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# The Role of Shame and Self-Critical Thinking in the Development and Maintenance of Current Threat in Posttraumatic Stress Disorder

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## Overview

Part 1 of this thesis is a literature review which explores the relationship between posttraumatic stress disorder (PTSD), shame and inner dialogues. Cognitive theory suggests that PTSD results when an individual processes the trauma/trauma sequelae in a way that causes an ongoing sense of current threat. Although fear is the emotion most readily linked with threat, following from the ideas of Ehlers and Clark (2000) this study suggests that the experience of shame might also contribute to an ongoing sense of current threat, as it attacks an individual's psychological integrity, leaving them feeling inferior, devalued and socially unattractive. This study suggests that shame results when individuals engage in self-critical inner dialogues and also lack self-reassuring inner dialogues, which can make the self feel safe again. Part 2 is an empirical paper which tests the relationships proposed in the literature review. Specifically it is hypothesised that individuals with PTSD associated with higher levels of shame, will be more prone to engage in self-critical thinking and less prone to engage in self-reassuring thinking, than individuals with PTSD who report lower levels of shame, and that this would be independent of levels of depression. The results largely supported the hypotheses, with the exception that shame was not associated with self-reassurance independently of depression. Part 3 is a critical appraisal. The first section offers reflections on the research process, including limitations and ideas for future research. The second section outlines clinical implications of the research.

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# Part 1: Literature Review

## Posttraumatic Stress Disorder, Shame and Inner Dialogues

**Abstract**

Fear, helplessness and horror are the emotions traditionally linked with posttraumatic stress disorder (PTSD) and are central to the current diagnostic criteria. However recent research suggests that a range of other emotions may also play a role in PTSD, and researchers have specifically identified a subgroup of people whose severity of PTSD was linked to the severity of shame they experienced. Recently researchers have been interested in the role individuals' inner dialogues have on the development and maintenance of shame. Specifically it has been suggested that shame is linked to self-critical inner dialogues and an inability to be caring and compassionate towards the self. In this paper these ideas are explored in relation to PTSD. It is suggested that self-criticism and a lack of a caring and compassionate part of the self can lead individuals who have suffered a trauma to experience high levels of shame and as a consequence feel as if their psychological integrity is under threat. Continued self-critical attacks maintain a sense of ongoing current threat, which as specified in Ehlers and Clark's (2000) cognitive model of PTSD is central to the creation and maintenance of PTSD. It is suggested that treatment interventions that focus on the development of a caring and compassionate part of the self are likely to prove a beneficial adjunct to traditional exposure based treatments for individuals who have PTSD associated with high levels of shame.

## Introduction

Shame and its relationship to psychopathology has received substantial interest in recent years. For instance, shame has been known to play an important role in depression (Andrews, 1995; Gilbert, Pehl & Allen, 1994), social anxiety (Gilbert & Trower, 1990), alcoholism (Brown, 1991), hostility (Tangney, Wagner & Gramzow, 1992) and narcissism (Gramzow & Tangney, 1992; Wurmser, 1987). There is also an increasing recognition that shame might play a role in posttraumatic stress disorder (PTSD) (Andrews, Brewin, Rose & Kirk, 2000; Brewin, Andrews & Rose, 2000; Grey, Holmes & Brewin, 2001; Grey, Young & Holmes, 2002; Holmes, Grey & Young, 2005; Lee, Grey & Reynolds, in preparation; Lee, Scragg & Turner, 2001). PTSD has traditionally been associated with the emotions of fear, helplessness and horror. Indeed this subjective experience is central to the diagnostic criteria of PTSD (DSM-IV-TR, American Psychiatric Association, 2000). However recent research has shown that other emotions also play a role in PTSD and Andrews et al. (2000) found that shame independently predicted PTSD at one month and six months post trauma. Similarly Lee et al. (in preparation) identified a subgroup of people whose severity of PTSD was associated with the severity of shame they experienced.

Recent attention has been given to the role that individuals' inner dialogues might play in the development of affect (Gilbert, 2000; Gilbert, Baldwin, Irons, Baccus & Palmer, in press; Gilbert, Clarke, Hempel, Miles & Irons, 2004). It is proposed that just as individuals have dialogues with those in the external world, individuals can also have inner dialogues with themselves. This idea presupposes that individuals can act out multiple internalised self-roles. It is specifically thought that dominant-subordinate self-

self inner dialogues are linked to shame, where one part of the self is attacking and critical while another part feels attacked and criticised. Gilbert (2000) notes that individuals who experience shame also seem to lack the ability to be caring and compassionate towards the self, making it more likely that they will submit to their own self-critical attacks. He suggests that helping people develop inner caring and compassion towards the self may be an extremely important therapeutic technique when working with individuals experiencing shame.

The role of fear as a key emotion in PTSD has led to the application of therapeutic techniques that focus on imaginal exposure/re-living (Foa & Kozak, 1986; Foa & Meadows, 1997). However the recognition of other emotions in PTSD has fuelled the development of alternative and complementary approaches to traditional exposure based-treatment (Grey et al., 2002; Lee et al., 2001; Tarrier, Sommerfield, Pilgrim & Humphreys, 1999). The recent finding that some individuals with PTSD experience high levels of shame suggests that techniques that focus on developing an individual's inner caring and compassion may also be helpful in the treatment of PTSD.

This paper reviews the literature on PTSD, shame and inner dialogues, exploring the theory, evidence and relationships between these concepts. The paper begins with an exploration of PTSD, reviewing the conceptual history, diagnostic criteria, theories and current treatment. Shame is then explored, starting with a discussion on how shame differs from other emotions such as guilt and self-esteem. The origins and development of shame are then considered, specifically focussing on an evolutionary perspective. The literature that links shame and PTSD is then reviewed. Then next section focuses on

inner dialogues, exploring conceptual issues, origins and development and research. The potential relationship between PTSD, shame and inner dialogues is then presented. Specifically it is suggested that self-critical inner dialogues and a lack of a caring and compassionate part of the self can lead individuals who have suffered a trauma to experience high levels of shame. It is suggested that the experience of shame causes and/or maintains the current threat associated with PTSD, as it attacks an individual's psychological integrity, leaving them feeling devalued, powerless and socially unattractive. It is therefore proposed that treatment interventions that focus on developing caring and compassion might prove beneficial when working with this client group. The review concludes with a summary and discussion of ideas for future research in this area.

## Posttraumatic Stress Disorder (PTSD)

### Conceptual History of PTSD

PTSD was first formally acknowledged as a distinct diagnostic category in DSM-III (American Psychiatric Association, 1980) and was added primarily to resolve a dilemma for clinicians of how to classify seemingly 'normal' individuals who went on to develop long-term clinical symptoms after involvement in an extremely traumatic event. DSM-I and DSM-II (American Psychiatric Association, 1952, 1968, respectively) acknowledged the influence that stressful events could have on clinical symptoms (gross stress reaction, transient situational disturbance) but viewed longer term reactions to stress as being related to an individual's pre-morbid vulnerabilities, and thus attracted diagnoses such as anxiety or depressive neuroses (Yuhuda & McFarlane, 1995). The inclusion of PTSD in DSM-III allowed post-trauma reactions to be seen within a

framework of normal behaviour, where the primary cause of clinical symptoms was exposure to a traumatic event rather than an individual's pre-morbid vulnerabilities. This addressed the social and political agenda at the time which was trying to deal with the humanitarian concern about victims of trauma being labelled and blamed for their post-trauma reactions.

However PTSD as a normal response to a traumatic event does not fully explain the clinical picture of PTSD that has emerged, and Yuhuda and McFarlane (1995) have outlined a number of points that contradict the notion of PTSD as a normal stress response. Firstly they highlight the research that has shown that following exposure to a traumatic event PTSD tends to be the 'exception rather than the rule' and that research has failed to show a consistent association between the severity of PTSD and the magnitude of the trauma, which would be expected if PTSD was a normal stress response. They also draw on the literature that shows that individuals with PTSD have high rates of co-morbidity with other psychiatric disorders, which suggests that exposure to a traumatic event may trigger a whole host of symptoms and not just those associated with PTSD. This suggests that PTSD might be associated with an underlying predisposition to certain states, which is triggered by exposure to a traumatic event rather than PTSD being an isolated and normal stress response.

Recent theories of PTSD no longer view PTSD as a normal response to trauma and focus instead on trying to formulate what factors determine whether an individual will develop PTSD following exposure to a traumatic event (see section on *Psychological Theories of PTSD* below).

## Current Diagnostic Criteria for PTSD

DSM-IV-TR (American Psychiatric Association, 2000) outlines a number of criteria that an individual needs to meet in order to receive a diagnosis of PTSD. Exposure to a traumatic event is defined by; (1) direct personal experience of an event that involves actual or threatened death, serious injury or threat to one's physical integrity or (2) witnessing an event that involves death, serious injury or threat to the physical integrity of another person or (3) learning that a family member or close associate has suffered an unexpected or violent death, serious harm or a threat of death or injury. In order to gain a diagnosis of PTSD a subjective criteria must be met; an individual's response during the trauma must have involved feelings of intense fear, hopelessness or horror. In addition an individual must also be experiencing a range of symptoms following trauma, which include persistent re-experiencing of the traumatic event, avoidance of stimuli associated with the trauma, a numbing of general responsiveness and persistent symptoms of increased arousal. These symptoms need to be present for at least 1 month and cause significant impairment in social, occupational or other important areas of functioning (American Psychiatric Association, 2000).

## Difficulties with Current Diagnostic Criteria for PTSD

Recently the subjective component of the DSM-IV-TR criteria for PTSD has been criticised. It specifies that individuals must have experienced certain emotional reactions during exposure to a traumatic event, namely those of fear, helplessness or horror. However, Brewin et al. (2000) suggest that some individuals might have memory loss, such as those having suffered drug rape or head injury, which makes it difficult or impossible to attribute specific emotions that were experienced during a traumatic event.

They also feel that it is not unreasonable to expect that some individuals may respond to a traumatic event by feeling numb or dazed which is likely to impact on their ability to register or fully experience their emotional states at the time of the trauma. Some traumatic events happen so quickly that it is difficult for an individual to be aware of their emotional state at the time, such as in some motor vehicle accidents. Brewin et al. (2000) additionally make the distinction between 'primary emotions', such as those experienced at the time of the trauma, and 'secondary emotions' which are experienced after a traumatic event. They suggest that secondary emotions may be fundamentally different to primary emotions as they are based on cognitive appraisals following the trauma. They suggest that these secondary emotional reactions are likely to have an impact on the later development of PTSD but that these are not made reference to in DSM-IV-TR. Indeed, while research by these authors demonstrated that the emotions of fear, helplessness and horror experienced at the time of the trauma were related to the later development of PTSD, they also found that a sub-group of individuals did not appear to experience intense emotions at the time of the trauma, despite experiencing the other persistent features of PTSD. These individuals did however report strong emotions of either anger or shame (hypothesised secondary emotions) and these emotions had independent effects on later PTSD. The authors suggest that these results indicate that the current diagnostic criteria for PTSD may have to be amended to include emotions other than just fear, helplessness and horror, and that it may be beneficial to include secondary emotional reactions as well as primary ones.

Although it has been shown that there are a variety of emotional experiences associated with PTSD, theories of PTSD generally hold that the predominant emotional experience

is fear and feeling under threat. However theories of PTSD differ in their emphasis on how fear/threat develops and is maintained post-trauma and recent theories in particular allow an examination of how emotions other than fear may contribute to this.

## Psychological Theories of PTSD

### Early Theories of PTSD

Adverse reactions to trauma have been addressed by many different theorists, which has led to the development of biological theories (e.g., Van der Kolk, Boyd, Kystal & Greenburg, 1984), psychodynamic theories (e.g., Freud, 1919) and behavioural theories (e.g., Fairbank & Brown, 1987). However it is perhaps the cognitive theories of PTSD that have received the most attention and generated the most research in recent years and it is on these theories that this review will focus.

Two early cognitive theories of PTSD are the social-cognitive theories and the information processing theories. Social-cognitive theories focus on the impact of the trauma on an individual's pre-existing beliefs and how new trauma related information is integrated into these beliefs and/or shatters existing beliefs (Horowitz, 1973, 1976; Janoff-Bulman, 1985, 1992). In contrast the information processing theories of PTSD emphasise how trauma related information is stored and processed in the cognitive system (Foa, Steketee & Rothbaum, 1989). While both of these approaches have been highly influential they are unable to account for all of the clinical symptoms and relevant research data on PTSD. They also do not adequately explain why some individuals exposed to a traumatic event go on to develop PTSD while others do not. Brewin and Holmes (2003) review three recent theories of PTSD that they believe have greater

scope and stronger explanatory power than the earlier theories described above. These are; (1) The emotional processing theory (2) The dual representational theory and (3) Ehlers and Clark's cognitive model.

**Emotional Processing Theory**

The emotional processing theory (Foa & Riggs, 1993; Foa & Rothbaum, 1998) is based on an earlier information processing theory proposed by Foa et al. (1989), which suggested that traumatic events led to the creation of a fear network in memory, which consists of strong associations between stimuli associated with the trauma (sights, sounds, smells, texture), emotional, behavioural and physiological responses (fear, running away, heart pounding) and the meaning of the event (defenceless, at risk). The fear network is proposed to be easily activated and brought to conscious mind (re-experiencing symptoms) because higher order conditioning and stimulus generalisation mean that even stimuli remotely similar to those associated with the trauma can cause its activation. In order for the traumatic event to be integrated into the normal memory system the associations within the fear network need to be weakened. Foa et al. (1989) suggest that this can be done by deliberately activating the fear network through exposure and modifying it by adding information that is incompatible to it (such as the habituation of fear). The emotional processing theory elaborates on the fear network approach by incorporating ideas from the social-cognitive theories. For example, it includes ideas about how an individual's beliefs prior, during and after exposure to a traumatic event might interact and contribute to chronic PTSD. It is suggested that the more rigid an individual's beliefs prior to a traumatic event the more likely it is that an individual will develop PTSD. This applies equally to rigid positive and negative beliefs;

it is conceived that an individual with rigid positive beliefs would find it extremely hard to integrate contradictory trauma related information into their belief system whereas an individual with rigid negative beliefs would take trauma related information as evidence that their negative beliefs were true. According to the emotional processing theory exposure not only reduces associations within the fear network but also offers the individual an opportunity to re-appraise the event and their actions and thus ultimately modify unhelpful beliefs that may have been reinforced or developed since the trauma (Foa & Rothbaum, 1998).

**Dual Representation Theory**

Brewin, Dalgleish and Joseph (1996) also integrated elements of the social-cognitive theories with the information-processing theories in their dual representational theory of PTSD. They propose that there are two types of trauma memory; (1) situationally accessible memories (SAMs), which are not readily accessible to the conscious mind and are encoded at the time of the trauma in a sensory, fragmented and context less manner and (2) verbally accessible memories (VAMs), which are readily accessible to the conscious mind and can be deliberately and progressively accessed and updated in autobiographical memory. SAMs are thought to be stored in the amygdala whereas VAMs are thought to be stored in the hippocampus (Brewin, 2001). SAMs cannot be deliberately recalled but are activated by stimuli associated to the trauma and once activated they are often experienced as if the traumatic event is happening again in the here and now (flashbacks). The authors suggest that the emotions associated with SAMs are 'primary emotions', which were experienced when the traumatic event occurred. In

contrast VAMs are thought to be associated with 'secondary emotions', which result from cognitive appraisals following the traumatic event.

Brewin (2001) proposed that SAMs are formed because under extreme threat the hypothalamus secretes glucocorticoid steroids, causing impaired hippocampal processing, and thus VAMs which are likely to be incomplete and disorganised. In contrast the function of the amygdala is proposed to be enhanced in situations of extreme stress making it likely that detailed SAMs will be encoded. It is hypothesised that SAMs and VAMs will compete for retrieval and thus VAMs which are incomplete and disorganised will make it more likely that SAMs will have a retrieval bias. Brewin et al. (1996) propose that persistent PTSD is characterised by continued activation of SAMs and a failure to create sufficient VAMs. They propose that successful resolution of PTSD occurs when a sufficient number of VAMs are created which block the activation of SAMs. It is proposed that VAMs will have a retrieval advantage if they contain trauma information which is more distinctive, better rehearsed, and more recent, than the trauma information represented in the SAM system.

**Ehlers and Clark's Cognitive Model**

This model proposes that persistent PTSD only develops if individuals process the trauma/trauma sequelae in a way that causes them to experience a sense of ongoing current threat (Ehlers & Clark, 2000). This threat can been seen as external, such as seeing the world as a more dangerous place, or internal, such as seeing oneself as a less capable or acceptable human being. Once this sense of current threat is manifest in the aftermath of trauma it is accompanied by re-experiencing symptoms, symptoms of

arousal and adverse emotional reactions, which in themselves perpetuate the sense of ongoing current threat. It is proposed that individuals engage in a number of coping strategies aimed at minimising this threat, such as avoidance and control strategies, which in the long run actually maintain rather than reduce the sense of current threat generated.

Ehlers and Clark's (2000) cognitive model of PTSD proposes that there are two factors which lead to the development of a sense of ongoing current threat; (1) the nature of the trauma memory and (2) appraisals of the trauma and/or the trauma sequelae. Ehlers and Clark (2000) proposed that trauma memories that are poorly elaborated and inadequately integrated in context of time, place, subsequent and previous information and other autobiographical memories, lead to a sense of current ongoing threat. This is caused by the here and now quality produced once these memories are activated and the failure of these memories to be incorporated into an individual's belief systems. Interacting with this are people's appraisals of the trauma and/or its sequelae. Ehlers and Clark (2000) proposed several types of appraisals that can contribute to a sense of current threat being generated which include; negative appraisals of the traumatic event, negative appraisals of how one reacted during the trauma or how one has reacted since the trauma, negative appraisals of the symptoms of PTSD, and negative appraisals of the meaning of the traumatic event.

The three recent theories of PTSD presented above have all been highly influential and to some extent describe similar or overlapping ideas. They have all generated a great deal of research and have been able to account for many of the phenomena associated

with PTSD (Brewin & Holmes, 2003). However it is Ehlers and Clark's (2000) cognitive model of PTSD that has provided the most detailed account of the development and maintenance of PTSD to date, and has thus perhaps had the greatest impact clinically (Brewin & Holmes, 2003).

## Cognitive Behavioural Treatment of PTSD

Along with the variety of theoretical approaches to PTSD there are also a number of different treatment approaches that have been applied. However it is the cognitive-behavioural treatments that have received the most attention in recent years. There is now a substantial evidence base which demonstrates the effectiveness of cognitive-behavioural treatments for PTSD (e.g., Blake & Sonnenberg, 1998; Foa & Kozak, 1986; Marks, Lovell, Noshirvani, Livanou & Thrasher, 1998; Richards, Lovell & Marks, 1994) and recent guidelines published by the National Institute of Clinical Excellence (2004) advocate trauma focused cognitive behavioural therapy as the treatment of choice for PTSD.

Based on the idea that fear is one of the primary emotions experienced at the time of the trauma and is also likely to be re-experienced again alongside trauma related intrusions many cognitive-behavioural approaches have focused on the use of exposure based paradigms such as re-living as an important component in the treatment of PTSD. This has been done in a number of ways including systematic desensitisation (e.g., Frank et al., 1988), imaginal exposure (e.g., Foa, Rothbaum, Riggs & Murdock, 1991), in-vivo techniques (e.g., Foa et al., 1991; Thompson, Charlton, Kerry, Lee & Turner, 1995) and writing a detailed account of the trauma (e.g., Resick & Schnicke, 1993). A great deal of

research has shown that the use of prolonged imaginal exposure to memories of the traumatic event is an effective treatment intervention for PTSD. Indeed in their review of different treatment approaches for PTSD Foa and Meadows (1997) concluded that prolonged exposure 'might be considered the treatment of choice for PTSD' (p. 475). Nevertheless other cognitive-behavioural approaches that do not include exposure as a specific component have been shown to be successful in the treatment of PTSD. For example, Foa and Meadows (1997) also found that stress inoculation training, which is an anxiety management program drawing on different educational and skill components (e.g., relaxation, thought stopping and guided self-dialog) is successful in reducing symptoms of PTSD. Other studies have shown that cognitive therapy without exposure is also effective in treating PTSD, and that this is as successful as prolonged exposure (Marks et al., 1998; Tarrier et al., 1999). However Grey et al. (2002) note that although studies have shown the effectiveness of cognitive therapy they have not to date shown that cognitive therapy alone shows any advantage over prolonged exposure.

More recently treatments methods that include both an element of prolonged exposure and cognitive therapy have been advocated for the treatment of PTSD (e.g., Kubany et al., 2004). Indeed the cognitive model of PTSD (Ehlers & Clark, 2000) suggests that treatment for PTSD needs to address a number of different areas and that a multi-component approach is necessary. They discuss the need to; (1) elaborate and integrate the trauma memory into an individual's autobiographical memory system, which will reconcile it with an individual's prior and subsequent experiences and reduce re-experiencing symptoms (2) tackle any unhelpful secondary appraisals about the trauma or its sequelae that are contributing to an ongoing sense of current threat and (3) tackle

any unhelpful behaviours or cognitive strategies which might be preventing the individual from elaborating and integrating the trauma memory, maintaining dysfunctional cognitions or exacerbating symptoms. They suggest a variety of approaches that could be implemented to achieve this but recommend some of the following; education and rationale for the treatment plan, exposure (both imaginal and in-vivo), cognitive restructuring (both prior to exposure and during exposure), and imagery techniques. It is interesting to note that although the rationale behind exposure was initially based on the concepts of classical and operant conditioning and the habituation of fear, the cognitive model of PTSD (Ehlers & Clark, 2000) offers a different rationale for the use of exposure. The authors suggest a number of functions that exposure might play: firstly it allows the trauma memory to be accessed and elaborated, promoting its integration in autobiographical memory; secondly it can help identify idiosyncratic appraisals of the trauma; finally it can act as a behavioural experiment to counteract beliefs that individuals may have about not being able to cope with thinking about the trauma.

Grey et al. (2002) elaborate on the idea of cognitive restructuring during exposure and provide a comprehensive exploration and description of how this can be achieved clinically. They discuss the notion of peritraumatic emotional 'hotspots', which are conceived as peak moments of emotional distress in the trauma memory. They argue that applying cognitive restructuring to tackle these 'hotspots' during re-living can significantly enhance the effectiveness of treatment for PTSD. They suggest that this technique might be particularly relevant for peritraumatic 'hotspots' associated with negative-self evaluation, such as those related to feelings of shame, guilt and anger,

which unlike cognitions related to fear, are unlikely to spontaneously restructure through traditional exposure methods .

It is important that treatment for PTSD continues evolving and responding to recent research findings. Of specific interest to this review is the finding that some individuals with PTSD appear to suffer high levels of shame (Andrews et al., 2000; Brewin et al., 2000; Grey et al., 2001; Grey et al., 2002; Holmes et al., 2005; Lee et al., in preparation; Lee et al., 2001). Although recent therapeutic techniques are beginning to address the range of emotions suffered by individuals with PTSD, it is likely to prove beneficial if more research and thought is given to specific techniques that might prove particularly effective for individuals with PTSD suffering high levels of shame. These ideas will be discussed further below (see section on, *PTSD, Shame, and Inner Dialogues*). However, firstly it is important that the concept of shame is explored in depth.

## Shame

### Definitions of Shame

Shame has been defined as a 'self-conscious' emotion relating to feelings of powerlessness, inferiority, a sense of social unattractiveness and a desire to hide or conceal deficiencies (Tangney & Dearing, 2002; Tangney, Miller, Flicker & Barlow, 1996). As a result the experience of shame is often considered a private emotion which involves 'the self evaluating the self' and can have a wide ranging impact on an individual and their relationships (Tangney & Dearing, 2002). Shame can have different foci and what each person experiences as shaming will depend a great deal on their upbringing and cultural background. For example, some people might experience shame

about a particular part of their body, whilst others might feel shame about the kind of person they think they are or the kind of things they have experienced. Others might experience reflected shame, where shame is brought upon them through their relationship with others (e.g., being related to a criminal). Alternatively one's own shame can reflect onto others (e.g., family members, friends or cultural group). Whatever the foci of shame, the end result is that an individual feels devalued, inferior and socially unattractive as a result of their perceived deficiencies. Gilbert makes the distinction between external and internal shame (Gilbert, 1997). He proposed that external shame is related to what we believe others think of us (belief that others consider us unattractive and devalued), while internal shame is related to how we see ourselves (the self is experienced as unattractive and devalued). Of course these concepts are not conveyed as mutually exclusive and many individuals may experience both external and internal shame.

Although many researchers and clinicians are interested in the concept of shame, it is often confused with other emotions. It is important however to distinguish shame from these other emotions as they have differing impacts on cognition, behaviour and the development of psychopathology.

**Shame and Guilt**

The concepts of shame and guilt are often used interchangeably and Tangney and Dearing (2002) note that this applies to researchers as well as lay people. They cite a variety of examples where clinicians/researchers talk about 'shame and guilt' as if they were one and the same thing. They also highlight the fact that lay people often talk about

'guilt' when what they have really described is shame and that this is related to the fact that guilt is seen as the more socially acceptable emotion. However research has shown that although shame and guilt are related concepts and that many individuals are prone to experience both, these two concepts are actually fundamentally different in a number of ways. Research has shown that the situations that give rise to shame and guilt do not appear to differ very much from one another in content or structure (Tangney, 1992; Tangney, Marschall, Rosenberg, Barlow & Wagner, 1994). This suggests that it is the interpretations made by an individual in a given situation that gives rise to the differing experiences of shame and guilt. Lewis (1971) proposed that the fundamental difference between shame and guilt was the focus of the evaluation of a situation. She wrote the following; '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. In guilt, the self is negatively evaluated in connection with something but is not itself the focus of the experience' (page 30). For example, imagine an individual steals something from a shop. If the individual then evaluates the act of stealing in a negative way (negative evaluation of behaviour), then they are likely to feel guilt. However if they take the act of stealing as a sign that they are a worthless individual (negative evaluation of self) then they are likely to feel shame This view has been highly influential and there is now a great deal of research that supports the differential focus on 'self' and 'behaviour' in shame and guilt (Tangney & Dearing, 2002).

Shame and guilt also differ in terms of the impact they have on an individual and relationships. Shame is generally seen as a more painful emotion which leads individuals

to hide and conceal their perceived inadequacies. Guilt on the other hand usually has a much less global impact on the individual because its focus is normally on a specific behaviour rather then the self as a whole. Subsequently individuals are much more likely to want to confess and make reparations for their behaviour than hide and conceal their actions (as seen in shame). Tangney and Dearing (2002) talk about 'the dark side of shame' but see guilt as much less pathological. For example, research has shown that shame but not guilt is associated with hostility and anger (e.g., Tangney, Wagner, Fletcher & Gramzow, 1992). The authors suggest that because shame poses a greater threat to an individual's global sense of self than guilt, this subsequently leads to the adoption of maladaptive coping mechanisms such as avoidance and concealment, anger towards the self or projecting one's negative feelings onto others. Research has also shown that shame is associated with a diminished ability to empathise with others, whereas guilt is associated with an increased ability to empathise with others (see Tangney & Dearing, 2002, for a review). Tangney and Dearing (2002) suggest that this results from the distinction between 'self-focus' and 'behaviour-focus' in shame and guilt respectively. For example, the focus on the self in shame means that others are often overlooked, whereas the focus on the behaviour in guilt makes people focus on what they have done to others and thus a consideration of how others might be feeling.

Shame has also been shown to play a role in a variety of psychopathologies (see section on *Shame and PTSD* below) but there is a degree of controversy about whether the same applies for guilt. Some studies have shown that guilt does play a role in psychopathology (e.g., O'Connor, Berry, Weiss & Gilbert, 2002) but Tangney and Dearing (2002) suggest that this is because of the overlap between shame and guilt. They show that in many

studies an association between guilt and psychopathology is removed once guilt is examined independently of shame (something they term 'shame-free' guilt) and that in some cases guilt has even been shown to play a protective function. However, because many studies that show an association between guilt and psychopathology do not include a measure of shame it is not possible to ascertain if this is the case for all studies. On a similar note Kugler and Jones (1992) highlight that whether or not an association with psychopathology is found, depends on what measures of shame and guilt are used. Other researchers suggest that guilt only becomes pathological when it is impossible for an individual to make reparations for their perceived wrongdoing (e.g., Lee et al., 2001).

**Shame, Humiliation and Embarrassment**

Shame has also been likened to experiences of humiliation and embarrassment but again there are important differences between these concepts that need to be highlighted. Humiliation is seen to arise from situations in which an individual feels that they have been treated unfairly or abused in some way and that they were powerless to do anything to stop this (Gilbert, 1998). Thus feelings of humiliation are linked to beliefs that someone else is to blame for a personally damaging event and the other is seen as the 'bad' one. This is in direct contrast to shame in which it is the 'self' that is seen as 'bad' or deficient in some way. The focus on the 'bad other' in humiliation and the sense of injustice manifested leads individuals to have desires to take revenge, get even and ruminate about the experience. Again this is in contrast to the desire to avoid and conceal, which shame is thought to evoke. However it is useful to note that, as discussed earlier, in some cases individuals may try to cope with their shame by projecting it into

the external world and in these cases shame may also be linked to anger and blame of the other.

When examining the concept of embarrassment in relation to shame, Gilbert (1998) notes that although it is also a self-conscious emotion, it is generally considered milder and less pathogenic than shame. Embarrassment generally arises from specific actions or attributes and may lead to laughter or a humorous response (Miller, 1996). This can be contrasted to the more global and disabling experience of shame. Indeed, Miller and Tangney (1994) found that embarrassment tends to be related to surprising and trivial events whereas shame is related to incidents which threaten to reveal an individual's 'deep-seated' flaws.

**Shame and Self-Esteem**

A final distinction that needs to be made is between shame and self-esteem, which both involve negative evaluations of the self. Tangney and Dearing (2002) highlight that whereas self-esteem refers to a 'self-evaluative construct representing how a person appraises him/herself', shame refers to an 'affective state' (p. 57). One could argue that shame is the affective response to low self-esteem but researchers have found that low-self-esteem is linked to a variety of different affective responses (e.g., depression, anxiety) and not just shame. Tangney and Dearing (2002) further elucidate the difference between shame and self-esteem by suggesting that self-esteem refers to the way an individual appraises him/herself in general, across situations over time, whereas shame is the affective response to a negative evaluation of the self that stems from a specific event, transgression or attribute and is thus not necessarily reflective of one's

general level of self-esteem. They review a number of studies that consistently show negative correlations between shame and self-esteem but highlight that these correlations are reasonably modest in size, which suggests shame and self-esteem are related but independent concepts. They acknowledge that shame-proneness influences self-esteem and vice versa but suggest that there are a variety of other factors that might independently affect self-esteem and shame and thus that it is reasonable to expect that there are individuals who are prone to experience shame but have reasonably high self-esteem and vice versa. Drawing on Gilbert's (1997) distinction between internal and external shame is also helpful when looking at the distinction between shame and self-esteem. It would seem that while the concept of internal shame might be associated with self-esteem, the concept of external shame does not necessarily assume such an association. Indeed it is clearly possible that individuals are able to have a positive sense of self in the face of feeling looked down on and devalued by others.

Criticism of the conceptual difference between shame and self-esteem is perhaps in part related to how shame is actually measured. Many measures of shame have relied on global negative evaluations of the self as indicators of the experience of shame. Indeed, Andrews, Qian and Valentine (2002) emphasise that many measures of shame do not even make reference to the concept being measured (e.g., do not use the word shame). It is clear to see how such measures might be criticised for their potential overlap with the measurement of other concepts such as self-esteem. Andrews et al. (2002) designed and tested an alternative measure of shame (The Experience of Shame Scale) to combat these concerns. This measure directly makes reference to the concept of shame being measured (e.g., Have you felt ashamed of the sort of person you are?) and does not rely

solely on global negative evaluations of the self. For example, the measure also includes questions about concealment of deficiencies and an individual's concern about how one appears to others, which are both intimately linked to the experience of shame but not necessarily associated to self-esteem or a more general negative evaluation of the self (Andrews et al., 2002).

**Origins and Development of Shame**

Gilbert (1997, 1998) and Gilbert and McGuire (1998) take an evolutionary perspective on shame which pre-supposes that the mechanisms that underlie shame developed prior to self-consciousness and self-awareness. The evolutionary approach to shame requires recognition that humans have evolved specialised, psychological processing systems to achieve specific biosocial goals (Gilbert, 1997). These systems provide us with templates for forming attachments, friendships, sexual relationships and dominant and subordinate relationships and orient us to respond in certain ways to specific signals (Gilbert et al., in press). For example, these systems orient us to respond differently to signals of love and affection than to signals of threat and challenge. Gilbert (1997) suggests that shame evolved in relation to the management of threat, challenge and social rank/status. He suggests that shame serves the purpose of alerting others and the self to detrimental changes in status. For example, a typical shame response in animals is demonstrated by the subordinate who drops his head and cowers away from the dominant other, signalling that they have recognised their lowered status, and that the dominant other need not continue their attack. There is some evidence that humans also show submissive behaviour when they feel shamed, such as averting eye contact (Dixon, Gilbert, Huber, Gilbert & Van der Hoek, 1997). Shame thus functions to inform us that

we have acted in a way that might provoke attack/rejection and hence it signals to us that we should stop doing what we are doing if we want to minimise damage and try and induce the attacker/shamer to de-escalate and refrain from causing us serious harm. Shame can therefore be viewed as an important strategy for controlling our own and others behaviour, which aids in the maintenance of hierarchy and balance within groups and ultimately enhances an individual's inclusive fitness.

Although it has been proposed that humans have innate, psychological processing systems which help guide our responses, these systems are also influenced by our experiences. Gilbert et al. (in press) argue that in order for our innate psychological processing systems to be used effectively they need to have been stimulated, practised and elaborated. For example, if a child is not shown love and affection they will not have their innate capacities for feeling love and support stimulated and thus will not lay down emotionally supportive memories to draw on in times of stress. However conversely a child may have certain innate capacities over-stimulated which may also become problematic. For example, over-stimulation of the capacity to feel shame may lead to a dominance in shameful memories, which plague us in times of stress (Gilbert et al., in press). Our understanding of how our innate capacities are stimulated through experience can be aided by Baldwin's (1992) notion of interpersonal schema (see Gilbert et al., in press). Baldwin (1992) proposes that people develop relational schema, which act as templates of how to act in self-other interactions. For example, a child who is constantly criticised may develop a relational schema that others are dominant and that they are subordinate (stimulating innate dominant-subordinate capacities). If these relational schema are repeatedly reinforced the child may copy these judgements into

their own self-schema. Thus how others have treated us contributes to how we learn to treat ourselves. The experience of shame can therefore be viewed as the result of the activation of shaming dominant-subordinate self-other and/or self-self schema, which is linked to the stimulation of innate psychological processing systems. This has important implications when considering the notion of shame; whilst shame was originally conceived as a response triggered by inter-personal activity (e.g., when one is attacked or rejected by others) it can now also be conceived as a response to intra-personal activity (e.g., when one is attacked or rejected by oneself). Thus we no longer need others to shame us as we can now shame ourselves. Inherent in this proposition is the idea that people can act out two internalised self-roles; (1) the role of the attacker and shamer and (2) the role of the attacked and shamed. Indeed an individual is likely to have a number of different internalised roles, which might be triggered in different situations. This will be discussed again later in relation to the concept of 'inner dialogues' presented below.

**Shame and PTSD**

Shame is now considered one of the most powerful human emotions and is seen as one of the major factors in the development of a range of psychopathologies (Kaufman, 1989). For example, shame has been shown to play a role in depression (Andrews, 1995; Gilbert et al., 1994), social anxiety (Gilbert & Trower, 1990), alcoholism (Brown, 1991), hostility (Tangney et al., 1992) and narcissism (Gramzow & Tangney, 1992; Wurmser, 1987). In addition the experience of shame for many individuals with PTSD is being increasingly recognised (Andrews et al., 2000; Brewin et al., 2000; Grey et al., 2001; Grey et al., 2002; Holmes et al., 2005; Lee et al., in preparation; Lee et al., 2001).

Brewin et al. (2000) found in his sample of individuals with PTSD, that there were a number who did not report experiencing strong emotions of fear, helplessness and horror but did report feelings of shame and anger with others, which independently affected PTSD. Similarly, Andrews et al. (2000) found that shame independently predicted PTSD at one month and six months post trauma, and Lee et al. (in preparation) have specifically identified a subgroup of people whose severity of PTSD was associated with the severity of shame they experienced.

As mentioned earlier, the emotional experiences associated with PTSD can be thought of as either primary emotions, which occur at the time of the trauma or secondary emotions that occur as a result of cognitive appraisals subsequent to the trauma. Although shame has most often been conceived as a secondary emotion in PTSD it is also possible that it could be experienced as a primary emotion at the time of the trauma (Lee et al., 2001). If one draws on Gilbert's (1997, 1998) evolutionary view, in which shame is seen as a defensive strategy mobilised in situations of threat and challenge it becomes easy to imagine that feelings of shame could be evoked at the time of a trauma. Grey et al. (2002) note that clinical experience of working with individuals with PTSD indicates that emotions other than fear are also experienced at the time of the trauma. Indeed, Grey et al. (2001) and Holmes et al. (2005) investigated the emotions contained in 'hotspots' of trauma memory and found that as well as fear, helplessness and horror, patients also reported a range of other emotions, including anger, sadness and shame. Drawing on Brewin et al.'s (1996) notion of SAMs and Ehlers and Clark's (2000) cognitive model of PTSD, shame as a primary emotion would be seen to be stored in a fragmented, sensory trauma memory which would not have been adequately integrated

in the autobiographical memory system. Thus shame as a primary emotion would be primarily experienced in relation to flashbacks and re-experiencing symptoms.

Shame as a secondary emotion results from cognitive appraisals following a trauma, as an individual tries to make sense of what has happened to them. Cognitive appraisals that lead to shame might relate to what happened to an individual during the trauma, the symptoms of PTSD they are subsequently experiencing or the process of having to disclose details of the trauma and their actions. Whether shame is a primary or secondary emotion in PTSD has important implications for treatment. For example, cognitive restructuring for secondary shame reactions is recommended before exposure takes place. This is because the experience of shame can seriously reduce the effectiveness or can even be counter-productive to exposure, because the re-lived event is continuously interpreted through the activated shame schema. However cognitive restructuring for primary shame reactions is best done during exposure (see Grey et al., 2002) because these reactions are stored within the fragmented and un-integrated trauma memory, which needs to be activated in order that cognitive restructuring can take place. It must be noted however that it is likely that many individuals experience shame as both a primary and secondary emotion and thus a mixture of cognitive restructuring both prior to and during exposure might be necessary.

Lee et al. (2001) propose a clinical model of shame-based PTSD, which highlights the role of pre-existing schemas. They suggest that when the meaning of the trauma relates to a loss of status, reduced social attractiveness or a sense of being attacked and this matches a deeper meaning about the self (schema congruence) core shame schemas are

activated, leading to the experience of high levels of shame and highly charged shame-based trauma memories. This typically leads to avoidance of all things trauma related and a subsequent arrest in emotional processing. However when this meaning does not match a deeper meaning about the self (schema incongruence), the resulting emotional reaction is more likely to be that of humiliation, with the individual experiencing highly charged humiliation-based trauma memories. The sense of self is left relatively intact with blame being assigned to others. However in some cases of schema incongruence, shame may result if the traumatic event is so devastating that new maladaptive schemas are created, which replace pre-existing schemas. Lee et al. (2001) additionally propose a guilt-based model of PTSD, which similarly looks at the relationship with underlying schemas. In contrast to the shame based model which focuses on individuals feeling devalued, attacked and a loss of social attractiveness the focus in the guilt based model is that an individual feels that they have acted in a way that departs from acceptable standards and that they are responsible for damage/harm caused. According to this model if these beliefs activate underlying schema (schema congruence) then this will lead to pervasive feelings of guilt (and also possibly inter-linked shame). However if these beliefs are schema incongruent the experience will be of circumscribed guilt for the specific trauma event. In both cases intrusive images are likely to be charged with guilt but in the case of the activation of underlying schemas the possibility of inter-linked shame means that individuals are more likely to want to conceal and avoid their wrongdoings. In the case of schema incongruence however, the circumscribed nature of the guilt is more likely to motivate people to confess, and make reparations and this often leads to rumination of how they might have acted differently.

PTSD associated with high levels of shame can also be interpreted using Ehlers and Clark's (2000) cognitive model of PTSD. According to this model PTSD results when individuals process the trauma/trauma sequelae in a way that causes them to experience an ongoing sense of current threat. Shame can be seen as causing an ongoing sense of current threat in that it attacks an individual's positive internal sense of self and threatens their psychological integrity. It leaves an individual feeling attacked, devalued, or unattractive either in the eyes of others or themselves which means their sense of self as a valued and attractive person is constantly under threat. As well as affecting PTSD directly through the generation of ongoing current threat, shame may also affect PTSD indirectly through the mobilisation of cognitive and behavioural strategies that inhibit or prevent recovery. For example, feelings of shame are associated with desires to conceal and hide perceived deficiencies, making is less likely that an individual would seek social support, ask for help or work through the trauma memories themselves. As stated in Ehlers and Clark's (2000) cognitive model of PTSD, this type of avoidance means that the trauma is unlikely to be adequately processed and that evidence that disconfirms negative beliefs about the self is not discovered, and thus PTSD symptoms are maintained.

In sum, shame has been shown to be a very powerful emotion that plays a role in a range of psychopathologies. Shame can be thought about in relation to the activation or creation of dominant-subordinate self-self schema, which suggests that people can act out two internalised self-roles; (1) the attacker/shamer and (2) the attacked/shamed. This introduces the idea that individual's might have different 'inner voices' which can

engage in dialogue with one another. These ideas will be discussed further in the section below.

## Inner Dialogues

### The Concept of Inner Dialogues

For some, the idea of an internalised 'inner voice' (Gilbert, 2000; Hermans, 1996) may conjure up images of individuals suffering from a psychotic illness and at one level this would be accurate. Psychosis can be seen at one end of a continuum in which individuals have lost the ability to distinguish between voices heard in the external world and their own inner voice (Gilbert, 2000). However the notion of an inner voice as an ordinary part of human experience becomes apparent when considering the types of phrases that are used in every day conversations. For example, one regularly hears phrases such as 'I was just talking to myself', 'I was thinking out loud', 'I have all these thoughts running inside my head' and on a more severe level 'I've been beating myself up [*with my critical thoughts*]'. Indeed, Gilbert et al. (2004) make reference to an interview by Tim Adams with Billy Connolly, the famous Scottish comedian, who recalls hearing an internal voice talking to him inside a floatation tank, which said in response to some future plans he was thinking about, '*No, you'll never do that. No you're not good enough...*' (p. 32). This is a good illustration of how critical our inner voices can be, even if one is highly successful. The degree to which people feel they have actually heard an 'inner voice' is likely to vary and indeed the notion of an inner voice in many cases should be taken as a metaphor for an individual's thoughts, cognitions and internal images. This links closely with the notion of *automatic thoughts* used in cognitive therapy (Beck, 1995) but can also be linked with concepts used in

other theoretical orientations too. For example, in psychoanalytic theory Freud (1917) wrote about the superego delivering attacks against the ego, which conjures up the idea of an internal attacking part of the self and an internal attacked part of the self.

Although the examples cited above have mainly made reference to a self-critical inner voice it is clear that an individual's inner voice is not consistent in either content or tone. For example, an individual's inner voice might be caring and nurturing ('Take it easy today'), forgiving ('Don't worry, you're only human') motivating ('Come on – just keep going for a bit longer') or self-critical ('You're useless!'). It would thus seem more appropriate to conceptualise individuals as having a variety of different 'inner voices' which are mobilised in different situations, rather than having just one stable and predictable inner voice. Indeed Gilbert (2000) notes that 'the social nature of the internal world gives rise to a plurality of possible selves' (p. 125) and Hermans (1996) suggests that different parts of the self are likely to have different voices. The idea of multiple inner voices gives rise to the notion of 'inner dialogue'; that an individual's different inner voices can converse with each other internally. It can thus be conceived that there may be conflict and competition between different inner voices. For example, whilst cleaning the house an individual's caring inner voice might tell the self to 'take a break and relax' but then their motivating voice might step in and tell the self to 'carry on and finish the job now!'. Indeed Hermans (1996) highlights that there is likely to be some competition between our different inner voices and that some may be dominant and hostile whilst other will be submissive and hardly heard.

**Origins and Development of Inner Dialogues**

Just as the origin and development of shame was explored in relation to evolutionary psychology and relational schemas the origin and development of the inner voice and inner dialogues can also be explored in this way too. As discussed earlier Gilbert (1997) suggests that humans have evolved specialised, psychological processing systems, which act as guides on how to achieve specific biosocial goals (e.g., forming attachments). The degree to which an individual has access to these different systems depends on the degree to which these systems have been stimulated in early life. One way of thinking about the representation of these systems is in terms of Baldwin's (1992) notion of interpersonal schema which act as templates of how to act in self-other interactions (see Gilbert et al., 2004). However with the development of consciousness human beings developed the capacity to relate with themselves and thus humans are also seen as having intrapersonal schemas too, which act as templates for self-self interactions. This notion suggests that individuals can act out a number of different internal roles, each of which can be conceived as having a different inner voice. For example, if a dominant-subordinate self-self schema is activated, this might lead to a self-critical inner voice attacking another part of the self (e.g., 'You are no good at anything'). This might then activate the subordinate inner voice which admits defeat and agrees with the criticism being made (e.g., 'It's true, I really am useless'). This particular type of interaction has been referred to as topdog – underdog by Gestalt therapists (Greenberg, 1979) and is a clear example of inner dialogue between different inner voices.

Gilbert (1997) suggests that although many researchers treat self-critical dialogue as a unitary construct, there may in fact be many different forms and functions of self-

criticism. For example, he suggests that individuals might criticize themselves in order to try and improve themselves, to motivate themselves, to prevent themselves from making errors in the future or as a form of self-hatred. Gilbert et al. (2004) suggest that the different forms and functions of self-criticism might have evolved from different strategies for regulating interpersonal relationships. They suggest that self-critical thinking that aims to facilitate self-improvement might have evolved from strategies aimed at the coercion of subordinates. For example, the coercion of subordinates involves regulating the behaviour of others and stopping them acting in a way that would be detrimental. Gilbert et al. (2004) suggest that this type of interaction might be internalised into our own relationships with ourselves through our early experiences of parents/carers treating us in this way. Indeed parents are often critical of their children as a means of trying to help them improve (e.g., 'Your hand writing is too messy' or 'You're not working hard enough'). In contrast Gilbert et al. (2004) propose that self-critical thinking that is more persecutory and destructive in nature might have evolved from strategies aimed at controlling enemies or the 'out-group'. They suggest that these kinds of strategies are focused on attacking and destroying a hated other or perceived contaminant rather than changing subordinate behaviour. This kind of relating to the self is likely to be internalised through exposure to early experiences of abuse in which the child is attacked and criticised in this way by parents or carers (e.g., 'You are a disgusting and bad child').

While the self-critical inner voice tends to be activated in situations when we feel we have failed, been devalued and/or lost attractiveness, and the resulting experience is often submission, it has been suggested that there are other way individuals can respond

in these situations. Gilbert (2000) suggests that self-support or compassion is one such alternative. He suggests that the ability to feel warmth, to reassure, to forgive and to feel compassion developed from evolved strategies for forming attachments, friendships and maintaining relationships. He suggests that just as individuals can internalise the ability to self-criticise, they can also internalise the ability to self-reassure and feel compassionate about the self. It is suggested that this is influenced by the amount of reassurance, understanding and compassion an individual experienced from their parents at times of failure and disappointment when they were younger (Gilbert et al., 2004). If an individual can internalise the ability to self-reassure, forgive and be compassionate towards the self then the resulting response is likely to be one of feeling reassured, understood and cared for. This can be contrasted to the feelings of defeat and submission elicited by self-criticism and attack. Interestingly there is now growing evidence that caring and supportive signals can have physiological benefits, such as improving immune function (Uchino, Cacioppo & Kiecolt-Glaser, 1996). This can be contrasted to research that has shown that threat displays from dominant primates can significantly reduce blood serotonin (5-HT) levels in subordinates, the neurotransmitter that has a major impact on positive mood states, regulation of sleep, appetite and arousal (Raleigh, McGuire, Brammer & Yuwiler, 1984).

**Research on Inner Dialogues**

Gilbert et al. (2004) suggest that there is clinical evidence that individuals can experience an internal dominant-subordinate self-self relationship and engage in inner dialogues. They draw on clinical material involving the Gestalt technique of the two-chairs (Greenberg, Elliott & Foerster, 1990; Greenberg, Rice & Elliott, 1993). Using this

technique patients role-play their self-critical attacks on themselves from one chair and then change to the other chair to role-play their response to these attacks. This can be used to give patients an important insight into their own internal conflicts and illustrates the power of one's inner dialogues. Gilbert et al. (2004) note that clinical experience of using the two-chair technique reveals that depressed patients often respond to their self-critical attacks by accepting them as valid and adopting a submissive posture in their chair. Whelton and Greenberg (2005) undertook a research study to investigate students' responses to their own self-critical attacks using the two-chair technique. They found that students who were identified as high in self-criticism prior to the experiment (using the Depressive Experiences Questionnaire), often submitted to their own self-critical attacks, displayed sad and shamed facial expressions and felt that they were unable to defend themselves from these attacks. Greenberg et al. (1990) suggest that one of the major factors in the development of depression is the inability to defend oneself from one's own self-attacks. Indeed there is now a range of research that suggests that self-criticism does play a significant role in depression. For example, Zuroff, Moskowitz and Cote (1999) found that self-critical thinking was linked to poor interpersonal relationships and depression, Murphy et al. (2002) found that self-disparagement was significantly associated with life-time diagnosis of depression and Teasdale and Cox (2001) found that individuals who had suffered from depression in their past (but had recovered) were significantly more likely to subsequently become self-critical when their mood lowered, than individuals who had not previously suffered depression. Another interesting study by Gilbert et al. (2001) investigated self-critical thoughts in individuals with depression and malevolent voices in schizophrenia. They found that the

degree to which these thoughts/voices were experienced as dominating and powerful was significantly associated with depression.

Gilbert et al. (2004) investigated the concepts of self-criticism and caring and compassion towards the self, using a female student sample. Particular interest was paid to developing a questionnaire that measured an individual's ability to be caring and compassionate towards the self (referred to as 'self-reassurance'), having noted that no such measure currently existed. However they also wanted to develop a measure that investigated the different forms and functions of self-criticism. They developed two questionnaires; (1) Forms of self-criticizing/attacking and self-reassuring scale (FSCRS), (2) Functions of self-criticizing/attacking scale (FSCS). Factor analysis of the FSCRS showed that self-criticism and self-reassurance separated into two distinct components but more interestingly self-criticism also separated into another two distinct components. The first component of self-criticism they called 'inadequate self' which related to being self-critical, dwelling on mistakes and a sense of inadequacy, and the second component of self-criticism they called 'hated self' which related to desires to hurt the self and feelings of self-disgust. Factor analysis of the FSCS showed that the functions of self-criticism also separated into two components; 'self-improving' relating to desires to improve and motivate the self and 'self-persecuting' relating to desires to take revenge and harm one-self for failures. Mediation analysis suggested that this second 'self-persecuting' function was particularly pathogenic and was positively mediated by the 'hated self' dimension of self-criticism and negatively mediated by self-reassurance.

Gilbert et al. (in press) found similar results when they used these measures, finding that while depression was positively associated with self-critical thinking it was also negatively associated with self-reassurance. They concluded that it may be an inability to generate self-compassion and self-reassurance, as much as self-criticism that may contribute to psychopathology. They suggest the need to investigate self-critical thinking and self-reassuring thinking in other disorders. Of particular interest to this current review is how these concepts might be linked to shame and PTSD. These ideas will be explored further in the section below.

## PTSD, Shame and Inner Dialogues

As suggested earlier shame is a self-conscious affect associated with feelings of powerlessness, inferiority and a desire to hide or conceal deficiencies. An evolutionary perspective sees shame as having evolved from mechanisms for social relating and in particular those of the dominant–subordinate relationship. It has been suggested that this type of relationship can be internalised into one's own relationship with oneself, and thus that we no longer need others to shame us as we can now shame ourselves. The method by which individuals shame themselves can be thought about in relation to inner dialogues. For example, when individuals are faced with a situation in which they feel they have failed, been devalued and/or lost attractiveness various relational schema are likely to be activated. One possibility is that a dominant-subordinate self-self schema is activated, which manifests itself in the form of a self-critical inner voice, which attacks the part of the self that is seen as inferior and unattractive. Shame is seen to result when individuals submit to their own self-critical attacks. However shame is not the inevitable response to self-criticism. Some individuals may be able to respond to their self-

criticism with a caring and compassionate inner voice, which aims to re-assure, empathise and nurture the self. Thus shame is also associated with an inability to fight back or re-assure and care for the self. It may be that some individuals automatically respond to situations in which they feel they have failed and lost attractiveness, with a caring and compassionate inner voice, whilst for others this response may only result once the self-critical inner voice has been activated (immediate *caring – cared for* schema activation versus delayed *caring – cared for* schema activation). The latter may reflect the process involved for self-critical individuals in therapy, who have been taught techniques that will facilitate the activation of their caring and compassionate inner voices at times when they notice themselves becoming self-critical.

In order to address the relationship between PTSD, shame and inner dialogues it is helpful to return to Ehlers and Clark's (2000) cognitive model of PTSD. This model suggests that PTSD results when individuals process the trauma/trauma sequelae in a way that causes them to experience an ongoing sense of current threat. As suggested earlier shame can be seen as causing an ongoing sense of current threat in that it attacks an individual's positive internal sense of self and threatens their psychological integrity, leaving them feeling attacked, devalued and/or unattractive either in the eyes of others or themselves. The notion of inner dialogues offers us a way of understanding how the devastating experience of shame develops for individuals with PTSD. For example, it can be proposed that individuals who later go on to develop PTSD associated with high levels of shame, are likely to have interpreted the trauma and/or its sequelae as meaning they have been devalued, attacked or lost social attractiveness. This then activates (or creates) a dominant-subordinate self –self schema which manifests itself in a self-critical

inner voice. It can be proposed that these individuals are then unable to defend from themselves from their own self-critical attacks (e.g., can not access a caring, self-reassuring and compassionate inner voice) and thus submit and feel defeated by their self-critical inner voice. This then causes the individual to experience shame which causes/contributes to a sense of ongoing current threat and the subsequent development of PTSD. Shame can also be seen as maintaining PTSD in that it will continually re-activate the self-critical inner voice and hence individuals will constantly re-shame themselves which perpetuates a sense of ongoing current threat. As mentioned earlier shame can also lead to the adoption of unhelpful cognitive and behavioural strategies that inhibit or prevent recovery. Although this formulation has emphasised shame as a major cause of current threat for individuals who suffer from PTSD associated with high levels of shame, shame is not seen as exclusively influencing the degree of current threat experienced. In line with the cognitive model of PTSD (Ehlers & Clark, 2000) this formulation suggests that current threat is likely to be the result of many potentially interacting factors (e.g., nature of the trauma memory, other cognitive appraisals etc) but highlights the central role that shame is likely to play.

The relationship between PTSD, shame and inner dialogues proposed above, has a number of implications for treatment. In particular it suggests that individuals with PTSD associated with high levels of shame, might benefit from therapeutic techniques that promote caring and compassion. Indeed Lee (in press) recently outlined a possible technique that can be used to help patients develop inner caring and compassion, which can be used alongside traditional cognitive behavioural therapy for trauma. This technique involves helping clients create an image of a 'perfect nurturer' who is caring,

compassionate and meets their needs perfectly. The perfect nurturer is not a prescriptive image and individuals are encouraged to create an image which they will find most helpful. The perfect nurturer is designed to activate self-soothing emotions and once practised can be used to re-frame negative cognitions. Lee (in press) cites a case example of a women suffering PTSD associated with high levels of shame and depression, for whom traditional cognitive therapy techniques had failed to produce an emotional shift. However when the same cognitive techniques were used in conjunction with the 'perfect nurturer' a significant emotional shift was achieved (reduction in depression score) and improvements in functioning were achieved (return to work). This is a good illustration of how shame and manifest current threat to psychological integrity may respond more effectively when strategies that promote caring and compassion are used alongside exposure and traditional cognitive restructuring.

## Conclusions

### Summary

PTSD is traditionally associated with the emotions of fear, helplessness or horror but recent research has suggested other emotions may also play a role in the development and maintenance of PTSD (Andrews et al., 2000; Brewin et al., 2000; Grey et al., 2001; Grey et al., 2002; Holmes et al., 2005; Lee et al., in preparation; Lee et al., 2001). Andrews et al. (2000) found that shame independently predicted symptoms of PTSD one month and six months post trauma, and Lee et al. (in preparation) have identified a subgroup of people who severity of PTSD was associated with the severity of shame they experienced. An evolutionary perspective (Gilbert 1997, 1998; Gilbert & McGuire, 1998) suggests that shame is related to an internalised dominant-subordinate relationship

with the self, where one part of the self acts as attacker, whilst another part acts as the attacked. This idea suggests that individuals can have inner dialogues with themselves, where two different parts of the self communicate with each other. Gilbert (2000) suggests that clinicians can help individuals deal with self-critical inner dialogues by helping them develop a caring and compassionate inner voice. If these concepts are applied to individuals with PTSD associated with high levels of shame, it can be suggested that self-critical inner dialogues and the lack of a caring, reassuring and compassionate inner voice causes/perpetuates threat to an individual's psychological integrity (shame) and thus contributes to the development and maintenance of PTSD. This has important implications for the type of treatment interventions that might be beneficial for individuals with PTSD associated with high levels of shame. Techniques that help individuals develop a caring, reassuring and compassionate inner voice might be an important adjunct to more traditional methods of exposure and cognitive re-structuring.

**Suggestions for Research**

Having presented a possible formulation for the role of self-critical inner dialogues and the lack of self-reassuring, caring and compassionate inner dialogues in the development of shame in PTSD, one possible suggestion for future research would be to use the measures developed by Gilbert et al. (2004) described earlier (Forms of self-criticizing/attacking and self-reassuring scale[FSCRS]; Functions of self-criticizing/attacking scale [FSCS]), to investigate these relationships. The experience of shame scale (ESS) developed by Andrews et al. (2002) could be used as the measure of shame as it attempts to avoid the possible confound of measuring shame purely through

global negative self-evaluations, which is too closely related to the concept of self-critical thinking. The ESS attempts to measure shame directly by making reference to the concept of shame being measured (e.g., Have you felt ashamed of the sort of person you are?) and also looks at the other qualities intimately linked to the experience of shame but not necessarily linked to self-criticism. For example the measure includes questions about concealment of deficiencies and an individual's concern about how one appears to others. If a researcher had the time and the resources the ideal design for such as study would be prospective. For example, a researcher could recruit recently traumatised individuals and ask them to fill out questionnaires measuring their levels of self-criticism and their levels of self-reassurance and also the reasons why they criticise themselves (using the FSCRS and the FSCS respectively). These individuals could then be followed up one - six months later to establish which of them went on to develop PTSD, and specifically if self-criticism and a lack of self-reassurance is correlated with PTSD associated with high levels of shame. It might also be interesting to investigate the role the different forms and functions of self-criticism might play. Based on Gilbert et al.'s (2004) results one might predict that the 'hated self' dimension of self-criticism and the 'self-persecuting' function would be particularly pathogenic.

An alternative retrospective method would involve using the same basic design but this time recruiting individuals who had already developed PTSD. The advantage of using this method is that it does not have so many constraints on time or resources but the disadvantage is that one cannot establish causal relationships. For example, if a relationship was found between shame and self-critical thinking in a PTSD sample it could be argued that the experience of PTSD associated with high levels of shame leads

to self-critical thinking, rather than as we propose that a propensity to self-criticise is one of the components that contributes to the development of PTSD associated with high levels of shame. However, whether a prospective or retrospective design was used it would be anticipated that this kind of research would have important implications for treatment approaches for this client group.

In sum it seems that an evolutionary perspective on shame and the exploration of inner dialogues is a promising area for future research within the field of PTSD. It will not only enhance the current knowledge base but hopefully will also contribute to the development of new and complementary treatment approaches for PTSD, such as interventions that focus on inner caring and compassion. Helping individuals create or access a caring and compassionate part of the self is likely to prove beneficial in the treatment of a whole range of disorders, especially those associated with shame, and as a consequence is likely be an area of growing research.

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## Part 2: Empirical Paper

# The Role of Shame and Self-Critical Thinking in the Development and Maintenance of Current Threat in Posttraumatic Stress Disorder

**Abstract**

Posttraumatic stress disorder (PTSD) has traditionally been associated with the emotions of fear, helplessness and horror. However there is increasing recognition of other emotions in PTSD and recent research has looked at the role of shame. Cognitive theory has suggested that PTSD is caused by a traumatic experience being processed in a way that causes ongoing current threat. Following from the ideas of Ehlers and Clark (2000), this study suggests that shame might contribute to the creation/maintenance of ongoing current threat as it attacks an individual's psychological integrity, leaving them feeling inferior, socially unattractive and powerless. This study used a correlational design to investigate some of the factors that might be contributing to a shame response within a PTSD sample. It was hypothesised that individuals with PTSD who report higher levels of shame would be more prone to engage in self-critical thinking and less prone to engage in self-reassuring thinking than individuals with PTSD who report lower levels of shame, and that these relationships would be independent of levels of depression. Data were gathered using self-report questionnaires sent to patients on the assessment or treatment waiting lists at clinics offering treatment for PTSD. Results showed that shame was positively associated with self-criticism and negatively associated with self-reassurance. However once the variance due to depression and symptom severity was accounted for, only the relationship between shame and self-criticism remained significant. Results are discussed in relation to the role shame might play in generating current threat in PTSD and the implications this research has for treatment.

## Introduction

The key emotions currently associated with the diagnosis of posttraumatic stress disorder (PTSD) are fear, helplessness and horror (DSM-IV-TR, American Psychiatric Association, 2000). However recent research has shown that other emotions also play a role in PTSD. For instance, Grey, Holmes and Brewin (2001) and Holmes, Grey and Young (2005) investigated the emotions contained in 'hotspots' of trauma memory (peak moments of emotional distress) and found that as well as fear, helplessness and horror, patients also reported a range of other emotions, including anger, sadness and shame. Brewin, Andrews and Rose (2000) described a number of individuals with PTSD who did not report experiencing strong emotions of fear, helplessness or horror but did report feelings of shame and anger with others, which independently affected PTSD. Similarly, Andrews, Brewin, Rose and Kirk (2000) found that shame independently predicted PTSD symptoms at one month and six months post-trauma, in victims of violent crime. Lee, Grey and Reynolds (in preparation) have also identified a sub-group of treatment-seeking individuals, whose severity of PTSD was related to the severity of shame they reported.

Understanding the role that shame might play in PTSD can be aided by Ehlers and Clark's (2000) cognitive model of PTSD. This model proposes that persistent PTSD only develops if individuals process the trauma/trauma sequelae in a way that causes them to experience a sense of ongoing current threat. Although fear is the emotion that corresponds most readily with the notion of threat in PTSD, the cognitive model of PTSD (Ehlers & Clark, 2000) allows attention to be paid to other emotions and the role these might play in the development of ongoing current threat. For example, Ehlers and

Clark (2000) suggest that current ongoing threat can be seen as external, such as seeing the world as a more dangerous place (fear), or internal, such as seeing oneself as a less capable or acceptable human being (shame). Shame can be seen as causing internal current threat in that it attacks an individual's psychological integrity leaving them feeling inferior, socially unattractive and powerless. It can therefore be proposed that for some individuals PTSD is not necessarily maintained by fear but rather it is maintained by shame.

Given the central role shame appears to play in PTSD for some individuals, it is important that research starts to explore some of the different factors that might contribute to the generation and maintenance of shame in this disorder. This could help the development of treatment interventions tailored to the specific needs of this client group. One approach that offers important insights into the origins and development of shame is the psycho-evolutionary approach (Gilbert, 1997, 1998; Gilbert & McGuire, 1998). This approach suggests that shame evolved prior to self-consciousness, in relation to the management of threat, challenge and social/rank status. It is suggested that the function of shame is to alert the self and others to detrimental changes in status, provoking a submissive response in the shamed and hopefully a subsequent de-escalation in attack from the shamer (Gilbert, 1997). Shame thus evolved as a strategy to keep the self safe. A typical shame response in animals is demonstrated by the subordinate who drops his head and cowers away from the dominant other, signalling that they have recognised their lowered status, and that the dominant need not continue their attack. However with the development of self-consciousness humans have evolved

the capacity to have a relationship with the self, and thus we no longer need others to shame us as we can also shame ourselves.

Inherent in this proposition is the idea that individuals can act out a number of different internal roles and can therefore engage in internal dialogues with the self. Gilbert, Clarke, Hempel, Miles and Irons (2004) suggest that there is clinical evidence that individuals can engage in dialogue with the self and can experience an internal dominant-subordinate self-self relationship (self-critical inner dialogues), which can produce feelings such as shame. They draw on clinical material involving the Gestalt technique of the two-chairs (Greenberg, Elliott & Foerster, 1990; Greenberg, Rice & Elliott, 1993). Using this technique patients role-play their self-critical attacks on themselves from one chair and then change to the other chair to role-play their response to these attacks. Gilbert et al. (2004) note that clinical experience of using the two-chair technique reveals that depressed patients often respond to their own self-critical attacks by accepting them as valid and adopting a submissive posture in their chair. Indeed there is now a range of research that suggests that self-criticism does play a significant role in depression (Murphy et al., 2002; Teasdale & Cox, 2001; Zuroff, Moskowitz & Cote, 1999).

While self-criticism tends to be activated in situations when we feel we have failed, been devalued and/or lost attractiveness (as is the case for some survivors of trauma), it has been suggested that there are other ways individuals can respond in these situations. Gilbert (2000) suggests that self-support or compassion is one such alternative. He suggests that the ability to feel warmth, to reassure, to forgive and to feel compassion

developed from evolved strategies for forming attachments, friendships and maintaining relationships. He suggests that just as individuals can internalise the ability to self-criticise, they can also internalise the ability to self-reassure and feel compassionate about the self. If an individual can internalise the ability to self-reassure, forgive and be compassionate towards the self then the resulting response is likely to be one of feeling reassured, understood and cared for. This can be contrasted to the feelings of defeat and submission elicited by self-criticism and attack. Interestingly there is now growing evidence that caring and supportive signals can have physiological benefits, such as improving the function of the cardiovascular, endocrine and immune systems (Uchino, Cacioppo & Kiecolt-Glaser, 1996).

In order to measure some these concepts Gilbert et al. (2004) developed two new questionnaires, using a female student sample. The first questionnaire measured self-criticism and self-reassurance and separated into three separate components: (1) self-criticism; inadequate self (being self-critical, dwelling on mistakes and a sense of inadequacy) (2) self-criticism; hated self (desires to hurt the self and feelings of self-disgust) and (3) self-reassurance (positive and warm disposition to the self). The second questionnaire measured the functions of self-criticism and separated into two separate components: (1) self-improving (desires to improve and motivate the self) and (2) self-persecuting (desires to take revenge and harm the self for failures). Mediation analysis suggested that this second 'self-persecuting' function was particularly pathogenic and was positively mediated by the 'hated self' dimension of self-criticism and negatively mediated by self-reassurance. Gilbert, Baldwin, Irons, Baccus and Palmer (in press) also used these measures and found that while depression was positively associated with self-

critical thinking it was negatively associated with self-reassurance. They concluded that it might be an inability to generate self-compassion and self-reassurance, as much as self-criticism that may contribute to psychopathology.

If one applies these ideas to the experience of shame within PTSD it can be hypothesised that individuals who develop PTSD associated with high levels of shame, are likely to have interpreted the trauma and/or its sequelae as meaning that they have been devalued, attacked or lost social attractiveness. This may then reinforce/activate or create a dominant-subordinate self–self relationship which manifests itself in self-criticism. It can be proposed that these individuals are then unable to defend themselves from their own self-critical attacks (e.g., cannot self-reassure and be compassionate to the self) and thus submit and feel defeated. This then causes the individual to experience shame which causes/contributes to a sense of ongoing current threat central to the development of PTSD (Ehlers & Clark, 2000). Shame can also be seen to maintain PTSD in that it will continually re-activate self-criticism and hence individuals will constantly re-shame themselves, perpetuating a sense of ongoing current threat.

This current study explored self-criticism, self-reassurance and shame in individuals referred for treatment for PTSD. It was hypothesised that; (1) self-criticism and shame would have a positive association, (2) self-reassurance and shame would have a negative association, (3) the 'hated self' component of self-criticism would have a stronger association with shame than the 'inadequate self' component, (4) the 'self-persecuting' function of self-criticism would have a stronger association with shame than the 'self-

improvement' function of self-criticism (5) the relationships described above would be independent of levels of depression.

## Method

### Participants

Participants were 37 patients referred for treatment for PTSD, recruited from five outpatient services within the U.K. National Health Service. 157 patients were invited to take part, giving a 24% uptake rate. Inclusion criteria were that participants were experiencing significant posttraumatic symptoms (based on *Posttraumatic Stress Diagnostic Scale* or clinician's judgment). Patients were not invited to take part in the research if they had an insufficient command of English to complete the questionnaires or if they had a current psychotic illness. The sample consisted of 20 (54%) women and 17 (46%) men. Their mean age was 37 (range 21 – 56). They were from a range of ethnic backgrounds; White British (n = 19; 51%), White Irish (n = 3; 8%), White Other (n = 2; 5%), Black African (n = 1; 3%), Black Other (n = 1; 3%), Indian (n = 1; 3%) and Other (n = 4; 11%). There were missing data on ethnicity for 6 patients (16%).

In order to assess volunteer bias, patients who did not volunteer were compared to patients who did volunteer; no significant differences in age ($t\ [133] = -0.48$, $p = 0.63$) or gender ($\chi^2\ [1] = 0.08$, $p = 0.78$) were found. It was not possible to ascertain reasons why patients did not volunteer, as it was made clear on the patient information sheet that patients did not have to give reasons for not taking part in the study and that refusal would not affect the care they received at the clinic.

**Procedure**

Patients on the assessment and/or treatment waiting lists at five outpatient services offering treatment for PTSD were sent an optional research pack in the post. This consisted of an invitation letter, patient information sheet, consent form and the questionnaires outlined below. The research pack also contained three questionnaires from another related study. Patients were offered payment of £6 for returning completed questionnaires. Patients agreeing to take part in the research were asked to sign the consent form and complete the questionnaires and then either send them back in the stamped addressed envelope provided or return them to their clinician at their next appointment. Some patients were followed up with a phone call to find out whether or not they wanted to take part in the research. Patients could let us know that they did not want to take part in the research by filling out an opt-out slip on the patient invitation letter and returning it to us in a postage page envelope. Interestingly no patients filled out an opt-out slip.

In some cases participants had already filled out some of the questionnaires used in this current study (*Beck Depression Inventory* and *Posttraumatic Stress Diagnostic Scale*) as part of the assessment process at the outpatient service they were attending. Therefore in some cases there is a lag between the date participants filled out these questionnaires and the rest of the questionnaires used in this study. Across the whole sample the mean delay between measures was 3 weeks (range 0 – 13).

The research was approved by Camden and Islington Community Health Services Local Research Ethics Committee and Oxfordshire Research Ethics Committee. Confirmation letters of approval are given in Appendix 1. The patient invitation letter, patient information sheet and consent form are given in Appendix 2.

## Measures

### *The Posttraumatic Stress Diagnostic Scale (PDS: Foa, 1995).*

This measure was designed to assist with the diagnosis of PTSD. It is a 49 item paper and pencil self-report instrument based on the DSM-IV (American Psychiatric Association, 1994) diagnostic criteria for PTSD (now DSM-IV-TR, criteria unchanged). A diagnosis of PTSD is only recommended if all six of the DSM-IV criteria for PTSD are endorsed. The first section of the PDS requires respondents to indicate any traumatic events they have experienced or witnessed from a checklist of 12 traumatic events, including an 'other' category. Respondents are then asked to indicate the traumatic event that 'bothers them the most' and then answer questions assessing whether this event involved physical injury to self or others, concerns that their own or others life were in danger and whether they felt helpless or terrified during the event (Criterion A). The next section requires respondents to answer 17 questions corresponding to the symptoms of PTSD: re-experiencing symptoms (Criterion B); avoidance/numbing symptoms (Criterion C); and arousal symptoms (Criterion D). Summation of the scores on all 17 symptom questions yields a symptom severity score. The final section of the PDS assesses whether the respondent has experienced symptoms for over 1 month (Criterion

E) and whether the symptoms have caused disruption to an individual's functioning (Criterion F).

Foa, Cashman, Jaycox and Perry (1997) demonstrated that the PDS has high internal consistency and good test-retest reliability using a clinical population aged between 18 - 65 years. They also demonstrated the validity of the PDS by showing high levels of diagnostic agreement with a clinical interview assessing PTSD (Structured Clinical Interview for the DSM-III-R; Spitzer, Williams, Gibbons & First, 1990) and strong correlations with other measures of trauma-related psychopathology.

***Beck Depression Inventory (BDI; Beck, Rush, Shaw & Emery, 1979).***

This is a well established measure of depression, consisting of 21 self-report items measuring cognitive, affective and vegetative symptoms of depression. It has been shown to have good reliability and validity (Beck, Steer & Garbin, 1988).

***The Experience of Shame Scale (ESS: Andrews, Qian & Valentine, 2002; Appendix 3).***

This measure is based on a previous interview measure by Andrews and Hunter (1997). It is a 25 item questionnaire that assesses characterological shame, behavioural shame and bodily shame and also yields a total shame score. Questions address three core components: (1) an experiential component addressing whether an individual felt shame, for example, *'Have you felt ashamed of the sort of person you are?'*, (2) a cognitive

component addressing concerns about what others think, for example, *'Have you worried about what other people think of the sort of person you are?'*, and (3) a behavioural component addressing avoidance and concealment, for example, *'Have you tried to conceal from others the sort of person you are?'*. Participants respond according to how they have felt in the past year and each item is rated on a 4-point scale, ranging from 1 (not at all) to 4 (very much). Andrews et al. (2002) demonstrated that the ESS has good validity (correlation with other shame scales), high internal consistency and good test-retest reliability, for both the total scale and the sub-scales.

***The Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS: Gilbert et al. 2004; Appendix 4).***

This measure consists of 22 items examining how self-critical/attacking or how supportive/reassuring people are when things go wrong for them. Participants are presented with the following probe statement, 'When things go wrong for me...' followed by 22 items. Participants then rate each item using a 5-point Likert scale (ranging from 0 = not at all like me, to 4 = extremely like me). Gilbert et al., (2004) conducted a principal components analysis which indicated that the scale consisted of three sub-scales; (1) inadequate self, which relates to feeling internally put-down, inadequate and defeated (2) hated self, which relates to feelings of anger and disgust towards the self and (3) reassured self (or trait self-reassurance), which relates to a positive and warm disposition to the self and. The inadequate self and hated self components can be combined to create one score (self-criticism total), which has been called trait self-criticism. It is important to note that individuals can theoretically score

high on self-criticism and high on self-reassurance as these components are not simply opposite ends of a unitary construct. Gilbert et al. (2004) reported good internal consistency for these components and good convergent and discriminant validity.

***The Functions of Self-Criticising/Attacking Scale (FSCS: Gilbert et al. 2004; Appendix 5).***

This measure consists of 21 items examining the functions of why people self-criticise. Participants are presented with the following probe statement, 'I get critical and angry with myself...', followed by 21 questions reflecting possible reasons for self-criticism. Participants are required to respond on a 5-point Likert scale (ranging from 0 = not at all like me, to 4 = extremely like me). Gilbert et al. (2004) conducted a principal components analysis, which indicated two sub-scales; (1) self-improving/correction, which relates to desires to self-improve and (2) self-persecuting/harming, which relates to desires to take revenge, harm or hurt the self for failures. Gilbert et al. (2004) reported good internal consistency for these components.

## Results

This section will begin by presenting the characteristics of the traumatic experiences and posttraumatic symptoms reported by the participants in this study. The descriptive statistics of the questionnaires will then be explored, followed by an inspection of the structure of the questionnaires. Correlational analyses and hierarchical multiple regression will then be presented to test the hypotheses of this study. This will be followed by exploratory analyses.

Skewness and kurtosis were examined for all variables in order to check for normal distributions. As most variables did not have normal distributions, non-parametric analyses were used to analyse the data. However multiple regression analyses were performed using parametric tests because there is not a non-parametric equivalent. All tests are performed at the two-tailed level, except where there is a directional hypothesis, in which case one-tailed tests are used. In order to control for Type 1 error, tests were conducted at $p < 0.01$.

**Characteristics of Traumatic Experiences and Posttraumatic Symptoms**

All participants reported that they had experienced a traumatic event. The frequencies of traumatic events reported are outlined below in Table 1. Of the 37 participants 34 were given a full diagnosis of PTSD. This was established using the PDS and through discussion with clinicians involved in the case. The 3 participants who did not meet full diagnostic criteria, all reported significant re-experiencing symptoms and were judged by clinicians to be suffering significant posttraumatic symptoms. Of the 37 participants 30 had been experiencing their symptoms for more than 3 months (chronic), 5 had experienced their symptoms between 1 – 3 months (acute), and there were missing data for 2 participants. 23 of the participants started experiencing their symptoms less than 6 months after the traumatic event, 10 started experiencing their symptoms over 6 months after the traumatic event (delayed reaction), and there was missing data for 4 participants.

Table 1. Index Traumas Reported by Participants

| Index Traumas | Frequency (%) |
|---|---|
| Serious accident, fire or explosion | 14 (38%) |
| Sexual assault; known assailant | 6 (16%) |
| Non-sexual assault; stranger | 5 (13%) |
| Sexual contact under 18 | 4 (11%) |
| Sexual assault; stranger | 2 (5%) |
| Imprisonment | 1 (3%) |
| Life threatening illness | 1 (3%) |
| Other | 4 (11%) |

**Descriptive Statistics**

Table 2 gives the means and standard deviations for the questionnaires used in this current study and those obtained from non-clinical student samples. The mean PDS symptom severity score for this sample (32. 46, SD = 12.06) was similar to that obtained from another study (33.59, SD = 9.96) using a large sample of participants suffering PTSD (Foa et al., 1997). Indeed analysis showed that these scores did not differ significantly from each other ($z = 0.45$, $p = 0.65$).

The mean BDI score places this sample in the moderate range for depression (Kendall, Hollon, Beck, Hammen & Ingram, 1987) and was greater than the mean BDI score for the non-clinical sample. The mean shame scores on the ESS for this current sample were greater than the non-clinical sample, except for the bodily shame sub-component where

Table 2. Descriptive Statistics of Questionnaires Used in This Current Study and Those Obtained From a Non-Clinical Sample

| | | Current Study | | Non-Clinical Sample [a] | | | |
|---|---|---|---|---|---|---|---|
| | | M | SD | M | SD | z | p |
| PDS: | Symptom Severity Score | 32.46 | 12.06 | na | na | na | na |
| BDI: | Depression | 27.23 | 10.68 | 5.90 | 7.50 | 11.66 | < 0.001 |
| ESS: | Characterological Shame | 31.86 | 10.75 | 24.43 | 7.25 | 4.21 | < 0.001 |
| | Behavioural Shame | 26.16 | 7.33 | 21.25 | 5.50 | 3.70 | < 0.001 |
| | Bodily Shame | 10.88 | 4.25 | 9.82 | 3.40 | 1.52 | = 0.13 |
| | Total Shame | 68.90 | 19.59 | 55.58 | 13.95 | 4.14 | < 0.001 |
| FSCRS: | Inadequate Self | 22.73 | 9.27 | 16.75 | 8.44 | 3.93 | < 0.001 |
| | Hated Self | 7.79 | 5.54 | 3.86 | 4.58 | 4.32 | < 0.001 |
| | Self-Criticism Total | 30.52 | 13.41 | 20.61 | 12.03 | 4.50 | < 0.001 |
| | Self-Reassurance | 13.94 | 6.54 | 19.81 | 5.92 | 5.87 | < 0.001 |
| FSCS: | Self-Improving | 20.35 | 11.22 | 19.27 | 11.10 | 0.57 | = 0.57 |
| | Self-Persecuting | 8.26 | 8.28 | 4.80 | 6.43 | 2.46 | = 0.02 |

*Note:* N's ranged from 34 to 37; PDS = Posttraumatic Stress Diagnostic Scale; ESS = Experience of Shame Scale; FSCRS = The Forms of Self-Criticising/Attacking and Self-Reassuring Scale; FSCS = The Functions of Self-Criticising/Attacking Scale.

[a] Non-clinical sample; means for ESS taken from Andrews et al. (2002), means for FSCRS and FSCS taken from Gilbert et al. (2004) and mean for BDI taken from O'Connor, Berry, Weiss & Gilbert (2002).

no significant difference in scores was found. The mean inadequate self, hated self and self-criticism total scores of the FSCRS were also greater in this current sample compared to the non-clinical sample, while the mean self-reassurance component of the FSCRS was lower. The mean self-persecuting component of the FSCS was higher than that of the non-clinical sample at the $p < 0.05$ level, but did not reach significance at the $p < 0.01$ level adopted. There was not a significant difference between the mean self-improving component of the FSCS for this sample and the non-clinical sample.

**Structure of Questionnaires**

***The Experience of Shame Scale (ESS)***

The three subscales of the ESS (characterological shame, behavioural shame and bodily shame) were moderately to highly inter-correlated; correlations ranged from 0.40 to 0.83 (correlations between all variables are presented in Table 3). The three shame sub-scales were therefore not explored further separately and subsequent analyses used the total shame score (highly correlated with all three sub-scales).

***The Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS)***

The inadequate self and hated self components of self-criticism were highly correlated (correlation of 0.59). However it was theoretically important to examine these components separately as well as using the self-criticism total score (aggregate of these two components). The self-criticism total score was highly correlated with the inadequate self and the hated self components (correlations of 0.91 and 0.85 respectively). The self-reassurance component was moderately to highly negatively

Table 3. Correlations Between all Variables

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| (1) PDS: Symptom Severity Score | | | | | | | | | | | |
| (2) BDI: Depression | 0.84** | | | | | | | | | | |
| (3) ESS: Characterological Shame | 0.49* | 0.60** | | | | | | | | | |
| (4) ESS: Behavioural Shame | 0.36 | 0.49* | 0.83** | | | | | | | | |
| (5) ESS: Bodily Shame | 0.35 | 0.43 | 0.40 | 0.43* | | | | | | | |
| (6) ESS: Total Shame | 0.45* | 0.57** | 0.93** | 0.93** | 0.60** | | | | | | |
| (7) FSCRS: Inadequate Self | 0.31 | 0.44* | 0.68** | 0.74** | 0.37 | 0.72** | | | | | |
| (8) FSCRS: Hated Self | 0.60** | 0.74** | 0.71** | 0.61** | 0.49* | 0.68** | 0.59** | | | | |
| (9) FSCRS: Self-Criticism Total | 0.52* | 0.65** | 0.79** | 0.75** | 0.49* | 0.79** | 0.91** | 0.85** | | | |
| (10) FSCRS: Self-Reassurance | -0.35 | -0.53** | -0.35 | -0.39 | -0.30 | -0.39* | -0.42 | -0.52** | -0.48* | | |
| (11) FSCS: Self-Improving | 0.37 | 0.43 | 0.44* | 0.45* | 0.23 | 0.46* | 0.54** | 0.37 | 0.51* | -0.26 | |
| (12) FSCS: Self-Persecuting | 0.54** | 0.65** | 0.63** | 0.52* | 0.46* | 0.61** | 0.41 | 0.71** | 0.60** | -0.45* | 0.53** |

*Note:* * $p < 0.01$, ** $p < 0.001$; N's ranged from 34 to 37; PDS = Posttraumatic Stress Diagnostic Scale; ESS = Experience of Shame Scale; FSCRS = The Forms of Self-Criticising/Attacking and Self-Reassuring Scale; FSCS = The Functions of Self-Criticising/Attacking Scale.

correlated with the inadequate self, hated self and self-criticism total scores (correlations ranged from -0.42 to -0.52).

### *The Functions of Self-Criticising/Attacking Scale (FSCS)*

The self-improving function of self-criticism and the self-persecuting function of self criticism were highly positively correlated (correlation of 0.53). Theoretically these components cannot be added together to create a total score, and thus the components are examined separately.

## Correlational Analyses

Correlation analyses were conducted to test the hypotheses of this study (see Table 3 for relevant correlations). Hypothesis 1 was supported; there was a positive correlation between self-criticism and shame ($r_s = 0.79$, $p < 0.001$). Hypothesis 2 was also supported; there was a negative correlation between self-reassurance and shame ($r_s = -0.39$, $p = 0.009$). Hypothesis 3 was not supported; the hated self component of self criticism did not have a stronger correlation with shame ($r_s = 0.68$, $p < 0.001$) than the inadequate self component ($r_s = 0.72$, $p < 0.001$). In fact the inadequate self component seemed slightly larger, although this did not prove statistically significant ($z = 0.16$, $p = 0.44$). Hypothesis 4 was also not supported. The self-persecuting function of self-criticism did seem to have a stronger correlation with shame ($r_s = 0.61$, $p < 0.001$) compared to the self-improving function of self-criticism ($r_s = 0.46$, $p = 0.002$), but the difference did not reach statistical significance ($z = 0.8$, $p = 0.21$).

Hypothesis 5 was tested using hierarchical multiple regression (see Table 4). As well as controlling for depression, posttraumatic symptom severity was also controlled for in the analyses. Two regression models were used to predict the variables outlined in the hypotheses:

- Model 1; Depression and Posttraumatic Symptom Severity
- Model 2; Depression, Posttraumatic Symptom Severity and Shame.

The amount of variance explained by each model was compared to ascertain if adding shame adds a statistically significant contribution. Results partially supported the hypothesis. Shame caused a significant addition to the variance explaining inadequate self, hated self and self-criticism total, above the variance explained by depression and posttraumatic symptom severity. However shame did not cause a significant addition in the variance explaining self-reassurance, the self-improving and self-persecuting functions of self-criticism, above that explained by depression and symptom severity.

**Exploratory Analyses**

Further exploratory analyses were applied to look at the relationships between self-reassurance and the different forms and functions of self-criticism (see Table 3). It was speculated that individuals who criticise themselves because they hate themselves might find it harder to reassure themselves compared to individuals who criticise themselves because they feel inadequate. There was a significant negative correlation between the hated self component and self-reassurance ($r_s = -0.52$, $p = 0.001$), while the correlation between the inadequate self component and self-reassurance only reached significance at the $p < 0.05$ level ($r_s = -0.42$, $p = 0.02$) and not the more stringent $p < 0.01$ level adopted. However there was not a significant difference between the sizes of the correlations

Table 4. Summary of Regression Analyses: Comparison of Variance Explained by Model 1[a] versus Model 2[b].

| | Dependent Variables | $R^2$ Model 1[a] | $R^2$ Model 2[b] | $R^2$ Change | F (1, 29) for $R^2$ Change |
|---|---|---|---|---|---|
| FSCRS | Inadequate Self | 0.25 | 0.61 | 0.36 | 26.61** |
| | Hated Self | 0.54 | 0.65 | 0.11 | 9.09* |
| | Self-Criticism Total | 0.43 | 0.74 | 0.31 | 33.60** |
| | Self-Reassurance | 0.35 | 0.36 | 0.01 | 0.45 |
| FSCS | Self-Improving | 0.21 | 0.27 | 0.06 | 2.83 |
| | Self-Persecuting | 0.41 | 0.46 | 0.05 | 2.96 |

*Note*: * $p < 0.01$, ** $p < 0.001$; PDS = Posttraumatic Stress Diagnostic Scale; ESS = Experience of Shame Scale; FSCRS = The Forms of Self-Criticising/Attacking and Self-Reassuring Scale; FSCS = The Functions of Self-Criticising/Attacking Scale.

[a] Model 1: Depression (BDI) and Posttraumatic Symptom Severity (PDS), predicting variables outlined in hypotheses. All $R^2$ were statistically significant, except inadequate self and self-improving.

[b] Model 2: Depression (BDI), Posttraumatic Symptom Severity (PDS) and Shame (ESS Total), predicting variables outlined in hypotheses. All $R^2$ were statistically significant, except self-improving.

between hated self and self-reassurance and inadequate self and self-reassurance ($z = 0.53$, $p = 0.60$).

It was also theorised that individuals who self-criticise to persecute themselves might find it harder to self-reassure than individuals who self-criticise to improve themselves. Although the negative correlation between self-persecuting and self-reassurance reached significance ($r_s = -0.45$, $p = 0.007$) and the negative correlation between self-improving and self-reassurance did not ($r_s = -0.26$, $p = 0.14$) the difference between the size of these correlations was not significant ($z = 0.87$, $p = 0.38$).

## Discussion

This study explored the relationship between shame, self-criticism and self-reassurance in individuals suffering significant symptoms of PTSD. The hypotheses of this study were largely supported. Shame was shown to have a significant positive correlation with self-criticism and a significant negative correlation with self-reassurance. Both components of self-criticism (inadequate self and hated self) were positively correlated with shame. Interestingly, inadequate self had a numerically stronger correlation with shame than hated self, but this difference was not significant. The self-improving and self-persecuting functions of self-criticism also had significant positive correlations with shame and as predicted the self-persecuting function had a numerically larger correlation. However the difference between these correlations was also not significant. Shame added a significant addition to the variance explaining self-criticism (inadequate self, hated self and self-criticism total) above that explained by depression and symptom severity, but did not add a significant addition to the variance explaining self-

reassurance, the self-improving and self-persecuting functions of self-criticism, above that explained by depression and symptom severity. Exploratory analyses revealed that the hated self component of self-criticism had a numerically stronger negative correlation with self-reassurance than the inadequate self component, but this difference did not reach significance. Similarly the self-persecuting function of self-criticism had a numerically stronger negative correlation with self-reassurance than the self-improving function of self-criticism but again this difference was not significant.

The sample in this current study had higher scores on depression and self-criticism compared to a non-clinical sample. Scores on shame were also significantly higher than the non-clinical population, except for the bodily shame sub-component, where no significant difference was found. This is not necessarily unexpected given that the non-clinical sample was an undergraduate student population, 82% of whom were female. The non-clinical sample had higher scores on self-reassurance and did not differ significantly from the current sample on the self-improving or self-persecuting functions of self-criticism. Again one would expect a non-clinical sample to score higher on self-reassurance, and it also might seem intuitive that a high-achieving student population would be prone to criticise themselves with the aim of self-improvement. It was surprising however that a difference was not found between the scores on the self-persecuting function of self-criticism, although the difference did approach significance with the clinical sample tending to have higher scores.

The findings from this current study add further support to research that has shown that some individuals with PTSD experience high levels of shame (Andrews et al., 2000;

Brewin et al., 2000; Grey et al., 2001; Holmes et al., 2005; Lee et al., in preparation) and that shame might play an important role in creating/maintaining the sense of ongoing current threat associated with PTSD (Ehlers & Clark, 2000). This current study found that shame had a positive association with self-criticism and a negative association with self-reassurance which corresponds with Gilbert et al.'s (in press) research, which found a similar relationship between self-criticism, self-reassurance and depression. However in this current study shame was not shown to add a significant contribution to the variance explaining self-reassurance, but did add a significant contribution to the variance explaining self-criticism, above that explained by depression and symptom severity. It seems likely therefore that self-reassurance is inversely related to general levels of negativity with the self or general levels of distress rather than shame specifically, whereas self-criticism seems to have a more direct relationship with shame.

Gilbert et al. (2004) used path analysis to look at the relationships between the different forms and functions of self-criticism and depression. They concluded that the self-persecuting function of self-criticism was particularly pathogenic and was positively mediated by the hated self dimension of self-criticism. Unfortunately the sample size in this current study was insufficient to use path analysis to investigate how the forms and functions of self-criticism interacted. However comparison between the strength of correlations in this current study failed to show that the hated self component of self-criticism had a stronger correlation with shame than the inadequate self component or that the self-persecuting function of self-criticism had a stronger correlation with shame than the self-improving function. It may be the sample size in this study was too small to

detect a possibly subtle effect or that the analyses used were too simplistic given the potential interactions between the variables.

However there may be other reasons why this study failed to show a difference between the different forms and functions of self-criticism. Gilbert et al. (2004) investigated self-criticism and self-reassurance in relation to depression. However in this study these concepts were investigated in relation to shame. Shame by definition is about feeling inferior and worthless, and therefore the inadequate self component of self-criticism might actually be just as important to shame, if not more so, than the hated self-component. Gilbert et al. (2004) also used a non-clinical sample to investigate these concepts, whereas this current study used a clinical sample. It may be that in a clinical sample all forms and functions of self-criticism are equally damaging, whether they are related to feelings of inadequacy or hatred or whether they are intended to improve the self or persecute the self. Indeed it could be argued that it is not the form self-criticism takes or the reason self-criticism is given that is important but how self-criticism is delivered. Gilbert (2000) emphasises that the impact of self-criticism is not just related to the words used or the beliefs involved but is also associated with affective qualities associated with the criticism (e.g., the tone of the criticism, the power with which criticism is delivered and images and memories that might accompany the criticism). It may be that clinical samples are prone to deliver any self-criticism with particular power and hostile tone, so that all self-criticism has an equally negative impact.

One finding of interest in this current study was that shame added a significant addition to the variance explaining self-criticism (inadequate self, hated self and self-criticism

total) above that explained by depression and symptom severity but failed to add a significant addition to the variance which explained the different functions of self-criticism (self-improving and self-persecuting) above that explained by depression and symptom severity. This suggests that individuals experiencing high levels of shame might be criticising themselves for some other function which is not being measured by the Functions of Self-Criticising and Attacking Scale (FSCS; Gilbert et al. 2004). Indeed it is likely that there are many different reasons why people criticise themselves and it may be that the distinction between criticising to improve oneself and criticising to persecute oneself is too narrow and under-inclusive. For example, some people might criticise themselves as a protective function, to stop them acting in a way that might prove detrimental (e.g., 'you are so disgusting' *[and therefore you must never reveal these qualities to anyone in case they reject you]*). The FSCS was influenced by Gilbert's clinical work with depressed patients and thus it may be that this measure is better at tapping into the functions of self-criticism linked to depression rather than those linked to shame. Alternatively it may be that the reasons people criticise themselves are so diverse and idiosyncratic that there is not any specific function which is specific to shame.

Clearly any conclusions drawn from this current study are tentative given the number of limitations, such as low sample size, use of multiple regression when variables were not normally distributed and the use of a cross-sectional design. For example, it is not possible to ascertain if self-criticism is a risk factor for PTSD, because we do not know if self-criticism causes shame (and subsequent current threat) or simply whether individuals with PTSD who feel shame then become more self-critical. Future research

would benefit from exploring these concepts using a prospective design, in which self-criticism and self-reassurance are explored post-trauma but prior to the development of PTSD. That said, the results of this study suggest a number of implications for the treatment of individuals with PTSD experiencing high levels of shame. Firstly it seems important that clinicians view the reduction of shame as a key factor in the treatment of PTSD, as it seems likely that shame contributes to the generation of ongoing current threat at the heart of PTSD. This study has shown that individuals experiencing high levels of shame are prone to engage in self-critical thinking and that when shame is accompanied by high levels of depression and symptoms are severe these individuals are also unable to reassure themselves and make themselves feel safe again. Cognitive techniques that teach patients how to challenge and change negative thoughts/beliefs have been used alongside traditional exposure based therapy for many years (e.g., Grey, Young & Holmes, 2002). However this research suggests that patients might also need to be taught techniques that help them develop inner caring, compassion and self-reassurance and that these techniques might prove an important adjunct to conventional methods of treatment for PTSD.

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## Critical Appraisal

## Introduction

This study was interested in the role that shame might play in the development and maintenance of posttraumatic stress disorder (PTSD). As postulated in the cognitive model of PTSD (Ehlers & Clark, 2000) PTSD develops when the trauma/trauma sequelae is interpreted in way that causes an individual to experience an ongoing sense of current threat. Although threat is normally thought about in relation to fear, following from the ideas of Ehlers and Clark (2000), this study suggested that shame might also contribute to the creation/maintenance of ongoing current threat through attack on an individual's positive sense of self and psychological integrity. It was therefore considered important to investigate the factors that might be contributing to a shame response in individuals with PTSD, so that these might be targeted in treatment interventions for this client group. The results of this study highlighted that individuals with PTSD associated with higher levels of shame had higher levels of self-criticism than individuals with lower levels of shame. It is therefore suggested that self-criticism may be creating/maintaining a shame response, which in turn contributes to ongoing current threat. It was also shown that the more severe individuals' symptoms of PTSD and the more symptoms of depression they had, the more likely they were to also lack the ability to self-reassure and make themselves feel safe again, making it harder for them to combat manifest current threat.

The first section of this critical review will offer reflections on the research process, discussing potential limitations of this study and presenting ideas for future research. The second section will focus on the clinical implications this study generates.

## Reflection on the Research Process

### Limitations

One of the potential problems of this study was that *The Posttraumatic Stress Diagnostic Scale (PDS: Foa, 1995)* was chosen to measure symptoms of PTSD. The PDS is a self-report instrument based on the DSM-IV (American Psychiatric Association, 1994) diagnostic criteria for PTSD and can be used to establish a diagnosis of PTSD and a symptom severity score. At the outset, it was decided that participants who did not meet full diagnostic criteria for PTSD based on the PDS, would be excluded from the study, and thus the PDS acted as a screening device as well as a measure of symptom severity. However a number of problems with this strategy arose once the research process was underway. Firstly the PDS relies on participants answering the questionnaire in full in order for a diagnosis of PTSD to be established. In this current study participants were required to fill out questionnaires on their own at home and then either return them by post or give them to their assessing clinician at their next appointment. Unfortunately this meant that some participants did not answer all of the questions, which meant that the PDS could not be used to make a diagnosis. In retrospect it should have been anticipated that this method of data collection was not the most appropriate for a screening device which relied on a questionnaire being answered in full. In addition the PDS is a fairly long questionnaire (49 items) and deals with a very sensitive subject matter (trauma) which makes it even more likely that some participants would leave some questions unanswered. These problems were resolved by adopting a second screening method which will be discussed further in the sections below.

Another problem that arose when using the PDS in this current study is that although the PDS is based on the DSM-IV (now DSM-IV-TR, American Psychiatric Association, 2000) criteria for PTSD, it does not map the criteria exactly. For example, Criterion A of the DSM-IV/DSM-IV-TR stipulates that an individual must have 'experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others'. While the PDS addresses physical injury to self or others and concerns about one's own or other's life being in danger, it fails to ask questions about physical integrity. Threat to physical integrity is likely to be a key factor for some individuals with PTSD, who were not necessarily injured or had concerns that their life was in danger (such as some cases of rape or childhood sexual abuse). Thus the PDS might classify some individuals as not having PTSD when in fact they do meet diagnostic criteria judged by the DSM-IV/DSM-IV-TR.

Another problem concerns the general use of the DSM-IV/ DSM-IV-TR criteria for PTSD and the problems of using and relying on diagnostic categorisation. Some clinicians argue that an over reliance on diagnostic categorisation can be unhelpful and emphasise that a diagnostic label is simply a group of symptoms that have been observed to cluster together with statistical significance, rather than representing a real entity that actually exists and that diagnoses are often unreliable. This view places individual formulation at the heart of treatment and discourages pre-occupation with labels and categories. However others argue that diagnostic categories can be useful as they can help researchers identify specific risk factors for specific illnesses, help with the identification of suitable treatments, can help an individual feel understood and can

aid understanding and communication for health professionals (see Bentall, 2003, for a review of this debate).

Other researchers have criticised specific criteria within certain diagnostic categories, arguing that they are under-inclusive. For example, Brewin, Andrews and Rose (2000) have criticised the subjective criteria of the DSM-IV/DSM-IV-TR diagnosis for PTSD, which specifies that individuals must have experienced fear, helplessness or horror during the traumatic event. They highlight that some individuals might have memory loss for the trauma, such as those having suffered drug rape or head injury, which makes it difficult or impossible to attribute specific emotional reactions. Indeed one of the participants in this current study had suffered drug rape and could not judge her emotional reactions during the trauma, but met all the other diagnostic criteria for PTSD. Brewin et al. (2000) also suggest that emotions other than fear, helplessness or horror might play an important role in PTSD, including secondary emotions which are based on cognitive appraisals following the trauma. They found a sub-group of individuals who did not appear to experience intense emotions at the time of the trauma despite experiencing the other persistent features of PTSD. These individuals did however report strong emotions of either anger or shame (hypothesised secondary emotions) and these emotions had independent effects on later PTSD. The authors suggest that these results indicate that the current diagnostic criteria for PTSD may have to be amended to include emotions other than just fear, helplessness and horror, and that it may be beneficial to include secondary emotional reactions as well as primary ones.

Another problem with the DSM-IV/DSM-IV-TR criteria for PTSD is that it places 'actual or threatened death or serious injury, or a threat to the physical integrity of self or others' as a central component in PTSD but fails to acknowledge the role that threat to psychological integrity may play. The cognitive model of PTSD (Ehlers & Clark, 2000) suggests that PTSD is caused by a sense of ongoing current threat and following from these ideas this study has suggested that shame can contribute to ongoing threat by attacking an individual's positive sense of self and psychological integrity. It can thus be proposed that some individuals will develop PTSD not because they have experienced 'actual or threatened death or serious injury, or a threat to the physical integrity of self or others' but rather because they are experiencing high levels of shame and feel that their psychological integrity has been threatened. However at present the current diagnostic criteria fails to acknowledge the potential role that threat to psychological integrity may play in PTSD.

Whilst this current study originally planned to use *a diagnosis of PTSD* as inclusion criteria for participation in the research, this was subsequently changed so that participants had to be experiencing *significant posttraumatic symptoms* to be included in this research. This was partly because low recruitment rates made it difficult to maintain such a strict inclusion criteria, but this decision was also made because of some of the problems with the DSM-IV/DSM-IV-TR criteria outlined above. This decision led to a change in the way participants were screened. Instead of relying solely on the PDS, clinicians' advice was sought on whether they considered their clients to either have met full diagnostic criteria for PTSD or whether they judged them to experiencing significant posttraumatic symptoms. This also solved the problem of what to do about missing data

from the PDS, as participants were now being screened by two methods; the PDS and/or clinical judgement.

As mentioned above this research did suffer from low recruitment rates. Although the aim was to recruit 50 participants, only 37 were actually recruited. Recruitment was particularly low in the first eight months of data collection and based on the recruitment rate at that point in time it did not seem likely that more than 25 participants would be recruited in total. In order to tackle this problem a number of steps were taken. Firstly a number of additional clinics offering treatment for PTSD were approached. This increased the research from a two site study to a five site study, thus increasing the amount of people invited to take part in the research. A number of amendments were also made to the initial protocol (for which ethical approval was gained). This included offering participants £6 for filling out and returning completed questionnaires and phoning potential participants about the research. Potential participants were only phoned if they had already been assessed and the assessing clinician thought this was appropriate. The aim of phoning participants was to check they had received an optional research pack, to remind them about the research, to ask them if they would like to take part in the research and to give them an opportunity to ask any questions they may have. It was also made very clear that participation in the research was voluntary and that a reason did not have to be given for not volunteering. Luckily the amendments to the protocol along with increasing the number of research sites led to an improvement in recruitment. With the benefit of hindsight, it would have been advantageous to have implemented these strategies at the start of the research process.

Another potential problem was that there was a time lag between the dates some of the different questionnaires were completed. This was because some clinics already had a set assessment procedure, which involved patients filling out a range of questionnaires including the PDS and BDI. Rather than disrupting this procedure it was decided that this research would use this questionnaire data, as in reality it was unlikely that there would be a long lag between patients filling out these questionnaire and those used in this current study. While this was the case for most participants, for some participants there was a longer time lag than expected. For three participants there was a lag of over nine months, which arose as these participants had been recruited from a treatment waiting list and had filled out the PDS and BDI when they were assessed over nine months earlier. In retrospect it would have been beneficial to have sent people who had been on the treatment waiting list for a long time another PDS and BDI to fill out alongside the questionnaires in this current study but unfortunately this was not done at the time. The PDS and BDI data for these three participants were removed from the analysis to prevent any potential confounding factors. It was still possible to ascertain however if these participants were still suffering significant posttraumatic symptoms because all three were subsequently taken on for treatment and thus the treating clinicians could be consulted. Having removed the PDS and BDI data for these three participants the longest time lag between measures was approximately three months. Although this was not ideal, it was tolerated. If the study were repeated it would be advantageous to try and send all questionnaires out at one time point. This would involve greater negotiation with the clinics used to recruit participants and the likelihood that some participants would be asked to fill out the PDS and BDI twice, albeit at different points in time.

**Ideas for Future Research**

Throughout this research process a number of ideas for future research have been generated. Firstly when the results of this study were analysed it was found that most of the variables were not normally distributed and therefore non-parametric correlations were implemented. However inspection of the histograms revealed interesting frequency distributions for some variables. Specifically the self-criticism total score and the shame total score raised the possibility of a bi-modal distribution with two distinct groups; low self-criticism versus high self-criticism and low shame versus high shame respectively. Interestingly Andrews, Brewin, Rose and Kirk (2000) reported dichotomising their shame scale into little or no shame versus high shame due to the distribution of their results. In this current study a median split analysis was considered but a decision was made to analyse the data using non-parametric correlations instead, as the bi-modal distribution was not as distinct as one would have ideally hoped for. However future research might benefit from investigating further the possibility of there being individuals with PTSD experiencing very little or no shame versus individuals with PTSD experiencing very high shame, and to explore in more depth what distinguishes between these two groups.

Another suggestion for future research stems from the finding that in this current study shame added a significant addition to the variance explaining self-criticism (inadequate self, hated self and self-criticism total) above that explained by depression and symptom severity but failed to add a significant addition to the variance which explained the different functions of self-criticism (self-improving and self-persecuting) above that explained by depression and symptom severity. This suggests that individuals with

PTSD experiencing high levels of shame may be criticising themselves for reasons not measured using the Functions of Self-Criticising and Attacking Scale (FSCS; Gilbert, Clarke, Hempel, Miles & Irons, 2004). Indeed the FSCS was influenced by Gilbert's clinical work with depressed patients and thus it may be that this measure is better at tapping into the functions of self-criticism linked to depression rather than those linked to shame. Future research might benefit from exploring these ideas further, using a qualitative design in which individuals with PTSD experiencing high levels of shame are interviewed and asked questions about the reasons they criticise themselves. It may be for example, that this particular client group have very specific reasons for criticising themselves which relate to the traumatic events they have experienced. Or it may be that individuals experiencing shame criticise themselves as a way of stopping themselves revealing or repeating the things they have done that they considered shameful (e.g., 'you are so disgusting' *[and therefore you must never reveal these qualities to anyone in case they reject you]*). Although this might seem to fit into the 'self-improving' function, there is a subtle difference in that the reason is much more about stopping someone seeing the self as bad rather than trying to improve the self or make others see the self as good. This would fit with the evolutionary view of shame which suggests that shame evolved as a protective function, to stop the self acting in a way that might provoke attack from dominant others. However research might alternatively show that the reasons people criticise themselves are so diverse and idiosyncratic that there is not any specific function which is specific to shame.

Another idea for future research would involve measuring the same concepts as those measured in this current study but following a prospective design. One of the problems

with this current study is that the direction of causation cannot be established. For example, we do not know if self-criticism causes shame (and subsequent current threat leading to PTSD) or simply whether individuals with PTSD who feel shame then become more self-critical. If self-criticism (and self-reassurance) were measured immediately post-trauma, and then individuals were followed up to see which individuals developed PTSD associated with high levels of shame, it would be possible to ascertain more clearly whether self-criticism was in fact a risk factor for the development of PTSD associated with high levels of shame.

## Clinical Implications of the Research

Traditional methods of treatment for PTSD have focused on techniques that aim to reduce fear (e.g., exposure), as fear is seen as one of the primary emotions experienced at the time of the trauma and is also likely to be re-experienced again alongside trauma related intrusions. A great deal of research has shown that the use of prolonged imaginal exposure to memories of the traumatic event is an effective treatment intervention for PTSD (e.g., Foa & Meadows, 1997). However recent research, including this current study, has shown that a range of other emotions also seem to play an important role in the development and maintenance of PTSD and this has fuelled the development of alternative and complementary approaches to traditional exposure based-treatment (Grey, Young & Holmes, 2002; Lee, Scragg & Turner, 2001; Tarrier, Sommerfield, Pilgrim, & Humphreys, 1999). Indeed recent research advocates treatment methods that include both an element of prolonged exposure and cognitive therapy in the treatment of PTSD. For example, Grey et al. (2002) discuss the importance of cognitive restructuring both prior to and during exposure/reliving and suggest that this might be particularly

relevant for individuals suffering shame, guilt, or anger, which unlike cognitions related to fear, are unlikely to spontaneously restructure through traditional exposure methods. It is likely to prove beneficial however, if research continues to explore in more depth the different factors related to specific emotions in PTSD, so that treatment interventions can continue to evolve and progress for this client group.

This study explored the factors that might be associated with shame within a PTSD sample and found that self-criticism seems to be a key factor in creating/maintaining a shame response. In addition when shame is accompanied by severe symptoms of PTSD and depressive symptoms, individuals are also more likely to have problems reassuring themselves, making it harder for them to combat their self-critical thoughts and thus contributing to the maintenance of shame. These results have important implications for treatment; they suggest that individuals with PTSD experiencing high levels of shame need to be taught techniques that help tackle self-critical thoughts and that an important component of this may involve helping patients learn to reassure themselves and make themselves feel safe again. This would hopefully reduce the shame response, contribute to a reduction in ongoing current threat and therefore contribute to a reduction in PTSD symptoms. Although many treatment approaches for trauma already advocate cognitive-behavioural techniques that help individuals challenge negative thoughts, the idea of using techniques that help individuals activate inner caring, compassion and the ability to self-reassure is a new and promising area.

One way of helping individuals activate inner caring and compassion involves using an adaptation of the two-chair technique (Greenberg, Elliott & Foerster, 1990; Greenberg,

Rice & Elliott, 1993), but this time adding a third chair (see Gilbert, 2000). Having role-played their self-critical attacks and then their response to these attacks, clinicians can then ask individuals to role-play a more caring and compassionate self in the third chair. This caring and compassionate self can speak to the defeated and attacked part of the self offering warmth, understanding and reassurance. However it can also speak to the attacking part of self too. For example the caring and compassionate part of the self might ask the attacking part of the self questions about when it first started criticising 'patient X' or what it feels it is gaining from criticising 'patient X'. Just as bullies in the external world have complex and diverse reasons for their actions an individual's 'internal bully' (Gilbert, 2000) can also have different reasons why it is critical. For example, Gilbert (2000) cites the example of a patient who realised that 'the bullying part of me is really quite frightened and thinks if I don't make the grade no one will care or love it' (p. 139). Thus learning to be compassionate to the self-critical part of the self can in some cases be just as important as learning to care for and be compassionate to the attacked and defeated part of the self. It is also important to note that learning to be compassionate towards the self is not always about changing a part of the self but it is also about learning to accept yourself and understand yourself which might mean learning to tolerate uncomfortable feelings rather than trying to get rid of them.

Another way of enhancing an individual's ability to be caring and compassionate towards the self is through the use of imagery. Gilbert (2000) highlights that individuals can often generate powerful images that accompany their self-critical thoughts and that the strength of an internal attack is thus not simply dependant on the words used or the beliefs involved but is also associated with affective qualities associated with the

criticism (e.g., what they look like, tone of voice). Indeed this current study failed to show that the different forms or functions of self-criticism had differential impacts on the experience of shame, suggesting that it may be the way individuals with high levels of shame criticise themselves that is paramount. These ideas can be applied to the caring and compassionate inner voice too. Gilbert (2000) suggests that generating an image to accompany an individual's inner caring and compassionate can help enhance the degree to which an individual responds in a cared for and understood way. This is equally true for the tone taken by a caring and compassionate inner voice. Gilbert (2000) emphasises that the messages given by a caring compassionate part of the self may be similar to those elicited using standard cognitive therapy. However he highlights that it is the way these messages are delivered that is the key to their success. It is easy to imagine that if clinicians are not careful individuals will recruit the self-critical part of the self to deliver the messages of cognitive therapy. Indeed Gilbert et al. (2004) cite a clinical example of a patient who turned the exercise of challenging her negative thoughts into another chance to criticise herself, (e.g., 'You must learn to focus on your positives and not think in black and white', p 47). Gilbert (2000) suggests that it is worth while getting patients to practise delivering messages to the self in therapy to ensure that they are delivering them in a caring and compassionate way.

Lee (in press) similarly advocates the use of an image to accompany an individual's inner caring and compassion. She highlights that traditional cognitive techniques can sometimes result in a discrepancy between what someone knows cognitively and what they feel emotionally and that without a congruent emotional shift, cognitive techniques are unlikely to prove beneficial in the long term. Lee (in press) suggests that one way of

tackling this discrepancy is by helping clients create an image of a 'perfect nurturer' who is caring, compassionate and meets their needs perfectly. Individuals are encouraged to create an image which they will find most helpful, as the perfect nurturer is not a prescriptive image. The perfect nurturer is designed to activate self-soothing emotions and once practised can be used to re-frame negative cognitions. Lee (in press) cites a case example of a women suffering PTSD associated with high levels of shame and depression, for whom traditional cognitive therapy techniques had failed to produce an emotional shift . The results of this study suggest that this woman would be particularly likely to have problems with self-reassurance, suggesting the need for techniques that promote inner caring and compassion. Indeed when Lee (in press) used the same cognitive techniques in conjunction with the compassionate technique of the 'perfect nurturer' a significant emotional shift was achieved (reduction in depression score) and improvements in functioning were gained (return to work). Lee (in press) suggests that the creation of an image to accompany self-compassion and inner warmth not only helps bring about emotional change but can also help create a retrieval bias for this way of inner relating, because the memories laid down are particularly distinctive.

Gilbert (2000) however notes that clinicians must be aware of some of the potential problems of using techniques to activate a caring and compassionate side of the self. Firstly he suggests that for some individuals caring and warmth can actually act as a threatening signal. For example, some individuals who have been abused will associate apparent warmth and caring with their abuser who might have used signals of warmth to instigate abuse. Secondly he suggests that for some individuals accessing a caring part of the self may actually activate a grieving process or increase a sense of aloneness as it

makes an individual aware of the care they might have missed out on in their past or leaves them feeling that they have an empty void inside them where their caring and compassionate self should be. Finally he suggests that clinicians need to be aware that individuals may have beliefs that cause resistance in accessing a caring and compassionate part of the self and that these may need to be dealt with before further work in this area can progress. For example, individuals may have beliefs that recruiting a caring, nurturing part of the self is weak and a sign of giving in, which would thus counteract any work done on trying to activate this part of the self.

## Conclusion

This current research project has been an interesting and rewarding process and has proved to be an important learning experience about the nature of research. It has demonstrated that researchers need to be flexible and adaptive throughout each stage of the research process, responding to things that don't go as planned and being prepared to make amendments when necessary. It has shown how ideas for future research can be generated and how research can offer important implications for treatment interventions. In sum it is hoped that this research project will contribute to the field of clinical psychology and offer important insights into the role shame, self-critical thinking and self-reassuring thinking may play in the development and maintenance of current threat in posttraumatic stress disorder.

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# Appendices

## Appendix 1

### Ethical Approval Letters:

- Camden and Islington Community Health Services Local Research Ethics Committee
- Oxfordshire Research Ethics Committee

Version 2

NHS

## Camden & Islington Community Health Services Local Research Ethics Committee

LREC Ref: 03/108
**PRIVATE AND CONFIDENTIAL**
Ms R Harman

27 February 2004

Dear Ms Harman

**Title: An investigation into shame and self-critical thinking versus self-reassuring thinking in Posttraumatic Stress Disorder.**

Thank you for submitting the above project for ethical consideration. The Committee gave careful consideration to your proposal at its meeting on 23rd February 2004. I am pleased to inform you that the Local Research Ethics Committee has no ethical objections to your project proceeding. This opinion has also been communicated to the North Central London Community Research Consortium.

**PLEASE NOTE THAT THIS OPINION ALONE DOES NOT ENTITLE YOU TO BEGIN RESEARCH, YOU MUST RECEIVE AN APPROVAL FROM EACH NHS TRUST HOSTING YOUR RESEARCH.**

Camden and Islington Community Health Service LREC considers the ethics of proposed research projects and provides advice to NHS bodies under the auspices of which the research is intended to take place. It is that NHS body which has the responsibility to decide whether or not the project should go ahead, taking into account the ethical advice of the LREC[1]. Where these procedures take place on NHS premises or using NHS patients, the researcher must obtain the agreement of local NHS management, who will need to be assured that the researcher holds an appropriate NHS contract, and that indemnity issues have been adequately addressed.

**N.B.** Camden and Islington Community Health Service LREC is an independent body providing advice to the North Central London Community Research Consortium. A favourable opinion from the LREC and approval from the Trust to commence research on Trust premises or patients are NOT one and the same. Trust approval is notified through the Research & Development Unit (please see attached flow chart).

**The following conditions apply to this project:**

- It should be made clear to patients, which questionnaires are for research and which are part of the clinics usual process.
- The title on patient literature should be changed to 'Positive and Negative Thinking'.
- You must write and inform the Committee of the start date of your project. The Committee (via the Local Research Ethics Committee Administrator or the Chair at the above address) must also receive notification:

  a) when the study commences;
  b) when the study is complete;

[1] Governance Arrangements for NHS Research Ethics Committees, *July 2001 (known as GAFREC)*

c) if it fails to start or is abandoned;
d) if the investigator/s change and
e) if any amendments to the study are made.

- The Committee must receive immediate notification of any adverse or unforeseen circumstances arising out of the project.
- It is the responsibility of the investigators to ensure that all associated staff, including nursing staff, are informed of research projects and are told that they have the approval of the Ethics Committee and management approval from the body hosting the research.
- The Committee will require a copy of the report on completion of the project and may request details of the progress of the research project periodically (i.e. annually for longer projects).
- If data is to be stored on a computer in such a way as to make it possible to identify individuals, then the project must be registered under the Data Protection Act 1998. Please consult your department data protection officer for advice.
- Failure to adhere to these conditions set out above will result in the invalidation of this letter of no objection.

**Please forward any additional information/amendments regarding your study to the Local Research Ethics Committee Administrator or the Chair at the above address.**

Yours sincerely

**LREC Chair**

Email: (LREC Administrator)

Enc/s:

Copy to:

29 June 2004

Ms Rachel M Harman
Trainee Clinical Psychologist
Camden and Islington Mental Health and

Dear Ms Harman,

***Full title of study: Shame, self-critical thinking and self-reassuring thinking in Posttraumatic Stress Disorder.***
***REC reference number: 04/Q1606/23***
***Protocol number: None***

Thank you for your letter of 11 June 2004, responding to the Committee's request for further information on the above research.

The further information was considered at the meeting of the Sub-Committee of the REC held on 18 June 2004 A list of the members who were present at the meeting is attached.

**Confirmation of ethical opinion**

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

The favourable opinion applies to the following research site:

Site: Oxfordshire Mental Health Care NHS Trust
Principal Investigator: Ms Rachel M Harman

**Conditions of approval**

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

**Approved documents**

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

Document Type: Application
Version: Parts A, B and C
Dated: 03/05/2004
Date Received: 30/04/2004

Document Type: Investigator CV
Version: Rachel Harman

Dated: 23/04/2004
Date Received: 04/05/2004

Document Type: Investigator CV
Version: Deborah Lee
Dated: 04/05/2004
Date Received: 04/05/2004

Document Type: Protocol
Version: None
Dated: 06/02/2004
Date Received: 04/05/2004

Document Type: Covering Letter
Version: None
Dated: 26/04/2004
Date Received: 04/05/2004

Document Type: Peer Review
Version: UCL Doctorate in Clinical Psychology - Proposal Review Form
Dated: 09/12/2003
Date Received: 04/05/2004

Document Type: Copy of Questionnaire
Version: FSCRS
Dated: 04/05/2004
Date Received: 04/05/2004

Document Type: Copy of Questionnaire
Version: FSCS
Dated: 04/05/2004
Date Received: 04/05/2004

Document Type: Copy of Questionnaire
Version: Experience of Shame Scale
Dated: 04/05/2004
Date Received: 04/05/2004

Document Type: Letters of Invitation to Participants
Version: 2
Dated: 11/06/2004
Date Received: 15/06/2004

Document Type: Participant Information Sheet
Version: 2
Dated: 11/06/2004
Date Received: 15/06/2004

Document Type: Participant Consent Form
Version: 2
Dated: 11/06/2004
Date Received: 15/06/2004

Document Type: Response to Request for Further Information
Version:
Dated: 11/06/2004
Date Received: 15/06/2004

Document Type: Other
Version: Data Protection Registration
Dated: 14/04/2004
Date Received: 04/05/2004

**Management approval**

The study may not commence until final management approval has been confirmed by the organisation hosting the research.

All researchers and research collaborators who will be participating in the research must obtain management approval from the relevant host organisation before commencing any research procedures. Where a substantive contract is not held with the host organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

**Notification of other bodies**

We shall notify the research sponsor, Oxfordshire Mental Health Care NHS Trust that the study has a favourable ethical opinion.

**Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**REC reference number:** 04/Q1606/23 **Please quote this number on all correspondence**

Yours sincerely,

**Chairman**

*Enclosures* *List of names and professions of members who were present at the meeting*

*Standard approval conditions*

## Appendix 2

**Patient Invitation Letter, Patient Information Sheet and Consent Form**

Camden and Islington NHS
Mental Health and Social Care Trust

Dear Patient,

This envelope contains two research studies that are being conducted at the Traumatic Stress Clinic. It is hoped that the results of these studies will help us to understand people's reactions to trauma better. Better understanding should allow us to develop more advanced treatments in the future.

We would be very grateful if you could take the time to complete these two studies. Completing both studies should only take 25-30 minutes. You would simply need to read the information sheet, sign the consent form, and complete the questionnaires. You could then post the questionnaires and consent form back in the stamped addressed envelope (included) or bring them to your first appointment at the Traumatic Stress Clinic and give them to your clinician. Full instructions can be found in the information sheets.

*** If you decide to take part we will send you a payment of £6.00 in the post when we have received your completed pack ***

You do not have to take part in these studies. Your decision whether to take part of not will not affect your care and management in any way. Some of the questionnaires could cause some distress. If you do feel distressed please contact (Consultant Clinical Psychologist) on and she will be happy to talk through these issues with you.

Thank you very much for your help!

Sarah and Rachel

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If you do not wish to take part in this research, please fill this slip in and bring to your clinician at the clinic or post it back to us in the stamped addressed envelope.

I do not wish to take part in this research

Signed: _____ Print Name: _____

Camden and Islington NHS

Mental Health and Social Care Trust

**INFORMATION SHEET**

Dear Patient,

**Studies:** "Unwanted Thoughts and Images" and "Shame, Negative Thinking and Positive Thinking in Posttraumatic Stress Disorder"
**Researchers:** Dr Sarah Marzillier and Rachel Harman (Trainee Clinical Psychologists)
**Supervisors:** Dr Craig Steel and Dr Peter Scragg; Dr Deborah Lee.
**Hospital:** The Traumatic Stress Clinic, 73 Charlotte Street, London W1T 4PL.

You are being invited to take part in two research studies. Before you decide it is important for you to understand why the research is being done and what it will involve. We are two Trainee Clinical Psychologists conducting studies as part of our training. Both studies have been combined into one questionnaire pack. One study is investigating whether some elements of a person's personality and beliefs can affect the intrusions (i.e. unwanted thoughts and images) that they experience after trauma. If we can understand why some people might experience more intrusions than others, then we might be able to understand why some people have a more disturbing reaction to trauma than others. The other study is investigating the feeling of shame in relation to PTSD and particularly how negative thinking and positive thinking may be related to this. It is hoped that the information gained from these studies may help us to treat future patients with PTSD better.

**What will I have to do?**
If you decide to take part in these studies, you will be asked to fill out some questionnaires. Some of these will be part of the standard assessment procedure at the Traumatic Stress Clinic, while others will be specific to this research. Filling out the questionnaires will take approximately 25-30 minutes. To take part in both studies (which have been combined into one questionnaire pack) you would simply need to:

1. Read this information sheet.
2. Read and sign the consent form.
3. Complete the 6 questionnaires included in this envelope. These may be in a random order and are called:
   - Trauma Intrusion Questionnaire
   - Beliefs and Experiences Scale
   - Dissociation Questionnaire
   - FSCS Scale
   - SASR
   - ESS
4. Put the completed consent form and questionnaires into the envelope provided. You can then put them in the post (postage has been prepaid) or bring them to your assessment appointment and give the envelope to your clinician along with the other questionnaires you have been asked to complete. All information that you give will remain *confidential* at all times.

Some details (e.g. date of trauma, gender, age, ethnicity) will also be collected from your files at the Clinic. We may also put the questionnaires that you complete back into your file at the clinic for your clinician to see (in order for them to have more

information about you that may be helpful for you). Please let us know on the consent form if you do not wish us to do this.

**Will I be paid for my time?**
If you decide to take part, you will be paid **£6.00** for your time. A postal order will sent to your address when we have received the completed questionnaire pack.

**Will you contact me?**
If we have not already received your completed questionnaire pack, we may telephone you within a few weeks of you receiving this optional research pack. This is to make sure that you have received the pack, to find out whether or not you wish to take part in the research, and to offer you assistance in completing the pack (if you wish to do so). Please feel free to let us know that you do not wish to take part in the research when we call you. The decision is entirely yours and we will not pressure you in any way to take part in these studies. ***If you do not wish us to telephone you, please let us know by completing the "opt-out" form on the bottom of the cover letter that you received with this pack and posting it back to us in the envelope provided.***

**You do not have to take part in this study if you do not want to. If you decide to take part you may withdraw at any time without having to give a reason. Your decision whether to take part of not will not affect your care and management in any way. Please be warned that some of the questionnaires relate to what may be upsetting and sensitive experiences.**

All proposals for research using human subjects are reviewed by an ethics committee before they can proceed. This proposal was reviewed by Camden and Islington Community Health Services Local Research Ethics Committee. If you have any questions or concerns about the study, please feel free to contact us. You can contact us at:

Sub-Department of Clinical Health Psychology
University College London, Gower Street
London WC1E 6BT

Thank you very much for your time and assistance with this study.

Yours sincerely,

Dr Sarah Marzillier
Trainee Clinical Psychologist

Rachel Harman
Trainee Clinical Psychologist

Camden and Islington NHS
Mental Health and Social Care Trust

## CONSENT FORM

**Study:** "Unwanted Thoughts and Images" and "Shame, Negative Thinking and Positive Thinking in Posttraumatic Stress Disorder"
**Researchers:** Dr Sarah Marzillier and Rachel Harman
**Hospital:** The Traumatic Stress Clinic, 73 Charlotte Street, London W1T 4PL.

To be completed by the patient. Please delete as necessary:

1. I have read the information sheet about these studies YES/NO
2. I have a contact address if I wish to ask questions and discuss these studies YES/NO
3. I have received sufficient information about these studies YES/NO
4. I understand that I am free to withdraw from these studies
   - At any time
   - Without giving a reason for withdrawing YES/NO
   - Without affecting my future medical care
5. I am happy for my clinician to see my questionnaires YES/NO

6. I do/ do not* agree to take part in these studies (* please delete as appropriate)

Signed..... Date.....

Name in Block Letters

.....

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If you would like to hear a summary of the results of these studies, please write your contact details below. These details will be kept separately from your questionnaires to make sure that your views are kept confidential.

There may also be the possibility of being involved in further research about this topic. If you are happy to be contacted about this, please indicate below.

6. I would like to receive a summary of the results of these studies YES/NO
7. I am happy to be contacted about further research into this area by this clinic YES/NO

Name:.....

Address:.....

.....

Postcode:.....

Tel:.....

Email:.....

## Appendix 3

**Experience of Shame Scale (ESS)**

**(Andrews, Qian & Valentine, 2002)**

## ESS

Everybody at times can feel embarrassed, self-conscious or ashamed. These questions are about such feelings if they have occurred **at any time in the past year**. There are no 'right' or 'wrong' answers. Please indicate the response which applies to you with a tick.

| | not at all | a little | moderately | very much |
|---|---|---|---|---|
| 1. Have you felt ashamed of any of your personal habits? | ( ) | ( ) | ( ) | ( ) |
| 2. Have you worried about what other people think of any of your personal habits? | ( ) | ( ) | ( ) | ( ) |
| 3. Have you tried to cover up or conceal any of your personal habits? | ( ) | ( ) | ( ) | ( ) |
| 4. Have you felt ashamed of your manner with others? | ( ) | ( ) | ( ) | ( ) |
| 5. Have you worried about what other people think of your manner with others? | ( ) | ( ) | ( ) | ( ) |
| 6. Have you avoided people because of your manner? | ( ) | ( ) | ( ) | ( ) |
| 7. Have you felt ashamed of the sort of person you are? | ( ) | ( ) | ( ) | ( ) |
| 8. Have you worried about what other people think of the sort of person you are? | ( ) | ( ) | ( ) | ( ) |
| 9. Have you tried to conceal from others the sort of person you are? | ( ) | ( ) | ( ) | ( ) |
| 10. Have you felt ashamed of your ability to do things? | ( ) | ( ) | ( ) | ( ) |
| 11. Have you worried about what other people think of your ability to do things? | ( ) | ( ) | ( ) | ( ) |
| 12. Have you avoided people because of your inability to do things? | ( ) | ( ) | ( ) | ( ) |
| 13. Do you feel ashamed when you do something wrong? | ( ) | ( ) | ( ) | ( ) |
| 14. Have you worried about what other people think of you when you do something wrong? | ( ) | ( ) | ( ) | ( ) |
| 15. Have you tried to cover up or conceal things you felt ashamed of having done? | ( ) | ( ) | ( ) | ( ) |
| 16. Have you felt ashamed when you said something stupid? | ( ) | ( ) | ( ) | ( ) |
| 17. Have you worried about what other people think of you when you said something stupid? | ( ) | ( ) | ( ) | ( ) |
| 18. Have you avoided contact with anyone who knew you said something stupid? | ( ) | ( ) | ( ) | ( ) |
| 19. Have you felt ashamed when you failed at something that was important to you? | ( ) | ( ) | ( ) | ( ) |
| 20. Have you worried about what other people think of you when you fail? | ( ) | ( ) | ( ) | ( ) |
| 21. Have you avoided people who have seen you fail? | ( ) | ( ) | ( ) | ( ) |
| 22. Have you felt ashamed of your body or any part of it? | ( ) | ( ) | ( ) | ( ) |
| 23. Have you worried about what other people think of your appearance? | ( ) | ( ) | ( ) | ( ) |
| 24. Have you avoided looking at yourself in the mirror? | ( ) | ( ) | ( ) | ( ) |
| 25. Have you wanted to hide of conceal your body or any part of it? | ( ) | ( ) | ( ) | ( ) |

## Appendix 4

**The Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS)**

**(Gilbert, Clarke, Hempel, Miles & Irons, 2004)**

# FSCRS

When things go wrong in our lives or don't work out as we hoped, and we feel we could have done better, we sometimes have *negative and self-critical thoughts and feelings*. These may take the form of feeling worthless, useless or inferior etc. However, people can also try to be supportive of themselves. Below are a series of thoughts and feelings that people sometimes have. Read each statement carefully and circle the number that best describes how much each statement is true for you.

When things go wrong for me:

| | Not at all like me | A little bit like me | Moderately like me | Quite a bit like me | Extremely like me |
|---|---|---|---|---|---|
| 1. I am easily disappointed with myself | 0 | 1 | 2 | 3 | 4 |
| 2. There is a part of me that puts me down | 0 | 1 | 2 | 3 | 4 |
| 3. I am able to remind myself of positive things about myself | 0 | 1 | 2 | 3 | 4 |
| 4. I find it difficult to control my anger and frustration at myself | 0 | 1 | 2 | 3 | 4 |
| 5. I find it easy to forgive myself | 0 | 1 | 2 | 3 | 4 |
| 6. There is a part of me that feels I am not good enough | 0 | 1 | 2 | 3 | 4 |
| 7. I feel beaten down by my own self critical thoughts | 0 | 1 | 2 | 3 | 4 |
| 8. I still like being me | 0 | 1 | 2 | 3 | 4 |
| 9. I have become so angry with myself that I want to hurt or injure myself | 0 | 1 | 2 | 3 | 4 |
| 10. I have a sense of disgust with myself | 0 | 1 | 2 | 3 | 4 |
| 11. I can still feel loveable and acceptable | 0 | 1 | 2 | 3 | 4 |
| 12. I stop caring about myself | 0 | 1 | 2 | 3 | 4 |
| 13. I find it easy to like myself | 0 | 1 | 2 | 3 | 4 |
| 14. I remember and dwell on my failings | 0 | 1 | 2 | 3 | 4 |
| 15. I call myself names | 0 | 1 | 2 | 3 | 4 |
| 16. I am gentle and supportive with myself | 0 | 1 | 2 | 3 | 4 |
| 17. I can't accept failures and setbacks without feeling inadequate | 0 | 1 | 2 | 3 | 4 |
| 18. I think I deserve my self-criticism | 0 | 1 | 2 | 3 | 4 |
| 19. I am able to care and look after myself | 0 | 1 | 2 | 3 | 4 |
| 20. There is a part of me that wants to get rid of the bits I don't like | 0 | 1 | 2 | 3 | 4 |
| 21. I encourage myself for the future | 0 | 1 | 2 | 3 | 4 |
| 22. I do not like being me | 0 | 1 | 2 | 3 | 4 |

## Appendix 5

**The Functions of Self-Criticising/Attacking Scale (FSCS)**

**(Gilbert, Clarke, Hempel, Miles & Irons, 2004)**

# FSCS

There can be many reasons why people become critical and angry with themselves. Read each statement carefully and circle the number that best describes how much each statement is true for you.

I get critical and angry with myself:

| | Not at all like me | A little bit like me | Moderately like me | Quite a bit like me | Extremely like me |
|---|---|---|---|---|---|
| 1. to make sure I keep up my standards | 0 | 1 | 2 | 3 | 4 |
| 2. to stop myself being happy | 0 | 1 | 2 | 3 | 4 |
| 3. to show I care about my mistakes | 0 | 1 | 2 | 3 | 4 |
| 4. because if I punish myself I feel better | 0 | 1 | 2 | 3 | 4 |
| 5. to stop me being lazy | 0 | 1 | 2 | 3 | 4 |
| 6. to harm part of myself | 0 | 1 | 2 | 3 | 4 |
| 7. to keep myself in check | 0 | 1 | 2 | 3 | 4 |
| 8. to punish myself for my mistakes | 0 | 1 | 2 | 3 | 4 |
| 9. to cope with feelings of disgust with myself | 0 | 1 | 2 | 3 | 4 |
| 10. to take revenge on part of myself | 0 | 1 | 2 | 3 | 4 |
| 11. to stop me getting overconfident | 0 | 1 | 2 | 3 | 4 |
| 12. to stop me being angry with others | 0 | 1 | 2 | 3 | 4 |
| 13. to destroy a part of me | 0 | 1 | 2 | 3 | 4 |
| 14. to make me concentrate | 0 | 1 | 2 | 3 | 4 |
| 15. to gain reassurance from others | 0 | 1 | 2 | 3 | 4 |
| 16. to stop me becoming arrogant | 0 | 1 | 2 | 3 | 4 |
| 17. to prevent future embarrassments | 0 | 1 | 2 | 3 | 4 |
| 18. to remind me of my past failures | 0 | 1 | 2 | 3 | 4 |
| 19. to keep me from making minor mistakes | 0 | 1 | 2 | 3 | 4 |
| 20. to remind me of my responsibilities | 0 | 1 | 2 | 3 | 4 |
| 21. to get at the things I hate in myself | 0 | 1 | 2 | 3 | 4 |