>87</td>
<td>54.0</td>
<td>8.2</td>
<td>33</td>
</tr>
<tr>
<td>PANAS-C Pos Aff</td>
<td>41.7</td>
<td>9.8</td>
<td>87</td>
<td>42.7</td>
<td>9.3</td>
<td>33</td>
</tr>
<tr>
<td>PANAS-C Neg Aff</td>
<td>30.9</td>
<td>10.8</td>
<td>87</td>
<td>29.2</td>
<td>9.9</td>
<td>33</td>
</tr>
<tr>
<td>RSE</td>
<td>18.9</td>
<td>5.1</td>
<td>87</td>
<td>20.5</td>
<td>5.0</td>
<td>33</td>
</tr>
<tr>
<td>AESC Trait Anger</td>
<td>20.3</td>
<td>5.6</td>
<td>87</td>
<td>20.5</td>
<td>5.6</td>
<td>33</td>
</tr>
<tr>
<td>AESC Anger Exp</td>
<td>10.7</td>
<td>3.6</td>
<td>87</td>
<td>11.4</td>
<td>3.9</td>
<td>33</td>
</tr>
<tr>
<td>AESC Anger Sup</td>
<td>9.9</td>
<td>3.2</td>
<td>87</td>
<td>9.1</td>
<td>3.0</td>
<td>33</td>
</tr>
<tr>
<td>AESC Anger Con</td>
<td>15.7</td>
<td>3.9</td>
<td>87</td>
<td>15.2</td>
<td>3.62</td>
<td>33</td>
</tr>
</tbody>
</table>

Note: All statistics rounded to nearest decimal point

3.2.4 Reliability

3.2.4.1 Internal consistency

Internal consistency (Cronbach alpha) for the total 22-item Shame Scale for Adolescents was as follows: Negative Evaluation of Self (0.90), Outward Expression (0.82) and Internalised Affect (0.82). These findings indicate that reliability is good and that all sub-scales are consistently measuring one underlying factor (Kline, 1994). Reliability for the whole 22-item scale was (0.89) and reflected the consistency of the overall SSA questionnaire.
3.2.5 Validity

3.2.5.1 Content and face validity

Content validity was maximised by ensuring items were theoretically grounded, and consultation with health professionals working with children and adolescents who experience shame added to this. The low proportion of missing data from the participants who completed the questionnaire was an indication of high face validity. Most importantly, the young people's knowledge and experience that was shared during the interviews contributed to both the content and face validity of the measure.

3.2.5.2 Criterion validity

Concurrent criterion validity was investigated by exploring the relationship between the SSA scores and the TOSCA-A shame scores. A Pearson product-moment correlation coefficient was conducted on the sample (N=87) and as predicted showed a significant moderate positive relationship between shame on the SSA and shame on the TOSCA-A (r=.43, p=<.01).

3.2.5.3 Construct validity

3.2.5.3.1 Convergent validity

Convergent validity was investigated by exploring the relationship between the scores on the SSA with the scores on the PANAS-C, the RSE and the AESC. Pearson correlation product-moment coefficients were conducted and as predicted there was a significant positive correlation between negative affect and shame (SSA) (r=.58, p=<.01), a significant negative correlation between self-esteem and shame (SSA) (r=-.57, p=<.01) and a significant positive correlation between anger, as measured by the Trait Anger subscale of the AESC, and shame (SSA) (r=.49, p=<.01). The relationship between shame (SSA) and the other anger subscales were: Anger Expression (r=.35, p=<.01), Anger Suppression (r=.26, p=<.05) and Anger Control (r=-.10, p=>.05).

The correlation coefficient is a commonly used measure of the size of an effect. Values of 0.1 represent a small effect, 0.3 a medium effect and 0.5 a large effect (Field, 2005).
3.2.5.3.2 Divergent validity

Divergent validity was investigated by exploring the relationship between the shame scores from the SSA and the scores from the guilt subscale of the TOSCA-A. A Pearson product-moment correlation coefficient was conducted and showed a significant weak positive correlation (r=.21, p=<.05). By comparison the relationship between the TOSCA-A shame and TOSCA-A guilt scores was investigated, and Pearson product-moment correlation coefficient showed a significant positive correlation (r=.57, p=<.01). Table 5 outlines the results of all correlations calculated between the SSA and other standardised measures completed by participants.

Table 5. Correlations between each factor of the SSA and SSA total

<table>
<thead>
<tr>
<th></th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>Total SSA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Negative</td>
<td>Outward</td>
<td>Internalised</td>
<td></td>
</tr>
<tr>
<td></td>
<td>evaluation of self</td>
<td>expression</td>
<td>affect</td>
<td></td>
</tr>
<tr>
<td>TOSCA-A Shame</td>
<td>.47**</td>
<td>.09</td>
<td>.35**</td>
<td>.43**</td>
</tr>
<tr>
<td>TOSCA-A Guilt</td>
<td>.29**</td>
<td>-.16</td>
<td>.30**</td>
<td>.21*</td>
</tr>
<tr>
<td>PANAS-C Negative Affect</td>
<td>.47**</td>
<td>.44**</td>
<td>.41**</td>
<td>.58**</td>
</tr>
<tr>
<td>PANAS-C Positive Affect*</td>
<td>-.20</td>
<td>-.15</td>
<td>.13</td>
<td>-.15</td>
</tr>
<tr>
<td>RSE</td>
<td>-.56**</td>
<td>-.35**</td>
<td>-.28**</td>
<td>-.57**</td>
</tr>
<tr>
<td>AESC Trait anger</td>
<td>.32**</td>
<td>.52**</td>
<td>.31**</td>
<td>.48**</td>
</tr>
<tr>
<td>AESC Anger expression</td>
<td>.19</td>
<td>.42**</td>
<td>.13</td>
<td>.35**</td>
</tr>
<tr>
<td>AESC Anger suppression</td>
<td>.26*</td>
<td>.03</td>
<td>.27*</td>
<td>.26*</td>
</tr>
<tr>
<td>AESC Anger control</td>
<td>-.08</td>
<td>-.27*</td>
<td>.18</td>
<td>-.10</td>
</tr>
</tbody>
</table>

Two tailed significance: * at 0.05 level; ** at 0.01 level

Note: Numbers underlined represent Spearman Rho correlations. All remaining correlations were calculated using Pearson product-moment correlation coefficient.

In addition to the results reported please refer to Appendix 21 for a complete table of all correlations conducted.
3.2.6 Gender

Gender differences were explored using Independent sample t-tests and Mann-Whitney U tests. These investigated if there were significant differences between males and females on any of the variables measured. The descriptive statistics table (Table 4) demonstrates that females had higher scores for the domains of shame (TOSCA-A and SSA), guilt, negative affect, anger suppression and anger control, and lower scores for self-esteem. T-tests revealed that these were significant differences on the TOSCA-A shame subscale (t (85) = -3.331, p=<.01), the TOSCA-A guilt subscale (t (85) = -3.050, p=<.01), the SSA (t (85) = -2.316, p=<.05) and the RSE (t (85) = 2.235, p=<.05). Mann-Whitney U tests also revealed that these differences were significant on Factor 1 (Negative Evaluation of Self) (U = 547.5, z=-3.009, p=<.01) and Factor 3 (Internalised Affect) (U = 606, z=-2.508, p=<.05) of the SSA subscales.

3.2.7 Age

Pearson product-moment correlation coefficients were conducted to explore the relationship between age and all variables. Age was not significantly correlated, positively or inversely, with any of the variables (See Appendix 21).
**4.0 DISCUSSION**

This section will consider the results of the study in relation to the hypotheses. The factor structure of the SSA will be discussed and each factor will be explored in detail. The SSA will then be compared to existing measures of shame. Implications for practice and research will be discussed, and recommendations will be suggested. The last section of the discussion will focus on the limitations of the study and the future of the SSA as a new measure of shame for adolescents.

**4.1 Hypotheses**

Hypothesis one was supported, as the SSA yielded more than one factor and the three factors were related to each other with positive correlations between them. Hypothesis two was supported as the SSA was found to have good validity when compared to the TOSCA-A (Tangney *et al.*, 1991). The SSA was also found to have good internal consistency. The results of this study also provide support for hypotheses three, four and five. Findings were similar to previous research; shame was positively correlated with negative affect (Ferguson *et al.*, 1999; Tilghman-Osborne *et al.*, 2008; Aslund *et al.*, 2007), shame was inversely correlated with self-esteem (Tangney & Dearing, 2002) and shame was positively correlated with anger (Tangney, Wagner *et al.*, 1992; 1996; Hoglund & Nicholas, 1995).

**4.2 Factor structure of the SSA**

The newly developed SSA had three factors, of which each will be discussed in turn and related to existing theory. The three factors, containing 22 items between them, were interpreted as *Negative Evaluation of Self, Outward Expression* and *Internalised Affect*. It can be concluded that these factors portray shame to be a multi-dimensional concept. The factors represent different aspects of shame that were demonstrated in the accounts from the adolescents interviewed. They are also comparable to factor analyses that have been carried out on other adult shame measures (ESS: Andrews *et al.*, 2002; ISS: Rosario & White, 2006). Shame has been found to consist of a cognitive dimension, an affect dimension, and a
behavioural dimension (Andrews et al., 2000) and the factor structure of the SSA is consistent with this.

4.2.1 Negative evaluation of self

Factor one was the dominant factor and it contained the most items. The 11 items related to a part of shame that is clearly evidenced in the literature; that shame is predominantly about a negative self evaluation (H. Lewis, 1971; M. Lewis, 1992). Most of the items are about thoughts participants have when they experience shame, and many of the thoughts correspond to negative self appraisal. These items fit with Lewis’s (1992; 2000) cognitive attribution theory, that for people to experience shame, what is required is a negative conscious self evaluation. Aside from the over arching theme of a negative view of the self, the items also capture Gilbert’s (1997; 1998) theory of external shame. He believes shame is best considered in terms of two dimensions; internal shame that focuses on negative evaluation of the self and external shame that is based on how one is seen by others or the fear of others judgements. External shame is still negative evaluation, but the focus is on what you think others think of you rather than what you think of yourself. For example some items from factor 1 of the SSA are what could be considered internal shame items (‘I am no good’ and ‘I am stupid’) but there are also external shame items (‘Other people must think I am no good’ and ‘Other people must think I am stupid’). The label Negative Evaluation of Self therefore encompasses both types of shame because the evaluation is about the self but it might come from either the self or the other. This leads us to question the importance of the external shame items of the SSA and as this is, as far as I am aware, the first adolescent measure to include items of external shame, much more research is needed of the SSA to clarify the importance of both types of shame in this factor.

4.2.2 Outward expression

Factor 2 contained six items that are evidently related to an expression of anger and aggression in an outward fashion. These items relate to the behavioural dimension of shame. Taking these items on face value it could be argued that they are not measuring shame at all, but instead are measuring anger. This is confirmed by the
positive correlation of factor 2 with trait anger (0.47) and the lack of correlation between the factor and the TOSCA-A shame scale (0.08). The small positive correlations between factor 2 and factors 1 (0.29) and 3 (0.16) also raises the question as to whether the items in factor 2 are strongly related enough to the other two factors. In order to address the usefulness of factor 2 it is important to explore this further.

The design of the SSA is very different to any other scenario-based shame measure like the TOSCA-A. Participants are asked in the SSA to think about personal situations in which they have experienced shame and then rate how they felt in relation to the shame. The behavioural responses desired by the adolescents are as a result of the feelings of shame, for example: ‘I wanted to shout and scream’ and ‘I wanted to hurt someone else’. This semi-idiographic style of questionnaire has not been used before and Andrews (1998b) promoted its development, suggesting that it could be a good way of capturing personally shaming experiences. Thus, although the factor looks as though it is measuring anger, this could be in relation to the humiliation and/or anger that results from the shaming experience for the individual. It could therefore be proposed that this factor might be an aspect of bypassed shame. Lewis (1971) describes bypassed shame as an avoidance or denial of the shame and it is thought to lead to externalised feelings of anger and hostility, rather than the more ‘typical’ affective shame state experienced in overt shame (Harper & Arias, 2004). So, if adolescents want to behave in a certain way as a result of their feelings, unconsciously the mind decides that a shame state might be ineffective in producing the desired behaviour. What happens instead is the shame is bypassed, and other emotional states are evident in place of the shame i.e. anger (Lewis, 2003) and this results in the desired behavioural response. It might be therefore that participants who scored highly on factor 2 were able to think about personally shaming experiences but did not experience the shame in the same way the participants who scored highly on factor 1 or 3 did. What resulted was a feeling of anger and it could be hypothesised that this was in fact shame (bypassed) presenting itself as anger. This could also fit with the “face saving” strategy known to be a typical source of male violence (Archer, 1994, as cited in Gilbert, 1998) whereby the cover for shame is anger.
4.2.3 Internalised affect

The third factor contained 5 items which were related to the feelings that happen as a result of shame. Items included 'I felt disappointed' and 'I had a horrible feeling inside' and were evidently about the affect that occurs with shame. This factor correlated positively with factor 1 (0.62) and with the TOSCA-A shame scale (0.34), and therefore it can be surmised that it does measure an aspect of shame. The feelings adolescents have when exposed to a shaming experience are a key element of this emotion. Like the other two factors, this can be related to a cognitive behavioural conceptualisation of shame. The affect that results from experiencing shame is pertinent in the cognitive-behavioural model, and this is also significant when you think about the potential clinical use of the items from factor 3.

4.3 The SSA

4.3.1 Is it a reliable measure of shame?

The main aim of this study was to develop a valid, reliable measure of shame and the results would indicate that this has been achieved. Reliability for the whole 22-item scale was confirmed to be good (Cronbach’s alpha = 0.89) and this reflects the consistency of the questionnaire. The hypotheses predicting correlations between SSA scores and low mood, low self-esteem and anger were supported, thus providing further evidence for its validity as a measure of shame. Additionally, the results of this study showed that female participants had higher levels of shame proneness than male participants. This difference was significant for both the SSA scores and the TOSCA-A shame scale scores. Although this was not a hypothesis, the result is further evidence for the validity of the SSA as a measure of shame. Almost all of the studies described throughout this project examined the gender differences of shame, and most of them also reported significantly higher levels of shame-proneness in female participants (Tangney & Dearing, 2002; Ferguson et al., 2000). These findings were independent of age, and Lewis et al. (1992) found that even pre-school aged girls had higher levels of shame when compared to boys.

The SSA was principally developed holding H. Lewis’s (1971) theory of shame in mind, with shame being an emotion that focuses on the self and results in feelings of worthlessness and inferiority. It was also developed on the basis of M. Lewis’s
(1992) attribution model of shame, in that shame occurs as a result of a self reflection and negative self evaluation. The items retained fitted into a cognitive behavioural model, in that they represent cognitions, affect and behavioural responses associated with shame. This was in line with previous conceptualisations of shame (Tangney, 1996; Andrews, 2002; Rosario & White, 2006), and suggests that shame is a multifaceted construct.

Carver (1989) outlines methods of evaluating multifaceted constructs in research strategy and highlights two approaches; the latent approach where all subscale scores are summed to produce a total, and the synergistic approach which is more than just summed parts as it looks at what each subscale gains from its relationship with its other subscales. In relation to shame measurement Andrews (1998b) suspects that the synergistic approach might be more appropriate. She describes an example where the statistical interaction between negative-self attitude and shame-specific components such as hiding or concealment may provide a more accurate reflection of shame, than simply summing all responses (p49). Carver suggests that where there are identifiable components in a measure (such as in the SSA) they should be tested separately in relation to the variables. This provides an explanation as to why the three factors of the SSA were analysed independently as well as together (SSA total).

In regards to the scoring of the SSA, it is proposed that each factor is named as a subscale and then summed separately. In addition, the subscale scores can be totalled together to achieve a total scale score. As well as these initial results suggesting that the SSA is a measure of shame proneness, they also suggest that the SSA is more than this. It appears to explore the ‘experience of shame’ for adolescents, rather than just high and low levels of shame proneness. This is something that the ESS (Andrews, 2002) does, but as of yet this has not been shown to be a valid tool for adolescents. Therefore, the SSA appears not only to be a reliable measure of shame, it also brings a different dimension of shame measurement in adolescents to the table.
4.3.2 The SSA compared to the TOSCA-A shame scale

The TOSCA-A appears to be the only widely available measure of shame for adolescents and it was therefore used to assess the relative performance of the SSA as a shame measure. The correlation between the SSA and the TOSCA-A shame scale is a moderate significant positive one ($r=.434$). This is perhaps lower than expected and the researcher would have hoped for a stronger correlation between the two measures. There are a number of reasons as to why this could have happened. Firstly, the SSA contains both internal and external shame items but the TOSCA-A only uses items that reflect internal shame. Secondly the TOSCA-A only covers scenarios where the person has done something or said something that then might result in a shaming response. The interviews carried out as part of this study demonstrated that adolescents in the United Kingdom today describe shame also occurring when something has been done or said to them, not only when they do or say something themselves. This represents an important aspect of shame that is missed by the TOSCA measures but something that is clearly relevant to young people’s shame experiences. Perhaps these different elements contributed towards the strength of the correlation between the SSA and the TOSCA-A shame scale.

Most importantly, what could have deflated the correlation between the SSA and the TOSCA-A shame scale, is the high correlation between the TOSCA-A shame scale and the TOSCA-A guilt scale. On average the correlation between shame and guilt has been found to be a moderate one (about .4) (Stuewig et al., 2010). Interestingly the results from the TOSCA-A in this current study found the correlation to be stronger than the average ($r=.57$, $p=<.01$), and this was also found in Andrews et al. (2002) study using the TOSCA. The relationship between the SSA and the TOSCA-A guilt scale was significantly correlated but at a much weaker level ($r=.21$, $p=<.05$), and this is something else Andrews et al. (2002) found between the ESS and the TOSCA guilt scale ($r=.23$, $p=<.01$.) The deflated relationship between our measure and the TOSCA shame could perhaps be because their shame scale is contaminated by guilt. Perhaps the ESS and the SSA are better at distinguishing between the two emotions and maybe this is due to both measures asking respondents to think about shame and for them being solely shame measures. Tangney & Dearing (2002) criticise questionnaires that assume participants know what shame is, but maybe this is something that needs revisiting. The qualitative
element of this research demonstrates that 11-16 years olds are able to talk about shame in a meaningful way.

With regard to clinical applicability, the SSA has more uses than the TOSCA-A. It allows respondents to think of personal shaming situations and therefore it enables young people to think of difficult and upsetting experiences. Tangney and colleagues (2002) have acknowledged that the scenarios chosen for the TOSCA measures are generic and do not capture the more difficult experiences, so the SSA is providing something different to the TOSCA-A. With its semi-idiographic style, the SSA is also able to capture gender differences. Participants are able to write down their own shaming experiences and there are no gender biases, like there possibly are in pre-defined measures of shame, such as the TOSCA-A. In addition, the three separate subscales also allow a more detailed look at how shame presents in adolescents, rather than it just measuring the overall propensity to shame. When working with adolescents in a clinical context, this could be really useful. It would enable clinicians to find out what the individual experience of shame is like for their clients, and whether that person's experience is one of cognitions, internalised affect, or outward expression.

4.4 Practice implications

4.4.1 We need to talk about shame

The interviews carried out in Study 1 provided the researcher with an idea of what 11-16 year olds from the United Kingdom think shame is. Although Study 1 was discussed in a limited manner, it did present some thought provoking data to those who work with young people in mental health services. What was apparent was all young people were able to think about personally shaming situations and were able to connect the thoughts and feelings that result from shame. What this means for the people that provide psychological services for adolescents suffering from distress is that shame should not be ignored. Clinically there is a lack of literature in regard to 'working with shame' in adolescence, and this might be because clinicians think that clients might struggle to identify and verbalise the shame experience (Tangney et al., 1995). This study suggests that this might not be the case. It is important to hold in mind however, that the participants in this study were not from a
clinical sample and therefore their shaming experiences might not be as painful or complex when compared to young people accessing mental health services.

The design of the SSA allows adolescents to write down some personal shaming examples themselves. The researcher had reservations about how much the young people participating would complete this section. In fact, all but three participants wrote down at least two examples and the majority wrote down three examples of shaming situations. This also demonstrates that young people are able to understand and express what shame means to them. Additionally a large number of the situations written down were in regards to school and peers, and this highlights how during adolescence, young people are exposed to potentially shaming situations on a regular basis. It also demonstrates how school and issues relating to school life, for example bullying, are perhaps potential breeding grounds for shame to develop and be maintained.

**4.4.2 Professionals need to learn about shame**

Another practice implication is in regards to the literature on early childhood, attachment and parenting, and how this is thought to impact shame proneness. This is in addition to the links confirmed in this study between shame and aspects of psychopathology. Because of these links, therapists and other mental health professionals need to be certain that they are trying to address the issue of shame. Gilbert (2010) and Tracy & Robbins (2007) both talk about how concerns with self-evaluation are central to many psychological therapies. But they also describe how in their experience, few clinicians locate their therapy within the shame literature. Perhaps shame proneness and the impact of this emotion needs to be explored in further detail in training programmes of psychologists, psychiatrists, and other mental health professionals. In addition, perhaps schools also need to be advised on the impact of shame, and provided with strategies and guidance on how to address the issue, particularly in relation to bullying.
4.5 Limitations of the study

4.5.1 Measurement issues

One potential measurement issue is in regard to participants not actually thinking of shame when they completed the SSA. This could be construed as a weakness of the questionnaire but this is questionable. Firstly, studies have shown that children over 9 years old have an understanding of what shame is and are able to describe it and relate it to personal situations (Ferguson et al., 1991; Berti et al., 2000), and therefore one can assume that most adolescents will have the ability to do the same. Secondly, it could be argued that if the respondents construct something as shaming then surely it represents a shaming experience for that person.

There are also possible limitations of the other questionnaires used in this project. The PANAS-C (Laurent et al., 1999), although validated against more traditional depressions measures for young people, does not measure depression. This was however an advantage for this study, as the schools involved were happier to complete a questionnaire that focussed on affect as opposed to a questionnaire that explored depressive symptomology. Additionally the AESC (Steele et al., 2009) is newly developed measure of anger expression and therefore there have been limited studies exploring the validity of the measure and the internal consistencies of the four different subtests. The studies carried out so far do suggest good validity and reliability but one alternative could have been to use a more established measure of anger and aggression.

4.5.2 Sample and design

One of the main limitations in regards to the present study was the sample size of 87. Previous factor analysis studies have been published using similar and less participants than this (Korotkov, 1991; Wright & Gudjonsson, 2007) but 100 is often considered the minimum amount for an acceptable factor analysis (Kline, 1994). In order to limit the effect of this small sample the researcher only opted to use items with a factor loading of more than .512. This has been used by Stevens (1992) as a way of providing verification for smaller sample sizes in factor analysis. One of the biggest contributing factors to the small sample size was parental consent. All of the schools that were used for data collection had agreed to use an opt-out form of
consent as opposed to an opt-in, however this was deemed unethical for participants as they were being asked to write down personal shaming situations. The percentage of returned questionnaire packs was extremely small (14.2%), many less than expected, and the lack of parental consent possibly contributed to this small attrition rate. Another limitation of the present study and the validation of the SSA was the lack of test-retest reliability. This was not carried out due to time constraints but is essential for future validation of the scale. Overall the results presented should be taken with caution as they are preliminary findings and more studies are needed, especially one that include test-retest reliability checks.

4.5.3 Shame and culture

The understanding of unconscious emotions such as shame is incomplete without an account of the role of cultural and societal factors. The sample used in this study represented a western culture and although ethnically diverse participants would have taken part, the sample is very specific to two areas of the United Kingdom. This is a limitation of this study and in the preliminary validation of the SSA. Most of the studies exploring shame and the development of shame measures have taken place in western societies, which could indicate that we are all only measuring what is relevant to this sample group. This is particularly applicable to many of the adult studies from America as they are carried out in Universities and this highlights how specific the sample groups are. Bedford and Hwang (2003) point out that theory and research in the area of shame must take into account the nature of different cultural differences in the conceptualisation and experience of shame. This is something to bear in mind if the SSA is developed beyond western cultures.

4.6 The future of the SSA

4.6.1 Questionnaire items

On evaluation of the measure as a whole, there were perhaps not enough items included that represented this sense of wanting to hide, shrink, or disappear (Lewis, 1971). The wording of the item 'I wanted to be on my own' does not wholly represent that sense of wanting to shrink into the ground described by some of the participants in the interviews and by participants in other studies (Wicker et al., 1983; Tangney
As this is the first version of the SSA it could always be altered before more analysis takes place. A couple of items could be added before the next set of data collection. Examples might include ‘I wanted to hide’, ‘I wanted to run away’, ‘I wanted to shrink into the ground’ and ‘I wanted to disappear’. What might result is an additional factor that is focussed on an internal removal of self as a result of the shame. It would then be interesting to compare differences with these items and the outward expression items.

4.6.2 Future studies

Other future studies might include a comparison of the SSA with other forms of shame measurement for children and adolescents, such as observational measures of non-verbal shame and practical interview measures such as the Thurston Cradock Test of Shame (Thurston & Cradock, 2009), as opposed to just self-report measures. In addition, research is needed in clinical populations and other sample groups of adolescents. For example the measure could be evaluated with young offenders or children in care; both groups of young people suspected of having high rates of shame proneness. The measure could also be evaluated with specific clinical populations like young people who are depressed.

The nature of the SSA would also permit respondents to think about specific shameful events i.e. the time of abuse, the experience of being bullied, or the experience of having an eating disorder. Clinically this could be useful as the SSA could then be completed as part of the therapy, particularly when using CBT techniques. It could be used to explore which cognitions might have changed and if these changes relate to an overall reduction in feelings of shame (Feiring, Taska & Lewis, 2002). The SSA could therefore potentially become a useful outcome measure to be used within clinical services.

4.7 Summary

One of the main findings from reviewing the literature on shame in adolescence is that it is somewhat neglected, both in research and practice. There are a limited number of studies that explore the links between shame and different psychopathologies in young people, and as indicated this could be because of the
lack of relevant measurement tools. The development of the SSA might help overcome some of these methodological issues. Although this study suggests that the SSA could potentially be a reliable measure of adolescent shame, more studies are required to validate this questionnaire. Test-retest analyses are needed to further assess reliability in particular. The factor structure of the SSA also needs confirming and as specified the outward expression factor needs further exploration. Clinically the SSA could possibly become a very useful tool, as it not only allows respondents to think of personally shaming situations but it also taps into the cognitive, affective, and behavioural components of the shame experience.


*Volume I – Research Dossier*


## APPENDIX 1: SYSTEMATIC LITERATURE REVIEW

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APPENDIX 2: LIST OF SHAME MEASURES

Adapted Shame and Guilt Scale (ASGS) – Hoblitzelle (1982), as cited in Harder and Zalma (1990)

Revised Shame and Guilt Scale (RSGS) – Hoblitzelle (1987)

The Other as Shamer scale (OAS) – Goss et al. (1994)

Adapted Dimensions of Conscience Questionnaire (ADCQ) – Gilbert et al. (1994)

The Compass of Shame Scale (CoSS) – Elison et al. (2006)
APPENDIX 3: PARTICIPANT INFORMATION SHEET (STUDY 1)

My name is Susie Chester and I am training to become a clinical psychologist. I would like to invite you to take part in my research study. Before you decide, you need to know what you will be asked to do. Please take the time to read this information sheet.

The research

The aim of this study is to develop a new questionnaire that measures shame in 11-16 year olds.

What will you need to do?

A teacher will have asked some people if they would like to take part in an interview about shame, and the teacher will have given you these forms to take home with you. Please give your parents this information sheet and the letter to read. Once you have read these forms you might have decided that you would like to take part in the interviews. If so, then you and your parents will need to sign the consent forms saying that you have agreed to do the interview. If you have decided to take part, then I will arrange with your school a good time for you to have this interview. If you want to ask any questions about this interview before you decide then you can email me on s.chester@surrey.ac.uk

I will try and make the interview as relaxed as possible, so it is more like a chat. You will be asked about what you think shame is, and you will also be able to talk about different situations that might make young people feel ashamed or shameful. You will not have to talk about personal situations if you do not want to. I just want to get a better idea of things or situations that make 11-16 year olds experience shame so I can use these ideas to design a new questionnaire. You might tell me something personal which I think someone else needs to know about. It would only be then that I would need to talk to someone at school about what you have told me.
I would also like your permission to audio tape the interview so that I don’t have to remember everything that is said. This also means that I will not have to write anything down during the interview. The tapes will be stored safely and destroyed when the study is finished.

**Writing up the research**

The things that you share during your interview will be used to help me design a new shame questionnaire. This questionnaire, when it is finished, might be published in a scientific journal or be used in the NHS to help health professionals’ work with children and teenagers. However, nobody will know who took part in the interviews and your name will not be on any of the information.

**Your rights as a participant**

If you decide that you would like to take part in this study, this does not mean that you cannot change your mind. You will not need to tell me why you have changed your mind; you can just pull out if you wish. If you feel that you need to talk to someone after you have taken part in this study then please speak to your form tutor or school counsellor. If you or your parents have any concerns about you taking part in this study, please contact me on s.chester@surrey.ac.uk or Ms Mary John (Course Director of Psych D in Clinical Psychology) on 01483 689 441.
Are you the parent of a child aged 11-16 years? If so, I am looking for young people who are aged 11-16 years to take part in some research interviews.

I am training to become a clinical psychologist at the University of Surrey and as part of my qualification I am required to carry out a major research project. My project is exploring shame in young people and as part of my research I am hoping to develop a new questionnaire that measures shame in 11-16 year olds. The project has been granted a favorable ethical opinion from the University and is being supervised by Ms Mary John (Course Director) and Dr Laura Simonds (Research tutor).

Stage one of the project requires me to interview a number of young people, asking their opinions on shame and asking them to talk about situations that might make someone feel ashamed/shamed. This is where your help is needed as I am looking for young people to take part in these interviews. The interviews would take place at the University campus (Guildford) during the summer holidays and would last no longer than 30 minutes. The young people that take part would be entered into a prize draw with the chance to win a gift voucher. Signed consent from both the young person and parent would be required.

So, if you have children between the ages of 11 and 16 (boys and girls) and you think they would like to take part in this research then please email me on s.chester@surrey.ac.uk I will then forward you more information about the project.

Many thanks for your help with this, it is much appreciated.

Susie Chester
Trainee Clinical Psychologist
APPENDIX 5: LETTER GRANTING ETHICAL APPROVAL
Chair's Action

Ref: 322-PSY-09 RS
Name of Student: SUZANNE CHESTER
Title of Project Measuring shame in children and adolescents: The design of a new shame questionnaire
Supervisors: Mary John and Laura Simonds
Date of submission: 24th March 2009
Date of re-submission 5th May 2009

The above Project has been re-submitted to the FAHS Ethics Committee.

Favourable ethical approval has now been granted.

Signed: Dg Adrian Coyle
Chair

Dated: 14th May 2009
To whom it may concern,

My name is Susie Chester and I am a trainee clinical psychologist from the University of Surrey. As part of my doctoral degree, and qualification to become a clinical psychologist, I am required to carry out some research. I am investigating shame in children and adolescents and I am hoping to develop a new shame questionnaire that will be published and used in future research and clinical practice. To make this questionnaire as reliable and valid as possible I require some help from 11-16 year olds. I approached your child’s school and asked if they would be willing to take part in this research, and they agreed.

I have enclosed an information sheet that describes in more detail how I would like your child’s help with my research. I have also enclosed two consent forms, one for yourself to sign, and the other for your child to sign. Participation in this study is completely voluntary, and you and/or your child have the right to say no to taking part in this study. If you do however choose to participate, please complete the consent forms as soon as possible and ask your child to return them both to their form tutor.

Thank you in advance for your willingness to help out with my research project. If you have any questions or concerns about this study, then please feel free to email me on s.chester@surrey.ac.uk

Yours sincerely,

Susie Chester
Trainee Clinical Psychologist
University of Surrey
Consent Form – Person with parental responsibility

- I understand that Susie Chester (Trainee Clinical Psychologist) would like my permission for .............................................. to take part in a research study that is developing a new questionnaire that measures shame in 11-16 year olds.
- I have read and understood the Information Sheet provided. I have therefore been given a full explanation by the researchers of the nature, purpose, location and likely duration of the study, and of what my child will be expected to do.
- I understand that the project will not contain any information that would reveal the identity of my child or their school.
- I understand that the only people that will have access to the information collected during this study will be the researcher and her supervisors at the University of Surrey. I understand that any published work that may result from this study will not contain any identifiable information about any of the participants.
- I understand that the project (and material relating to it) is kept in securely locked premises.
- I understand that my child is free to withdraw from the study at any time without needing to justify their decision.
- I understand that in consideration for my child taking part in this study they will be entered into a prize draw with the chance to win a £10 Waterstones voucher.
- I confirm that I have read and understood the above and freely consent to my child participating in this study.

Name:
Signed:
Date:

Name of researcher: Susie Chester
Signed:
Date:
Assent Form – Young person

- I agree to take part in this study that is developing a new shame questionnaire.
- I have read and understood the Information Sheet provided. I have been given a full explanation of the study and I understand what I need to do.
- I understand that the project will not contain any information that will reveal my name or the name of my school.
- I understand that the only people that will have access to the information collected during this study will be Susie Chester and her supervisors at the University of Surrey. I understand that the questionnaire might become a published piece of work. If this happens, nobody will know the names of the people that took part in the study.
- I understand that the project (and material relating to it) is kept in securely locked premises.
- I understand that I can change my mind at any time and decide that I do not want to take part anymore. I will not need to say why I have changed my mind.
- I understand that for taking part in this study I will be entered into a prize draw with the chance to win a £10 Waterstones voucher.
- I confirm that I have read and understood the above and freely agree to take part in this study.

Name:

Signed:

Date:

Name of researcher: Susie Chester

Signed:

Date:
APPENDIX 8: INTERVIEW GUIDE

- Why did you decide to take part in this interview?
- What does the word shame mean to you?
- Tell them a definition if needed...ask if they agree/disagree.
- What do you think the difference between shame and guilt is?
- Again, tell them definitions...ask if they agree/disagree.
- Can you each describe a situation that might make someone feel shame?
- What are your experiences of shame (if want to share)?
- What does shame feel like? In mind? In body?
- What does shame make you think? Examples to get them thinking.
- What does shame make you feel like doing? Does it make you want to hide?
  Does it make you angry? What else does it make you feel like doing?
- What is the most shaming thing you can think of?
- Who feels shame? Are some people more prone to feeling like this?
- Is there a difference in shameful situations between boys and girls?
- Talk them through some of the TOSCA-A examples. Ask if they agree/disagree. Have they ever felt like that in similar situations?
I: First question. Why did you decide to take part in this interview?

P: Umm, a lot reasons. Firstly so I could get out of lesson (laughs), and because I'm part of something, part of research from a good university, and third because it seems quite fun. And I'm really happy that I got chosen as well.

I: Good honest answers, thanks for that. Now, a pretty tough question but how would you describe shame. What comes to mind when you think of the word shame?

P: Ummm, embarrassing, ummm, deceiving, like I don't know letting down your family and stuff. Ummm, untrusting comes into my head.

I: Brilliant thanks. Well I have a definition here and I want you to tell me if you agree with it, or if you thought shame was something different.

*Reads definition of shame* - Shame is described as an emotion that might make you feel small, worthless, and powerless. You might also feel exposed and you may want to escape, hide, or shrink into the ground.

P: Yeah, yeah

I: So was that what you were thinking about when you were describing shame?

P: Yeah really the same

I: Okay, so that's shame. Now shame and guilt are often used together..

P: in the same context?

I: Yeah. So people often use the two words interchangeably and get confused about the two things, whereas I think shame and guilt are different. How would you describe guilt?

P: Embarrassed, ummm, shameful maybe. Ummm...

I: And when do you think people feel guilt?
P: When they have done something, they feel guilty about what they have done. Like something to do with emotions as well.

I: Okay well again I have a definition so tell me what you think of this.

*Reads definition of guilt* - Guilt is an emotion that involves a sense of tension, remorse, and regret over the ‘bad thing’ done. When people feel guilt they wished they had behaved in a different way or wish they could undo the deed.

P: Yeah, I was thinking of bad things. So you feel guilty when you have done something bad.

I: Okay, so I have given you those because as I said people often get confused. So when I ask you the rest of the questions I want you to try and remember the difference between the two, and also try and remember your definitions of shame. So try and remember that shame is about how you feel in yourself about something, and guilt is more about the feeling about the thing done, not about yourself. Does that make sense?

P: Yeah, but shame can also happen after something has happened or you have done something bad.

I: Yeah definitely, but the difference in my mind is about what the feeling is about. So if you do something bad and you feel awful about the thing that you did then that would be more guilt. But if you did something bad and you felt awful about yourself and you wanted to hide or disappear then that would be shame.

P: Oh right, okay, yeah that makes sense. But you can still feel both can’t you? Because you might do something and feel guilty about it but then when your family find out you then feel ashamed as you have let them down.

I: Yeah that is a good example. Thanks.

I: So thinking more generally, not relating to you personally, what situations would make someone feel shame or ashamed?

P: Stealing, lying, ummm, betraying someone, ummm doing something bad to someone, doing things you shouldn’t be doing, like when you do something and you know you shouldn’t have done it. Umm, and making people feel less than they should do, like making people feel like they are not worth it.
I: Thanks for those. And now thinking a bit more personally, if you are happy sharing can you tell me a time where you have felt shame?

P: When I got my results back from school. I thought I had done really well and then my parents found out what levels I got and they were like well your older sister, she got all of these 8's and 7's and stuff, and it made me feel worthless. And it makes me feel that I shouldn't bother anymore because I'll never compare to what she is. As much as and as hard as I try I'll never reach her levels. But my parents don't understand that.

I: So that is a time where you have really felt ashamed?

P: Yeah

I: And that sounded like it was quite strong feeling of shame, and quite difficult to cope with.

P: Yeah coz you think that you have done your hardest and you are proper happy and then someone to come to you and be like, is this all you can do, it makes you feel shame.

I: And in that example do you think you felt any of those things? (points to definition)

P: Yeah, I felt like hiding and felt exposed as well.

I: Umm

I: Thinking more about the school context, what other things do you think make young people feel ashamed about at school?

P: Ummm, the type of things they wear and the clothes they wear. Most people feel ashamed about where they are from, so their background and stuff. But I don’t see the point of that because it is who you are and you should be proud of it.

I: But you think that is maybe a common thing for young people?

P: Especially if you are not, well everyone knows at school that there is levels. You get popular people and you get quiet, clever people. So if you are one of those quiet people and a popular person comes along and says look at you getting on with your work. The person might be ashamed of who they are.

I: So you think at school it is to do with popularity and being teased?
P: Yeah

I: And what about for young people at home. You have already mentioned how school work and grades can affect you at home, but can you think of any other situations at home that might make someone feel ashamed?

P: Umm, well little children when they wet the bed (laughs), that could be shameful. And, umm, that is all I can think of.

I: What about when young people do things they know they shouldn’t be doing?

P: Yeah and I think that comes under guilt as well, coz, like say smoking for example. You know all of your friends are doing it, and they’re all like you should do it, so you try it and then there is something in the back of your mind saying why are you doing this. And then your parents find out and they talk to you and you are like oohhhh why did I do that and you feel like you have shamed your family. And then you feel guilty coz there was part of you saying don’t do it and you felt like you should have listened to that other part.

I: That’s great thank you. So now if we use when of those examples, maybe the one where you talked about your grades as that was a good example, if you had to describe that feeling of shame in your body, what did it feel like? If you try and remember back when you felt ashamed how did your body feel?

P: Well when my mum said sometimes I wish you could be more like her....maybe I’m saying too much. But basically my sister is not my mum’s daughter, she is my step dad’s. And she said that she wished she could be her daughter and not me, so she could feel proud of her. And that made me feel like I wasn’t wanted. And that made me sad and feel like worthless because I thought that she was the one person who I could tell everything to and I thought she would understand how I was feeling. But instead it was like there was a wall there....the colour purple comes to mind for some reason.

Pause

P: And it also feels like stuff is being ripped apart inside. For me, well me and my mum have been through a lot and when she does not understand me it feels like that everything we had is now worth nothing. And for her to say that she is not proud of me, that is really shameful. Pause. I suppose the feeling is to cry. Curl up in a ball and hide away.
I: So I suppose you describe there a sense of longing to feel different?

P: Yeah and also a sense of regret. And you blame yourself for everything as well, even though you know you can't help stuff you still feel like you are to blame.

I: Hmm, thank you for sharing that.

I: Okay so we have talked about how shame can make you feel, and you have already touched on this next bit, but what does shame make you think?

P: ummm, what have I said already?

I: You talked about thinking that you were worthless and that you were to blame

P: It makes me think of the past and how things would have been if my dad had stayed, so I guess thoughts about how did stuff end up like this. Yeah.

I: So thinking about that example, what did the shame make you want to do? You mentioned wanting to curl up and cry but does it make you want to do anything else?

P: Yeah, well coz I get angry quite easily it makes me want to take it out on my older sister as well. It makes me want to hurt her for making me feel like that. So like I'll take something of hers and destroy it. Like I took her yearbook and ripped the pages. I think I wanted to do something to him that time but I couldn't do anything to him so I did something to her instead. And other times, I shout at her, scream at her, hit her...and at the time it feels good but when my mum finds out and after I have done it the whole thing happens again, so the shame feelings are there again about what I did. There was a stage when I thought it would be better if I wasn't around, as in dead, but I don't think like that anymore. I think that I was made and am on this world for a reason so...

I: Hmmm, sounds tough. And you say you don't think like that anymore, like you wish you were dead?

P: Nah, I think what's the point of feeling so sad. It's like I said, I was made to be someone and I always try and think that things will be better in the future.

I: But for you then there was a real sense of not wanting to be there anymore...

P: Yeah and I have packed my bags before.
I: So you wanted to not only hide for a short time but actually leave?

P: Yeah

I: So it was a pretty strong feeling?

P: Yeah

I: And the other thing you spoke about was that feeling of anger. So do you think shame can make someone feel angry?

P: Yeah, because there is nothing else you can do. You feel embarrassed and shameful so you try and brush it off with getting angry and physical. But you still have that pain at the back of your mind.

I: So, you think that not only can shame lead you to feel angry it can also make someone act on it too?

P: Yeah. They feel angry with themselves and that person that makes you feel like that. And for me I couldn't get to that person so I used the next best thing if you know what I mean.

I: Yeah, so not only is the anger at yourself but it also at the person that made you feel shamed?

P: Yeah

I: And thinking about in young people today and thinking about all the things that have been in the media about gun and knife crime, do you think shame could lead someone to do something like that?

P: I think that yeah and you probably know about all the gangs and that. Well some of my friends are involved in gangs and I try talking to them but they just get angry so I leave it. But one time this boy called this other boy gay, and that boy went up to him and started hitting him and I don't know why but maybe you know the male pride, well the pride they have. And I said to him why did you do that and he just went blah blah...

I: So do you think shame was involved there?

P: Yeah coz maybe he felt ashamed that he had been called gay, you know, and especially as he worked so hard to get his leadership.
I: Okay, so thinking more generally again, what thing do you think would be the most shaming ever?

P: For me?

I: Well it might be easier to relate it to yourself, but what do you think would be the most shaming thing that could happen?

P: Well I have a friend who is Indian and she hates it at parents evening coz her parents always come in their cultural clothes.

I: So for her the shame is about her family and culture?

P: Yeah

P: For me, ummm I don’t know

I: Do you think for you friends or family could make you feel the most ashamed?

P: Family, Yeah

I: And do you think everyone feels shame?

P: Everyone in their lifetime has felt shame at some point, adults, everyone.

I: And do you think some people are more prone to feel shame?

P: Uh huh

I: And what would make someone more prone do you think?

P: Maybe if they don’t like the way they are, their appearance or their background. The things they have, the things they don’t have. The way they live, like how their life is, and why sometimes things always go wrong for them.

I: Do you think personality has something to do with it?

P: It could, but you can’t really help who you are. Yeah maybe, if you are a type of shy person then maybe you tend to yeah... And then if you were a big, bold person then you wouldn’t care. Like if you were Muslim and you wore a headscarf then you would be like, and your point is! You wouldn’t care.

P: So you’re saying that if someone is more sensitive and shy, and not bold or the big person?
I: Okay, here I have some examples of shame. They are ones which other young people have spoken about before. If I read them then you can say if you agree or disagree if each example would be shaming for you. Try and think if that was you, if that happened do you think you would feel shame?

I: The first one, you trip in the school canteen and spill your drink. You think that everyone is looking at you and laughing at you.

P: I'll get up and start laughing so no

I: You and your friend are talking in class and you get into trouble. You think that everyone in the class is looking at you and talking about you.

P: I wouldn't really care (laughs)

I: Next one. You do not do very well in a test at school. You think that you are stupid.

P: Yeah, I get that a lot

I: Okay. You are being bullied by people in your year. You wonder why you do not have any friends and why no one likes you.

P: Ummm, there has been a time when I have thought that but I know that is not true now.

I: But if you were this person and you did think that no one liked you, do you think you would feel shame?

P: It depends, I don't know....

I: That's fine...don't worry

I: Okay, so bullies at school get hold of your homework and read it out to people in the playground. You want to run away and hide for a long time.

P: I would be like go ahead and read it! So no

I: And finally, you and your brother are fighting with each other but your mum only tells your brother off. You feel like you are a weak person for not saying anything.

P: I would laugh if that would happen because it is never going to happen!
I: Well thank you for that and can you think of anything else we haven't talked about or if you have any questions?

P: No, that's fine
APPENDIX 10: CODES AND FREQUENCIES

What is shame?

- Depends who you are with (friends, bullies, people you didn’t know – different reaction to same scenario (1)
- It is about what everyone thinks of me (1)
- Other people are involved (1)
- Disappointment (4)
- Feeling let down (1)
- Shouldn’t really feel it – bad thing to feel (1)
- Shame is about yourself/the feelings you have about yourself (5)
- You do something to yourself and you are upset with yourself (1)
- You have to do or say something to feel shame (3)
- Deceiving (1)
- Untrusting (1)
- Purple (1)
- The feeling you get when you have done something wrong, that you have let yourself down (2)
- It is just inside, you can’t really describe it. But it is a feeling you have about yourself (1)
- You can’t stop the feeling (1)
- Definitely an emotion (3)
- You want to get away from the feeling (1)
- I guess it does make you feel bad (2)
- Showing a side of you that you don’t want to be seen. You don’t want people to know how you are feeling (1)
- A feeling that you might feel but not show (1)
- Feeling that lives with you (1)
- The feeling you have inside you about you, that is shame (1)
- Bit like embarrassment but worse (1)
- Does not have to be about something you have done, can be about what other people do or say too (1)
- The definition describes it really well (3)

Scenarios – Times I have felt shame

- Ashamed of my family (1)
- Let my family down (I have shamed my family) (3)
- People cussing you in the street (1)
- The way I look (2)
- Friends have loads of new stuff – parents well off and you don’t have it (1)
- Arguing with mum (2)
• Arguing with people at school (3)
• Rape (girls' perspective) (1)
• Behaving really good at school and then you go and do something silly or stupid that gets you into lots of trouble (1)
• Bad in a test (2)
• Definitely more family life than school life (2)
• Not doing something that someone expected you to do well (1)
• Being bullied (9)
• Not having any friends (3)
• Getting told off (3)
• Being the bully (5)
• Foreign people coming into England (1)
• Parent is an alcoholic – make the child feel bad (1)
• Done something wrong (2)
• Saying something and not meant it (2)
• Everyone looking at you in class when you get something wrong (2)
• Sick over everyone (1)
• Someone in your family had special needs (1)
• If your mum is not the prettiest (1)
• If you are poor (1)
• Losing in sport (boys) (2)
• People laughing at you (4)
• Throwing your life away – missed opportunities (1)
• Getting into trouble at school (2)
• Not doing your course work (1)
• Not doing something but knowing that you are capable (1)
• Fighting with sister (1)
• Smoking behind mum's back (2)
• Peer pressure (1)
• Stealing (2)
• Asked to do something and you do not do it (1)
• Lying (2)
• Betrayal (1)
• Making people feel like they are not worth anything (1)
• Getting exam results back (1)
• Wearing the wrong clothes (2)
• What background you are from i.e. India (2)
• When little children wet the bed (1)
• On stage – forget what meant to say – everyone starring (1)
• Everyone else knowing the answer (1)
• Burnt some food (1)
• If you don’t have a mum or dad (1)
• If you don’t have a family (1)
• Committing a crime (1)
• Murder (2)
- Letting someone you care about down (1)
- Physically or mentally hurt your family or friends (1)
- Hurting someone behind their back (2)
- Trying to kill themselves but didn’t – ashamed for trying (1)
- Giving into peer pressure and doing something you didn’t want to do (2)
- Hurting someone by accident (1)

What shame feels like

- Something bad has happened to me (1)
- Feel that worthless feeling (2)
- Like I want to shrink (2)
- A deep sick feeling (1)
- Like you are really nervous and you shake a little bit (1)
- Worried feeling (2)
- Butterflies in your stomach (1)
- Sadness (5)
- Anger (6)
- Anger at myself (7)
- Anger at other people (5)
- Anger at the person that made them feel bad (5)
- Stupid (4)
- Weak (2)
- Depression/depressed (2)
- Small (3)
- Feel bad in yourself (2)
- Embarrassed (4)
- Anxious feeling (1)
- Shaky and worried (1)
- Annoyed at self (1)
- Frustrated inside (1)
- Fear (1)
- Low about yourself (1)
- Feels rubbish (2)
- Not a nice feeling (1)
- Felt like the elephant in the corner (1)
- Disappointed in yourself (1)
- Sick (3)
- Cross at yourself (1)
- Exposed (2)
- Ripped apart inside (1)
- Regret (1)
- A pain in the back of your mind (1)
- Powerless feeling (1)
• Downhearted (1)
• Self-conscious (1)
• Felt like I had been infected (1)
• Low (1)
• Deflated (1)
• Evil (1)
• Lonely (2)
• Bright red (1)
• Mixture between feeling worried and feeling embarrassed (1)
• Nervous, sick feeling (1)

When I feel shame I think....

• I want to run away (1)
• I want to get out of the situation (4)
• I am stupid (4)
• I am a nasty person (1)
• I am worthless (2)
• I have let myself down (5)
• I am ashamed of myself (2)
• Why did I do that? (3)
• I wish I could turn back time (2)
• No one likes me (6)
• I wonder what is going to happen today (school) (1)
• Why me? (1)
• It is going to happen again (1)
• I don't want to be here (1)
• It is my own fault (1)
• I should tell someone (1)
• I am useless (1)
• I don't exist (1)
• What are people thinking of me? (1)
• Why did I say that? (3)
• Why was I so stupid? (2)
• I want to magic myself away (1)
• I am no good (1)
• I hate that feeling (1)
• I am not good enough (1)
• I wish I could disappear (2)
• There is no point bothering anymore (1)
• I'll never compare to that person (1)
• I can't cope (1)
• I am ashamed of who I am (1)
• I am not wanted (1)
• I want to be different (1)
• I am to blame for everything (1)
• How did stuff end up like this? (1)
• It would be better if I was not around (1)
• I don’t want to be here anymore (1)
• Why didn’t I try harder? (1)
• I wish I could shrink away (2)
• I need to escape (1)
• The thing just replays in my mind, over and over (1)
• Why did I act like that? (1)
• I want to be somewhere else (1)
• I want to wake up from this nightmare (1)
• I want to camouflage into a wall (1)
• Oh my god…..arrrrrgghhh (1)
• I wish I didn’t do that (1)
• I wish it wasn’t me (1)

What shame makes me do

• Hide (3)
• Threaten someone (1)
• Sit in my room on my own and hide under the covers (1)
• Cry (2)
• Build up a cover, like a front, make themselves someone else (2)
• Exaggerate stuff, boast. (1)
• Make themselves sound better than they are (1)
• Seek revenge (2)
• Hurt someone physically (2)
• Throw evidence away (results) (1)
• Punch walls (1)
• Not speak to people/talk to anyone (2)
• Do something they do not want to do i.e. fights, stabbings, killings, suicide (1)
• Hurt others – the person who made you feel shame (4)
• Hurt yourself (1)
• Hurt other people not directly connected (1)
• Hit people (3)
• Scream at people (1)
• Run away (4)
• Escape (2)
• Shout (1)
• Stay off school (1)
• Curl up in a ball (2)
• Walk out of class (2)
• Destroy other people’s belongings (1)
• Pack my bags (1)
• Be on my own (3)
- Might try and kill themselves (2)
- Change who I was (1)
- Change the way I looked (2)
- Fly off the handle
- Look down on things (1)
- Try and fix the situation (2)
- Cover your face (1)
- Be violent (1)
- Break stuff (1)

Shame and guilt

- Shame comes in after guilt (1)
- Shame stays with you, guilt feelings change (1)
- Guilt is about what you did or said (4)
- Other people see the shaming thing and react to it (2)
- You might feel guilty about what you did but then you might feel shame because you feel bad in yourself (1)
- Feel both (2)
- Do something and feel guilty about what you did, but you might also feel shame about yourself as you have let yourself down (2)
- Shame is when people know about something, guilt is when no one knows about it (2)
- Shame stays in your mind longer (1)
- Feel shame and guilt together (2)
- Shame is about yourself, guilt is about other people, what you did to other people (2)

Girls and boys

- Girls feel more shame than boys (3)
- In boys it is more about money (1)
- Shameful situations might differ (4)
- Different make-up inside (1)
- Girls are more likely to keep it rather than let it go (1)
- Boys feel the anger more (2)
- Girls more likely to hide (2)
- Boys more likely to fight (3)
- Men feel it the same as females but they just don't show it (1)
- Stereotyping about the different situations that make girls and boys feel shame (1)
- Boys try and 'fix' it = fighting (2)
- Some situations might make girls feel ashamed but not boys, and vice versa (1)
- Some situations would be the same (2)
- Boys - sport (3)
- Girls - things that were said about them (2)
- In bulling = the same (2)
- Boys brush it off (2)
- Boys = aggressive route (1)

Does everyone feel shame?

- Yes – a feeling you are born with (2)
- Events trigger it (1)
- Worst childhood – more prone (1)
- Sensitive people feel it more (3)
- The causes differ (2)
- Experiences effect it (1)
- Situation versus personality (1)
- If you are a worry person then you might feel more shame (1)
- Everyone has a reason to feel ashamed (3)
- Can’t help the feeling (1)
- Vulnerable people might feel it more (1)
- Shy person = more (2)
- Bold/big people = less (1)
- If you have had something terrible happen to you (1)
- We all have a mind so we all feel it (1)
- Teenagers feel quite a lot of shame (1)
- Teenagers feel more (1)

Other things

- Hierarchy at work
- TOSCA scenario, Tripping in canteen – more embarrassed than ashamed – look like an idiot (5)
- In relation to stabbings/gun crime – the shame happens within the house, go out and take their anger out on someone else.
- You need space and time to get rid of the feeling
- Always be this feeling that would get in the way
- Try and ignore the feeling
- Leadership in gangs
- Bullies bully because they feel shame and they want to try and get rid of it. They make other people feel ashamed to make themselves feel better.
- Shame makes me want to try and fix the situation so I feel better
- Bullies can’t take the feeling of shame so they pass it on to someone else.
- Maybe the people who didn’t intend to bully feel shame. They might feel shame when they didn’t mean to act in such bad ways.
- When you feel angry and hit the bully you feel even more shame. Doubly shamed because you have hurt someone now as well.
- People in gangs blank out the feelings of shame and act hard
- Shame is a cycle (attempt suicide – not do it – shame – attempt suicide again because acting on the shame)
- Have to do something bad or wrong to feel shame (3)
- You might be angry at yourself for being so weak
- High levels of shame when lots of things in someone's life are bad/unfortunate
APPENDIX 11: CATEGORIES FROM THE CONTENT ANALYSIS

Shaming situations
School
Being bullied
Bulling
Being horrible to others
Family ashamed of me
Ashamed of my family
Peer pressure
Money
Crime
Lying and betrayal
Suicide

What shame feels like
Worried
Embarrassed
Disappointed
Angry at self
Angry at other people
Sadness
Frustrated
Not a nice feeling
Worthless
Thoughts associated with shame
What other people think of me
I want to....... 
Why? 
Give up 
Let self down 
I am......... 

What shame makes me do
Damage property 
Be alone 
Hurt self 
Hurt others (non physical) 
Hurt others (physical) 
Crying 
Shout and scream 
Change self 
Build cover or front 
Fix situation (Guilt response?)
Are you the parent of a child aged 11-16 years? I am looking for young people to take part in an online research study.

I am training to become a clinical psychologist at the University of Surrey and I am currently developing a new questionnaire that measures shame in 11-16 year olds. For my project I need a large number of young people to fill in some online questionnaires – this should take approximately 20 minutes. All participants will be entered into a prize draw with the chance to win book vouchers.

Before your child can take part, you will need to give your consent. This can be done online when you click the link below. As soon as consent has been gained your child can complete and submit the questionnaires via the same link.

So, if you have children between the ages of 11 and 16 (boys and girls) and you think they would like to take part in this research then please click here:

Many thanks for your help, it is very much appreciated.

Susie Chester
Trainee Clinical Psychologist
University of Surrey

This project has been granted a favorable ethical opinion from the University and is being supervised by Ms Mary John (Course Director) and Dr Laura Simonds (Research tutor).
WANT TO TAKE PART IN A PSYCHOLOGY RESEARCH PROJECT?

Hello. My name is Susie Chester and I am training to become a Clinical Psychologist. I would like to invite you to take part in my research study. Before you decide, you need to know what you will be asked to do. Please take the time to read this information sheet.

The research

The aim of this study is to develop a new questionnaire that measures shame in 11-16 year olds.

What you will be asked to do?

I am going to ask young people from your school to fill in some questionnaires. These questionnaires look at different feelings and emotions including shame, mood, self-esteem and anger. I have designed one of these questionnaires and as part of my research I need to check if my questionnaire is working ok. To do this I need lots of 11-16 year olds to fill in the questionnaires.

You do not have to take part in this study, but if you do want to take part you will need to sign a consent form (please see the attached forms). If you are under 16 you will also need to get your parents’ permission. Can you please give your parents/guardian this information sheet to read and the consent forms. You will need to bring both consent forms back before you can fill the questionnaires in.

Writing up the research

I am hoping the questionnaire I have designed will be good at measuring shame. If it is then my questionnaire might be published in a scientific journal. It might also be used to help professionals’ work with children and teenagers who are experiencing problems in their lives. However, nobody will know who took part in this research,
and your name or school will not be on any of the information that is published or available to others.

**Your rights as a participant**

If you decide that you would like to take part in this study, this does not mean that you cannot change your mind. You will not need to tell the researcher why you have changed your mind; you can just pull out if you wish. If you feel that you need to talk to someone after you have taken part in this study then please speak to your form tutor or school counsellor. If you or your parents have any questions or concerns about you taking part in this study, please contact me on s.chester@surrey.ac.uk
APPENDIX 14: PARENT/GUARDIAN LETTER (STUDY 2)

Dear Parent/Guardian,

My name is Susie Chester and I am a Trainee Clinical Psychologist from the University of Surrey. As part of my doctoral degree, and qualification to become a Clinical Psychologist, I am required to carry out some research. I am investigating shame in children and adolescents and I am hoping to develop a new shame questionnaire that will be published and used in future research and clinical practice. To make this questionnaire as reliable and valid as possible I require some help from lots of 11-16 year olds. I approached your child’s school and asked if they would be willing to take part in this research, and they agreed.

I have enclosed an information sheet that describes in more detail how I would like your child’s help with my research. I have also enclosed two consent forms, one for yourself to sign and the other for your child to sign. Participation in this study is completely voluntary, and you and/or your child have the right to say no to taking part in this study. If you do however choose to participate, please complete the consent forms as soon as possible and ask your child to return them to their form tutor.

I hope all of this makes sense and I thank you in advance for your willingness to help out with my research project. If however you have any questions or concerns about this study, then please feel free to email me on s.chester@surrey.ac.uk

Thank you again,

Yours sincerely,

Susie Chester
Trainee Clinical Psychologist
University of Surrey
INSTRUCTIONS

Please read all of the information at the start of each questionnaire and answer all of the questions. Even if you are not sure of an answer please pick one. There are no right or wrong answers; you just have to pick the answers that describe you best. Please work on your own.

Name....................................................................
Form group............................................................
Age........................................................................
Male/Female (Please circle)

Thank you for taking part in this study.
QUESTIONNAIRE 1 (TOSCA-A)

Below are descriptions of a variety of situations. After each situation you will see two statements about different ways that people might think or feel. As you read each statement, really imagine that you are in that situation now. Please indicate which box (with a tick) describes how likely it is that the statement would be true for you.

EXAMPLE:

You wake up early one morning on a school day.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not at all likely</th>
<th>Unlikely</th>
<th>Maybe (half and half)</th>
<th>Likely</th>
<th>Very likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would eat breakfast right away.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would feel like staying in bed.</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Now look at the situations below and mark with a tick how true each statement is for you:

1. You trip in the cafeteria and spill your friend’s drink.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not at all likely</th>
<th>Unlikely</th>
<th>Maybe (half and half)</th>
<th>Likely</th>
<th>Very likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would be thinking that everyone is watching me and laughing.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would feel very sorry. I should have watched where I was going.</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

2. For several days you put off talking to a teacher about a missed assignment. At the last minute you talk to the teacher about it, and all goes well.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not at all likely</th>
<th>Unlikely</th>
<th>Maybe (half and half)</th>
<th>Likely</th>
<th>Very likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would regret that I put it off.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would feel like a coward.</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
3. While playing around, you throw a ball and it hits your friend in the face.

<table>
<thead>
<tr>
<th></th>
<th>Not at all likely</th>
<th>Unlikely</th>
<th>Maybe (half and half)</th>
<th>Likely</th>
<th>Very likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would feel stupid that I can't even throw a ball.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would apologise and make sure my friend feels better.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. You and a group of classmates worked very hard on a project. Your teacher singles you out for a better grade than anyone else.

<table>
<thead>
<tr>
<th></th>
<th>Not at all likely</th>
<th>Unlikely</th>
<th>Maybe (half and half)</th>
<th>Likely</th>
<th>Very likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would feel alone and apart from my classmates.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would tell the teacher that everyone should get the same grade.</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

5. You break something at a friend’s house and then hide it.

<table>
<thead>
<tr>
<th></th>
<th>Not at all likely</th>
<th>Unlikely</th>
<th>Maybe (half and half)</th>
<th>Likely</th>
<th>Very likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would think ‘This is making me anxious. I need to either fix it or replace it.’</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would avoid seeing that friend for a while.</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

6. At school, you wait until the last minute to plan a project, and it turns out badly.

<table>
<thead>
<tr>
<th></th>
<th>Not at all likely</th>
<th>Unlikely</th>
<th>Maybe (half and half)</th>
<th>Likely</th>
<th>Very likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would feel useless and incompetent.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would feel that I deserve a bad grade.</td>
<td></td>
<td></td>
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</tbody>
</table>

7. You wake up one morning and remember it’s your mother’s birthday. You forgot to get her something.

<table>
<thead>
<tr>
<th></th>
<th>Not at all likely</th>
<th>Unlikely</th>
<th>Maybe (half and half)</th>
<th>Likely</th>
<th>Very likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would think “After everything she has done for me, how could I forget her birthday?”</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would feel irresponsible and thoughtless.</td>
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<td></td>
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<td></td>
<td></td>
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</tbody>
</table>
8. You walk out of a test thinking you did extremely well. Then you find out you did poorly.

<table>
<thead>
<tr>
<th>Not at all likely</th>
<th>Unlikely</th>
<th>Maybe (half and half)</th>
<th>Likely</th>
<th>Very likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would feel that I should have done better. I should have studied more.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would feel stupid.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. You make a mistake at school and find out a classmate is blamed for the error.

<table>
<thead>
<tr>
<th>Not at all likely</th>
<th>Unlikely</th>
<th>Maybe (half and half)</th>
<th>Likely</th>
<th>Very likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would keep quiet and avoid the classmate.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would feel unhappy and eager to correct the situation.</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

10. You were talking in class, and your friend got blamed. You go to the teacher and tell him the truth.

<table>
<thead>
<tr>
<th>Not at all likely</th>
<th>Unlikely</th>
<th>Maybe (half and half)</th>
<th>Likely</th>
<th>Very likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would feel like I always get people in trouble.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would think &quot;I'm the one who should get into trouble. I shouldn't have been talking in the first place.&quot;</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

11. You and a friend are talking in class, and you get in trouble.

<table>
<thead>
<tr>
<th>Not at all likely</th>
<th>Unlikely</th>
<th>Maybe (half and half)</th>
<th>Likely</th>
<th>Very likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would think &quot;I should know better. I deserve to get into trouble.&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would feel like everyone in the class was looking at me and they were about to laugh.</td>
<td></td>
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</tbody>
</table>

12. You make plans to meet a friend. Later you realise you stood your friend up.

<table>
<thead>
<tr>
<th>Not at all likely</th>
<th>Unlikely</th>
<th>Maybe (half and half)</th>
<th>Likely</th>
<th>Very likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would think &quot;I'm inconsiderate.&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would try to make it up to my friend as soon as possible.</td>
<td></td>
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</tr>
</tbody>
</table>
13. You volunteer to help raise money for a good cause. Later you want to quit, but you know your help is important.

<table>
<thead>
<tr>
<th></th>
<th>Not at all likely</th>
<th>Unlikely</th>
<th>Maybe (half and half)</th>
<th>Likely</th>
<th>Very likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would feel selfish,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and I’d think I am</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>basically lazy.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would think “I</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>should be more</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>concerned about doing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>whatever I can</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>to help.”</td>
<td></td>
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</tr>
</tbody>
</table>

14. Your report isn’t as good as you wanted. You show it to your parents when you get home.

<table>
<thead>
<tr>
<th></th>
<th>Not at all likely</th>
<th>Unlikely</th>
<th>Maybe (half and half)</th>
<th>Likely</th>
<th>Very likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Now that I got a bad</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>report, I would feel</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>worthless.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would think “I</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>should listen to</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>everything the teacher</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>says and study</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>harder.”</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

15. You have recently moved to a new school, and everyone has been helpful. A few times you had to ask some big favours, but you returned the favours as soon as you could.

<table>
<thead>
<tr>
<th></th>
<th>Not at all likely</th>
<th>Unlikely</th>
<th>Maybe (half and half)</th>
<th>Likely</th>
<th>Very likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would feel like a</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>failure.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would be especially</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>nice to the people</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>who had helped me.</td>
<td></td>
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</tr>
</tbody>
</table>
QUESTIONNAIRE 2 (SSA first version)

It is common for young people to experience feelings of shame. However, people vary in the type of situation that makes them feel shame or ashamed. Shame can occur when you have done something or when someone else has done something to you.

Here are some examples of situations that might make young people feel shame:

- You are being bullied
- You make a mistake in front of your whole class and everyone laughs
- You do badly in a test and you feel like you let yourself or your family down
- Your family can't afford to buy you all the newest gadgets or most fashionable clothes
- You are horrible about your best friend behind his/her back

IMPORTANT

Can you think of some situations that have happened recently where you have felt shame? Please write down a few situations like the examples above.

1.

2.

3.
Now read each item below and circle the box next to how you would generally think and feel in situations like the ones you have written down.

**EXAMPLE:** Thinking back to times when you have felt shame you need to rate how much you thought “I am rubbish at everything”.

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little bit</th>
<th>Quite a bit</th>
<th>A lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>I thought “I am rubbish at everything”</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Complete the statements below thinking back to the times you have felt shame.

<table>
<thead>
<tr>
<th>When I felt shame........</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Quite a bit</th>
<th>A lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>I thought “I have let myself down”</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I felt worried</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I thought “I have let other people down”</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I felt worthless and small</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I wanted to be on my own</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I thought “Other people must think I am no good”</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I thought “I am a nasty person”</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I wanted to shout and scream</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I wanted to change who I was</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I felt angry at myself</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I felt angry at other people</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I wanted to seek revenge</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I thought “No one likes me”</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I felt disappointed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I wanted to cry</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I thought “Other people must think I am stupid”</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I thought “I can’t cope”</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I wanted to punch walls or break things</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I felt sad</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I had a horrible feeling inside</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I thought “I am no good”</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I wanted to hurt myself</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I wanted to build up a cover or front</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I felt embarrassed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I thought “Other people must think I am nasty”</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I thought “I am stupid”</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I wanted to hurt someone else</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I felt frustrated</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I wanted to destroy other people’s belongings</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I thought “It is better if I was not around”</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
**QUESTIONNAIRE 3 (PANAS-C)**

This scale consists of a number of words that describe different feeling and emotions. Read each item and then circle the appropriate answer next to that word. Indicate how much you have felt this way **during the past few weeks**.

<table>
<thead>
<tr>
<th>Feeling or emotion</th>
<th>Not much or not at all</th>
<th>A little</th>
<th>Some</th>
<th>Quite a bit</th>
<th>A lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interested</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Sad</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Frightened</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Excited</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Ashamed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Upset</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Happy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Strong</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Nervous</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Guilty</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Energetic</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Scared</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Calm</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Miserable</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Jittery</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Cheerful</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>Active</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Proud</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Afraid</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Joyful</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Lonely</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Mad</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Disgusted</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Emotion</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>-----------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Delighted</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blue</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Gloomy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Lively</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
**QUESTIONNAIRE 4 (ROSENBERG SE SCALE)**

Below is a list of statements dealing with your general feelings about yourself. If you strongly agree tick the **Strongly Agree** box. If you agree with the statement, tick **Agree**. If you disagree, tick **Disagree**. If you strongly disagree, tick **Strongly Disagree**.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel that I am a person of worth, at least on an equal plane with others.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel that I have a number of good qualities.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All in all, I am inclined to feel that I am a failure.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am able to do things as well as most other people.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel I do not have much to be proud of.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I take a positive attitude toward myself.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>On the whole, I am satisfied with myself.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I wish I could have more respect for myself.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I certainly feel useless at times.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At times I think I am no good at all.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
QUESTIONNAIRE 5 (AESC)

Everyone feels angry from time to time, but people differ in how they act when they are angry. Below are some statements that people might use to describe themselves and how they act when they feel angry. Read each statement and describe how often the statement applies to you when you feel angry. You should circle the number in the box that you think is true for you.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Almost never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Almost always</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel angry.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I feel like yelling at someone.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I get very impatient if I have to wait for something.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I lose my temper easily.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I feel like breaking things.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I feel grouchy or irritable.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I get in a bad mood when things don’t go my way.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I have a bad temper.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I get very angry if my parent or teacher criticises me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I get in a bad mood easily.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I slam doors or stomp my feet.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I keep it to myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I control my temper.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I let everybody know it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I try to be patient.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I argue or fight back.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I keep my cool.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I hit things or people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I feel it inside, but I don’t show it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Statement</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>I stay well behaved.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I say mean or nasty things.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I stay mad at people but keep it a secret.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I try to stay calm and settle the problem.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have a temper tantrum.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I hold my anger in.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I try to control my anger feelings.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

THANK YOU!
Appendix 16: QUESTIONNAIRE ITEMS FROM THE THREE DIMENSIONS

Cognitive dimension
I thought I had let myself down
I thought I had let other people down
I thought it was better if I was not around
I was thinking I wanted to disappear
I thought “I am no good”
I thought that other people must think I am no good
I thought “I am a nasty person”
I thought that other people must think I am nasty
I thought that other people must think I am stupid
I thought “I am stupid”
I was thinking no one likes me

Affective dimension
I felt embarrassed
I felt worried
I felt disappointed
I felt frustrated
I felt angry at myself
I felt angry at other people
I felt worthless and small
I felt sad
I had a horrible feeling inside
Behavioural dimension

I wanted to be on my own
I wanted to hurt myself
I wanted to hurt someone else
I wanted to seek revenge
I wanted to shout and scream
I wanted to change who I was
I wanted to build up a cover/front
I wanted to cry
I wanted to destroy other people's belongings
I wanted to punch walls or break things
### APPENDIX 17: TABLE SUMMARISING NORMALITY OF VARIABLES

<table>
<thead>
<tr>
<th>Total sample (N = 87)</th>
<th>Transformation</th>
<th>Skewness</th>
<th>Kurtosis</th>
<th>Kolmogorov-Smirnov</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Statistic</td>
<td>Std. Error</td>
<td>Z-score</td>
<td>Statistic</td>
</tr>
<tr>
<td>TOSCA SHAME</td>
<td>N/A</td>
<td>-.298</td>
<td>.258</td>
<td>-.135</td>
</tr>
<tr>
<td>TOSCA GUILT</td>
<td>N/A</td>
<td>-.198</td>
<td>.258</td>
<td>-.599</td>
</tr>
<tr>
<td>PANAS POS AFF</td>
<td>N/A</td>
<td>-.584</td>
<td>.258</td>
<td>-.178</td>
</tr>
<tr>
<td>PANAS NEG AFF</td>
<td>N/A</td>
<td>.796</td>
<td>.258</td>
<td>.299</td>
</tr>
<tr>
<td>AESC TRAIT</td>
<td>N/A</td>
<td>.647</td>
<td>.258</td>
<td>.353</td>
</tr>
<tr>
<td>AESC ANG EXP</td>
<td>INVERSE</td>
<td>1.029</td>
<td>.258</td>
<td>.270</td>
</tr>
<tr>
<td>AESC ANG SUP</td>
<td>N/A</td>
<td>.414</td>
<td>.258</td>
<td>-.542</td>
</tr>
<tr>
<td>AESC ANG CON</td>
<td>N/A</td>
<td>-.037</td>
<td>.258</td>
<td>-.700</td>
</tr>
<tr>
<td>RSE</td>
<td>N/A</td>
<td>.095</td>
<td>.258</td>
<td>-.394</td>
</tr>
<tr>
<td>SSA TOTAL</td>
<td>N/A</td>
<td>.439</td>
<td>.258</td>
<td>-.494</td>
</tr>
<tr>
<td>SSA FACTOR 1</td>
<td>N/A</td>
<td>.692</td>
<td>.258</td>
<td>.394</td>
</tr>
<tr>
<td>SSA FACTOR 2</td>
<td>N/A</td>
<td>.743</td>
<td>.258</td>
<td>-.399</td>
</tr>
<tr>
<td>SSA FACTOR 3</td>
<td>N/A</td>
<td>-.170</td>
<td>.258</td>
<td>-.278</td>
</tr>
</tbody>
</table>

Note: Criteria used to assess normality of kurtosis and skewness values (Field, 2005): Small sample size (N<100): Z-score of >2.58 considered non-normal.
## APPENDIX 18: TOTAL VARIANCE EXPLAINED (SEVEN-FACTOR SOLUTION)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Total</th>
<th>% of Variance</th>
<th>Cumulative %</th>
<th>Total</th>
<th>% of Variance</th>
<th>Cumulative %</th>
<th>Total</th>
<th>% of Variance</th>
<th>Cumulative %</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10.107</td>
<td>33.692</td>
<td>33.692</td>
<td>9.723</td>
<td>32.411</td>
<td>32.411</td>
<td>6.676</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2</td>
<td>3.772</td>
<td>12.574</td>
<td>46.266</td>
<td>3.410</td>
<td>11.367</td>
<td>43.778</td>
<td>3.558</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>3</td>
<td>2.086</td>
<td>6.952</td>
<td>53.218</td>
<td>1.682</td>
<td>5.606</td>
<td>49.384</td>
<td>5.990</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>1.308</td>
<td>4.359</td>
<td>57.577</td>
<td>.945</td>
<td>3.148</td>
<td>52.532</td>
<td>3.220</td>
<td></td>
<td></td>
<td></td>
</tr>
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Extraction Method: Principal Axis Factoring

a. When factors are correlated, sums of squared loadings cannot be added to obtain a total variance.
APPENDIX 19: TOTAL VARIANCE EXPLAINED (THREE-FACTOR SOLUTION)

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Extraction Method: Principal Axis Factoring

* a. When factors are correlated, sums of squared loadings cannot be added to obtain a total variance.
Shame Scale for Adolescents

It is common for young people to experience feelings of shame. However, people vary in the type of situation that makes them feel shame or ashamed. Shame can occur when you have done something or when someone else has done something to you.

Here are some examples of situations that might make young people feel shame:

- You are being bullied
- You make a mistake in front of your whole class and everyone laughs
- You do badly in a test and you feel like you let yourself or your family down
- Your family can't afford to buy you all the newest gadgets or most fashionable clothes
- You are horrible about your best friend behind his/her back

IMPORTANT

Can you think of some situations that have happened recently where you have felt shame? Please write down a few situations like the examples above.

1.

2.

3.
Now read each item below and circle the box next to how you would generally think and feel in situations like the ones you have written down.

**EXAMPLE:** Thinking back to times when you have felt shame you need to rate how much you thought "I am rubbish at everything".

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<th>Not at all</th>
<th>A little bit</th>
<th>Quite a bit</th>
<th>A lot</th>
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<td>I thought &quot;I am rubbish at everything&quot;</td>
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Complete the statements below thinking back to the times you have felt shame.

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<th>Quite a bit</th>
<th>A lot</th>
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</thead>
<tbody>
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<td>I thought &quot;I have let other people down&quot;</td>
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<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>I felt worthless and small</td>
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<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>I thought &quot;Other people must think I am no good&quot;</td>
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<td>3</td>
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<tr>
<td>I thought &quot;I am a nasty person&quot;</td>
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<td>3</td>
<td>4</td>
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<tr>
<td>I wanted to shout and scream</td>
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<td>3</td>
<td>4</td>
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<tr>
<td>I felt angry at other people</td>
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<td>4</td>
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<tr>
<td>I wanted to seek revenge</td>
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<td>3</td>
<td>4</td>
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<tr>
<td>I thought &quot;Other people must think I am stupid&quot;</td>
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<td>3</td>
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<tr>
<td>I wanted to punch walls or break things</td>
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<tr>
<td>I felt sad</td>
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<td>I had a horrible feeling inside</td>
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<tr>
<td>I wanted to hurt myself</td>
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<td>3</td>
<td>4</td>
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<tr>
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<tr>
<td>I wanted to hurt someone else</td>
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<tr>
<td>I felt frustrated</td>
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<td>I wanted to destroy other people's belongings</td>
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APPENDIX 21: CORRELATIONS (PEARSON COEFFICIENTS AND SPEARMAN’S RHO)

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<td>13. SELF-ESTEEM</td>
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Note: Numbers underlined are Spearman’s Rho calculations. Two-tailed significance: * is significant at 0.05 level; ** is significant at 0.01 level.
Research Log
## Research Log Checklist

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1</td>
<td>Formulating and testing hypotheses and research questions</td>
</tr>
<tr>
<td>2</td>
<td>Carrying out a structured literature search using information technology and literature search tools</td>
</tr>
<tr>
<td>3</td>
<td>Critically reviewing relevant literature and evaluating research methods</td>
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<tr>
<td>4</td>
<td>Formulating specific research questions</td>
</tr>
<tr>
<td>5</td>
<td>Writing brief research proposals</td>
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<tr>
<td>6</td>
<td>Writing detailed research proposals/protocols</td>
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<td>7</td>
<td>Considering issues related to ethical practice in research, including issues of diversity, and structuring plans accordingly</td>
</tr>
<tr>
<td>8</td>
<td>Obtaining approval from a research ethics committee</td>
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<tr>
<td>9</td>
<td>Obtaining appropriate supervision for research</td>
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<td>10</td>
<td>Obtaining appropriate collaboration for research</td>
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<tr>
<td>11</td>
<td>Collecting data from research participants</td>
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<td>12</td>
<td>Choosing appropriate design for research questions</td>
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<td>13</td>
<td>Writing patient information and consent forms</td>
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<td>14</td>
<td>Devising and administering questionnaires</td>
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<tr>
<td>15</td>
<td>Negotiating access to study participants in applied NHS settings</td>
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<tr>
<td>16</td>
<td>Setting up a data file</td>
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<td>17</td>
<td>Conducting statistical data analysis using SPSS</td>
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<td>18</td>
<td>Choosing appropriate statistical analyses</td>
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<tr>
<td>19</td>
<td>Preparing quantitative data for analysis</td>
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<td>20</td>
<td>Choosing appropriate quantitative data analysis</td>
</tr>
<tr>
<td>21</td>
<td>Summarising results in figures and tables</td>
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<tr>
<td>22</td>
<td>Conducting semi-structured interviews</td>
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<tr>
<td>23</td>
<td>Transcribing and analysing interview data using qualitative methods</td>
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<tr>
<td>24</td>
<td>Choosing appropriate qualitative analyses</td>
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<tr>
<td>25</td>
<td>Interpreting results from quantitative and qualitative data analysis</td>
</tr>
<tr>
<td>26</td>
<td>Presenting research findings in a variety of contexts</td>
</tr>
<tr>
<td>27</td>
<td>Producing a written report on a research project</td>
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<tr>
<td>28</td>
<td>Defending own research decisions and analyses</td>
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<tr>
<td>29</td>
<td>Submitting research reports for publication in peer-reviewed journals or edited book</td>
</tr>
<tr>
<td>30</td>
<td>Applying research findings to clinical practice</td>
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</tbody>
</table>
Exploring trainees' perceptions of pregnancy and motherhood during clinical training, focusing particularly on whether there is a right time to have a baby.

ABSTRACT

This study adopted a qualitative methodology to explore trainees' perceptions of pregnancy and motherhood during clinical psychology training. Due to the specific nature of the research question, the five participants that took part in this study were current first year clinical psychology trainees from the University of Surrey. Participants each took part in a semi-structured interview which was subsequently transcribed and analysed using interpretive phenomenological analysis as outlined by Smith (2003). An interdependent matrix of themes emerged from the analysis consisting of four super-ordinate themes: 'coping with the course and life', 'searching for stability', 'is it the right time?' and 'juggling identity and role' and several related cluster themes. The results highlight trainees' perceptions of the factors influencing their decisions to become mothers during training. This study has potential implications for the course as to how they approach this issue in the future.