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Shame in Forensic Populations

Section A: Examining Shame in Forensic Populations:
A Systematic Review

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An Interpretative Phenomenological Analysis

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Summary of Major Research Project

Section A: Literature Review

This section presents a systematic review of the existing quantitative literature pertaining to the experience of shame for individuals detained in forensic settings. Seventeen papers published in peer-reviewed journals were identified as meeting eligibility criteria and were assessed against quality checklists. A narrative overview of themes were identified and discussed in relation to the wider literature and existing theories of shame. Clinical and research implications are also considered within the review.

Section B: Empirical Paper

This section presents a qualitative exploration of male forensic patients' experiences of shame. Semi-structured interviews were conducted with nine men who were detained in secure hospitals and analysed using Interpretative Phenomenological Analysis (IPA). Analysis of the data identified four group experiential themes and sixteen sub-themes. Results were discussed in relation to their research and clinical implications, and limitations of the study are also considered.

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Section A

Title: Examining Shame in Forensic Populations: A Systematic Review

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Abstract

Background: Shame is a self-conscious emotion and is recognised as a universally painful experience. Shame has been associated with a range of psychological difficulties, as well as violent offending through links with anger and aggression. It is therefore likely that shame is commonly experienced by individuals who have offended.

Method: A systematic review was conducted of the existing quantitative literature investigating shame in individuals detained in forensic institutions. Searches on online databases PsychInfo, Web of Science, EMBASE and ASSIA identified 17 studies which met eligibility criteria and were assessed using quality appraisal tools. A narrative approach was taken to synthesise the review findings.

Results: Findings from the included research were grouped into themes in relation to shame: guilt, anger, psychological difficulties, harmful behaviours, psychopathy, criminogenic factors and recidivism, and the impact on psychological interventions. The prevalence of shame in relation to different demographic groups was also identified and discussed. The findings suggest that the experience of shame can have several implications for offender populations and is associated with mental health difficulties and criminogenic risk factors which can increase recidivism.

Discussion: The quantitative studies included in this review measured different aspects of shame using a range of self-report questionnaires. Future research employing qualitative methods to explore the subjective experience of shame for individuals who have offended would be beneficial.

Keywords: shame, forensic, offending, forensic mental health

Introduction

Shame

Shame is one of the self-conscious emotions (Lewis, 1992) and is a universal experience. The feeling of shame varies between individuals, as well as the intensity in which it is experienced (Nathanson, 1992). Despite the variation in the experience of shame, the literature suggests that for most people shame is an intensely painful feeling involving self-reflection and evaluation (Tangney, 2003, Tangney & Tracy, 2012). These evaluations of the self can invoke feelings of being ridiculed, exposed, and condemned (Vikan et al., 2010) and an individual can come to see themselves as fundamentally flawed, bad, or inadequate (Blythin et al., 2020; Gilbert & Procter, 2006).

Shame is often triggered when an individual engages in an act which violates moral and social norms in some way (Ferguson et al., 1991; Keltner & Buswell, 1996). Furthermore, shame is more likely to be experienced if others are aware of an individual's moral and social transgressions (Smith et al., 2002), and thus some have argued that shame serves an adaptive role as it can regulate individuals' social behaviour, discourage moral or social norm violations, and protect the self against social devaluation (Sznycer et al., 2016). However, due to the painful feelings associated with shame, individuals tend to engage in behavioural avoidance such as distancing oneself from the shame-inducing event (Schmader & Lickel, 2006) and engaging in submissive, hiding behaviour (Gilbert, 2000). Therefore, shame is often considered to be a maladaptive emotion (Orth et al., 2006).

Shame and Guilt

Whilst many researchers have attempted to define shame and consider the functions of the emotion, it is also important to distinguish shame from the emotion of guilt. Guilt is another of the self-conscious emotions (Lewis, 1992), and shame and guilt are often described as being the same. However, despite having similarities and often coexisting together, they are distinct emotional states with different affective and cognitive profiles

(Tangney & Dearing, 2002). Miceli and Castelfranchi (2018) argue the importance of differentiating between the two emotions due to the very different psychological and behavioural outcomes associated with them both.

Lewis (1971) has proposed that one of the key distinguishing features of guilt and shame is the focus of the self-conscious scrutiny, in that shame involves negative evaluations of the self, whereas guilt focuses on negative feelings regarding the act. For example, guilt is concerned with a person feeling as if they did a bad *thing* compared to when a person experiences shame, they feel as if they are a bad *person* (Niedenthal et al., 1994). Thus, it is proposed that the intense pain associated with feelings of shame is due to the emphasis on the self as the core self is at stake (Galmiche, 2018).

In their research exploring shame and guilt, Tangney and Dearing (2002) found that guilt tended to motivate repair action behaviours such as apologising, amending, and undoing. In contrast, shame tended to lead people to withdraw or escape, and even led to hostile and self-defensive reactions. In a later study, Miceli and Castelfranchi (2018) further described the differences between the two emotions and proposed that shame implies an individual's lack of power to meet the ideal standards of the self, whilst guilt implies how an individual violates their moral self. Thus, they argue that guilt can either motivate an individual to be reparative or to self-punish, whilst shame is likely to lead to an individual either withdrawing or striving towards their aspired-to identity.

Internal and External Shame

Traditional conceptualisations of shame have centred on an individual's perception of themselves. However, several authors have attempted to conceptualise different aspects of shame itself, and Gilbert (1997, 1998) identified the differences between internal shame and external shame. Whilst internal shame concerns an individual's judgement about the self and a sense of failure to meet one's own internalised standards (Tarrier et al., 1998), external

shame is linked to public exposure and regards a person's awareness of how they may be viewed by others (Gilbert, 1998, 2003).

It has been proposed that external shame is more likely to activate an individual's defences such as wanting to hide, conceal, and 'not be seen' (Gilbert, 1998), due to the potential of becoming an object of ridicule in the eyes of others. Interestingly, internal shame and external shame are not always correlated (Lewis, 1992). For example, an individual may not experience internal shame and may only become concerned about their flaws if they believe that they may be revealed to others. Similarly, a person may not feel ashamed of their behaviours even though they are aware that others may find their behaviour shameful (Gilbert, 1998).

Proneness to Shame

Theorists of shame have highlighted how shame can be experienced as either a *state* or a *trait*. When shame occurs in relation to a specific incident or event, this feeling of shame is often fleeting and typically passes, hence being labelled as state shame. Contrastingly, trait or dispositional shame occurs when shame is experienced in a more enduring and pervasive way (Del Rosario & White, 2006). Out of the two, state shame is considered more helpful and adaptive than trait shame. One hypothesis for this is that whilst state shame typically passes after an event where an individual may feel humiliated or rejected, these feelings are usually so powerful that it acts to inhibit the behaviour and protect the individual from violating social norms and expectations in the future (Karen, 1992).

In contrast, shame as a trait is thought to be maladaptive and unhelpful as this tendency, or proneness, to experience shame becomes part of an individual's personality (Claesson et al., 2007). Shame-proneness can be particularly painful, incapacitating, and often leads to feelings of hopelessness and helplessness (Andrews et al., 2002). Furthermore, individuals who are prone to shame tend to experience shame across a range of situations (Covert et al., 2003; Tangney, 1990) and are more likely to experience shame in both an

anticipatory and consequential way (Tangney et al., 2007). It is for this reason that trait shame, or shame-proneness, has been associated with maladaptive outcomes and difficulties (Tangney et al., 1992) in contrast to shame as a transient emotional state (Andrews, 1998).

Shame and Psychological Difficulties

Unsurprisingly, shame has been associated with psychological distress and a range of mental health difficulties. Previous studies have demonstrated that shame is linked with anxiety disorders (Fergus et al., 2010), eating disorders (Troop et al., 2008), post-traumatic stress disorder (Andrews et al., 2000), depression (Kim, 2011), schizophrenia (Suslow et al., 2003), and self-harm (Sheehy et al., 2019). Furthermore, trait shame has been found to be more strongly associated with anxiety and depression than state shame (Allan et al., 1994). Individuals with mental health difficulties who experience high levels of shame are also likely to have low self-esteem (Velotti et al., 2017), in addition to greater levels of hopelessness and stress (Rüsch et al., 2009, 2014).

The underlying processes of how shame may play a role in the development of mental health difficulties can be understood within a psychological framework. Central appraisals in shame are concerned with negative self-evaluations (Lewis, 1995), and cognitive-behavioural models of understanding emotions (Beck, 2020) describe how negative core beliefs of the self as “bad” or “wrong” can lead to mental distress. Furthermore, compassion focused therapy (CFT; Gilbert, 2009) conceptualises shame as something which develops as a response to earlier difficult experiences. This can over-stimulate the threat system and hinder the soothing system, leading to impaired psychological functioning and distress.

Shame and Violent Offending

In addition to considering the clinical implications of shame, it is also important to consider the construct of shame in our understanding of violent behaviour. Research has shown how shame is linked to anger arousal, resentment, a tendency to blame others for negative events, suspiciousness, and hostile expressions (Tangney et al., 1992). It is also

positively correlated with anger and aggression (Elison et al., 2014; Harper et al., 2005), which is related to violent offending (Paulhus et al., 2004; Tangney et al., 2011a).

In his research with male offenders, Gilligan (1996) hypothesised that men who have committed violent acts hide behind a mask of bravado and arrogance in an attempt to hide their deep sense of shame. He suggested that when an individual experiences shame, humiliation, or ridicule, violence acts as a way of replacing feelings of shame with feelings of pride and self-esteem. Since then, various studies involving offender populations have demonstrated that shame is linked with anger and violent offending (e.g. Howells & Day, 2006; Kivisto et al., 2011; Walker & Knauer, 2011).

Shame in Forensic Populations

The forensic population consists of a highly heterogenous group in which individuals who have committed a crime are involved in the criminal justice system (Barnao et al., 2010). While many individuals who have been convicted of a crime are living in the community or accessing community-based forensic services, individuals detained in prison or other secure settings, such as forensic hospitals, are more likely to have committed serious violent crimes (Cornell et al., 1996), have a history of offending (Cuthbertson, 2017), and have complex additional needs (Durcan, 2021; McIntosh et al., 2023).

Given that shame is a moral emotion, and often highly correlated with an individual breaking social norms and standards (Tangney et al., 1996), shame is likely to be a common experience amongst those who have committed a crime. Furthermore, individuals in forensic settings may experience further shame due to the stigma of being in prison, or having been detained in a forensic hospital, as being formally labelled as an offender through imprisonment or being diagnosed with a mental health problem is a stigmatising experience (Knaak et al., 2017; Lemert, 1974).

Rationale and Aims

In a previous review, Tangney et al. (2011a) described the differences between shame

and guilt, and the implications for criminal and risky behaviour. They noted a lack of research with offenders but found that shame was related to increased recidivism risk, anger, and criminogenic risk factors in the general forensic population. However, to our knowledge, no systematic reviews have been conducted examining shame in individuals who are detained in forensic settings.

Therefore, the aim of this review was to describe and critically appraise the existing literature pertaining to shame in individuals who are in prison or a forensic hospital; to better understand the potential implications for this group of people, to help inform practice, and identify areas for future research. As the terms *shame* and *guilt* are often used interchangeably in research (Tangney et al., 2007; Tracy et al., 2007), only studies that quantitively measure shame will be considered in this review.

Method

This review aimed to explore the existing literature examining shame in individuals currently detained in forensic institutions. Therefore, a systematic review was chosen as an appropriate way to address the research aims. Systematic reviews aim to systematically search for, appraise, and synthesise research evidence (Grant & Booth, 2009). Given the broad nature of the research aims, a narrative approach was taken to allow a textual synthesis of the findings (Green et al., 2006).

Literature Search

A scoping electronic search of the literature related to this topic was conducted in August 2023. The scoping exercise helped identify and develop the search terms used in the database searches, as well as to identify whether any systematic reviews were already in existence. A final search was conducted in September 2023. Databases searched were PsychInfo, Web of Science, EMBASE, and ASSIA. Search terms are shown in Table 1.

Table 1

Search Terms

	Search Terms
1	(shame* OR shame-prone* OR ashamed)
	AND
2	(prison* OR offen* OR foren* OR crim* OR perpetrator* OR convic* OR felon* OR inmate OR jail* OR mental* OR psychiatric* OR secure*)
	AND
3	(measurement OR measure* OR outcome OR questionnaire* OR test OR instrument OR survey OR self-report* OR checklist OR scale OR rating)

Search terms were applied to the title and/or abstracts in all databases. Filters were added to only include papers which were peer-reviewed and written in English. No time limit was applied due to the non-existence of previous systematic reviews. A manual search of Google Scholar was also conducted to identify any additional qualifying papers. Exact duplicates were removed, and then titles and abstracts were screened for relevance. Following this, full texts were assessed for eligibility. A PRISMA flow diagram of the search process is shown in Figure 1.

Eligibility Criteria

Table 2 summarises the inclusion and exclusion criteria for the search and screening process. Studies which examined shame in individuals who were currently detained in a forensic setting were included in this review. In accordance with the aims of this review, only quantitative studies using an existing validated measure of shame were included. Due to the limited scope of this review, and for ease in making meaningful comparisons, only studies including adult participants were included.

Due to the additional complexity and offending histories of those who are residing in forensic institutions (Cornell et al., 1996; Cuthbertson, 2017; Durcan, 2021), clinical psychologists are most likely to work with this subset of the forensic population, and thus

papers examining shame in a community sample were not included. Studies evaluating the effectiveness of interventions regarding shame were not included as this did not fit with the aims of the review. Papers were also excluded if only part of the study sample met the inclusion criteria; for example, using a mixed sample from forensic community and secure settings, or a mixed adolescent and adult sample. The exception to this was if the findings from the sample were presented separately.

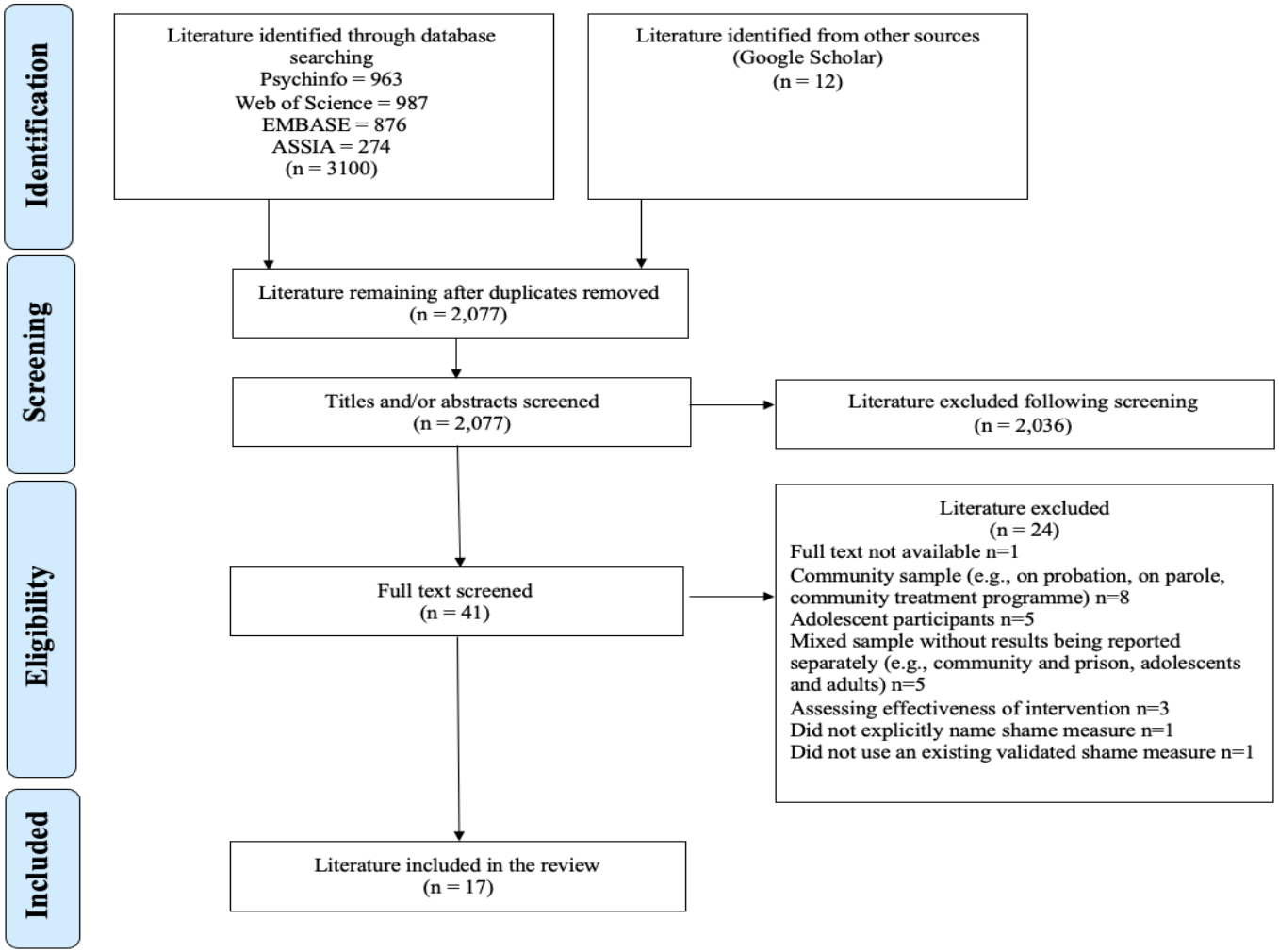
Table 2

Inclusion and Exclusion Criteria

Inclusion	Exclusion
• Peer-reviewed published article • Written in English • Full text available • Quantitative study • Includes adult participants (aged 18 or older) • Measures shame in a secure forensic setting (i.e., a young offender institute, prison, jail, or a forensic inpatient mental health setting) • The study uses an existing validated measure of shame, and the shame measure is explicitly named in the paper	• Thesis, dissertation, unpublished study, or review article • Qualitative study, intervention study, does not explicitly measure shame, does not mention the name of the shame measure, or uses archived data or records to measure shame • Study uses a juvenile/adolescent only sample • Participants are from a forensic community setting (i.e. individuals on parole, probation, or attending a court ordered community treatment programme) • Study uses a non-validated measure of shame

Figure 1

PRISMA Diagram of Search Strategy



Adapted from: Moher et al. (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLOS Medicine, 6(7), 1-6. doi:10.1371/journal.pmed1000097

Assessment of Quality

The quality of the studies was assessed using a checklist tool. The Centre for Evidence Based Medicine (CEBMa, 2014) Critical Appraisal of a Cross-Sectional Study tool was chosen as it has been recognised as a tool which can systematically assess the quality of different research designs (Stone et al., 2023), and covered the most salient factors of the studies. The subjectiveness associated with using checklists means that quality ratings are not always reliable (Grant & Booth, 2009). Therefore, overall ratings were not given for each paper and the checklist was not used as a tool to compare the papers. Instead, the aims of using the CEBM critical appraisal tool were to consider the quality of each paper and to help contextualise the findings.

Results

This section will provide a summary of the papers included in this review, and a quality appraisal of their strengths and limitations. The main findings will then be discussed in relation to the aims of the review.

Overview of Studies

A total of 17 studies were deemed to meet eligibility criteria and included in the review. Table 3 provides a summary of the main characteristics of the included papers, including the main aim and findings of the studies in relation to shame.

The studies included research from seven countries, including the United States, the United Kingdom, Canada, Italy, Poland, Ghana, and Rwanda. A total of 3426 participants were included across the studies and were recruited from a range of settings. Eleven of the papers used participants from prison or jail, four were based in a forensic psychiatric hospital, one was based in a young offender institute, and one used a mixed

sample with participants recruited from a medium secure hospital and a prison (Shanahan et al., 2011).

In terms of gender, most studies used male participants. Nine studies had all male participants, six studies had a mixed sample but reported that most participants were male, and two studies had female only participants (e.g. Milligan & Andrews, 2005; Muziki et al., 2022). All participants were aged 18 or older, with ages across studies ranging between 18 and 83 years old. The mean age of participants ranged between 19.09 years (Farmer & Andrews, 2009) and 39.6 years (Wright et al., 2008).

Eight validated measures of shame were used across the papers. Most papers used just one measure of shame in their study, however, Fuller et al. (2019) and Wright and Gudjonsson (2007) used more than one measure. Twelve studies used the questionnaires as part of a cross-sectional design, three papers used a cross-sectional design as part of a larger longitudinal study, one study had a longitudinal design, and one study used a repeated survey design.

Table 3

Summary of Included Studies

Study (author(s), year, title)	Aim (in relation to shame)	Setting	Participants	Design and Method	Shame Measure	Country	Key Findings
Dearing et al. (2005) On the importance of distinguishing shame from guilt: relations to problematic alcohol and drug use.	To assess the relationship between shame-proneness, guilt-proneness and substance use problems.	Jail	332 pre- and post-trial inmates. 90% males. Average age 31.4 years. All participants had been charged with at least one crime.	Quantitative Cross-sectional design Used self-report questionnaires to measure drug and alcohol problems, shame-proneness and guilt-proneness.	Test of Self-Conscious Affect for Socially Deviant Populations (TOSCA-SD; Hanson & Tangney, 1996).	US	There was a positive link between shame-proneness and problematic alcohol and drug use. Shame- proneness was most strongly associated with drug and alcohol dependence. Frequency of alcohol and marijuana use were unrelated to shame.

Farmer & Andrews (2009) Shameless yet angry: shame and its relationship to anger in male young offenders and undergraduate controls.	To assess the relationship between shame and anger.	Young offender institute	56 young male offenders, aged between 18 and 21 years old. Average age 19.09 years. Most participants were on remand.	Quantitative Cross-sectional design Used self-report questionnaires to measure shame, anger, depression, and defensiveness.	Experiences of Shame Scale (ESS; Andrews et al., 2002).	UK	The young offenders had lower levels of shame-proneness than undergraduates. Shame-proneness was not associated with anger in the young offender group. There was no significant correlation found between shame, and depression and defensiveness in the young offenders.

Fuller et al. (2019) Are guilt and shame in male forensic patients associated with treatment motivation and readiness?	To assess the relationship between guilt, shame and treatment motivation and readiness to change in forensic patients.	Forensic mental health unit	66 males detained in a forensic secure unit, aged between 23 and 65 years old. Average age 39.05 years.	Quantitative Cross-sectional correlational design Self -report questionnaires used to measure guilt and shame proneness, offending-related shame and guilt, and motivation to engage in treatment.	Test of Self-Conscious Affect for Socially Deviant Populations (TOSCA-SD; Hanson & Tangney, 1996) and The Offence-Related Shame and Guilt Scale (ORSGS; Wright & Gudjonsson, 2007).	UK	Shame proneness was not significantly correlated with motivation or readiness to engage in treatment. A small but significant correlation was found between offence-related shame and guilt proneness and self-reported treatment readiness.

Garofalo & Velotti (2021) Shame coping and psychopathy: a replication and extension in a sample of male incarcerated offenders.	To examine the relationship between maladaptive and adaptive shame coping styles and psychopathic traits in violent offenders.	Prison	266 male violent offenders. Average age 37.42 years.	Quantitative Cross-sectional design. Self-report questionnaires used to measure shame coping styles, psychopathic traits, and emotion dysregulation.	Compass of Shame Scale (CoSS; Elison et al., 2006)	Italy	Externalising shame coping styles were positively related to psychopathic traits across domains. Internalising shame coping styles were negatively related to the interpersonal and affective traits and psychopathic antisocial traits.

Merecz-Kot et al. (2020) Shame, guilt, time perspective, time of imprisonment and PTSD symptoms in sentenced motor vehicle accidents perpetrators - a preliminary report.	To explore the relationship between PTSD symptoms, trauma-related guilt, time perspective, guilt and guilt/shame-proneness among perpetrators of motor vehicle accidents.	Prison	37 imprisoned perpetrators of motor vehicle accidents. 97% male. Average age 39 years.	Quantitative Pilot cross-sectional design Used self-report questionnaires to measure PTSD symptoms, trauma-related guilt, guilt-proneness and shame-proneness.	The Guilt and Shame Proneness Scale (GASP-PL; Cohen et al., 2011).	Poland	No association was found between the tendency to experience shame and PTSD symptoms.

Milligan & Andrews (2005). Suicidal and other self-harming behaviour in offender women: the role of shame, anger and childhood abuse.	To consider how childhood abuse, shame and anger influence self-harming behaviours in women prisoners.	Prison	89 female prisoners. Average age 31.8 years.	Quantitative Cross-sectional design Used self-report questionnaires to measure anger, shame, and impulsive behaviours (including self-harm). Childhood abuse was assessed by semi-structured interview.	Experience of Shame Scale (ESS; Andrews et al., 2002).	UK	There was a significant relationship between shame and self-harm. Shame was significantly correlated with trait anger and anger-in.

Morrison & Gilbert (2001) Social rank, shame and anger in primary and secondary psychopaths.	To explore whether primary and secondary psychopaths differ in their internal shame sensitivity.	High security forensic hospital	50 male offenders detained under the Mental Health Act. All participants had a diagnosis of Psychopathic Disorder. Average age 38.26 years.	Quantitative Cross-sectional design Used self-report questionnaires to measure antisocial personality traits, social standing and rank, shame, and anger.	The Internalised Shame Scale (ISS; Cook, 1993, 1996).	UK	Secondary psychopaths have more internalised shame, and greater shame overall, than primary psychopaths. Non-psychopaths reported less internalised shame than psychopaths.

Mossière & Marche (2021) Emotionality during and after the commissions of an offence: a look at offence-related shame and intrusive memories in justice-involved adult males.	To examine shame and the instrumentality-reactivity of an offence in relation to intrusive memories.	Jail	100 justice-involved males, aged between 18 and 61 years old. Average age 34.17 years. One quarter of participants reported to have a mental health diagnosis.	Quantitative Cross-sectional design Used self- report questionnaires to measure trauma symptoms, intrusive memories, trauma-related shame and guilt, instrumentality-reactivity, and memory characteristics.	Trauma related shame inventory (TSRI; Øktedalen et al., 2014).	Canada	Guilt and shame were positively correlated. Shame contributed the most unique variance in the prediction of intrusive memories. Offences that were more reactive in nature were associated with higher levels of offence-related shame.

Muziki et al. (2022) Negative emotions and personal well-being among incarcerated filicide mothers in Rwanda.	To assess the prevalence of negative emotions experienced by filicide mothers in Rwanda and how they were associated with personal wellbeing.	Prison	55 mothers who had committed filicide. Average age 26.69 years.	Quantitative Cross-sectional design Used self-reported questions to assess anxiety, anger, depression, state shame, guilt and pride, and personal well-being.	The State Shame and Guilt Scale (SSGS; Marschall et al., 1994)	Rwanda	All participants had clinically significant levels of shame. There was no statistically significant differences in shame between young and adult filicide mothers. Guilt was strongly correlated with shame. Anger was correlated with shame.

Osei-Tutu et al. (2021) Self-forgiveness among incarcerated individuals in Ghana: relations with shame- and guilt-proneness.	To investigate the relationship between self-forgiveness, shame and guilt in a non-Western context.	Prison	310 incarcerated offenders, aged between 18 to 83 years old. 83.87% male. 16.13% female. Average age 39.35 years old. Almost all of the participants were first-time offenders.	Quantitative Cross-sectional design Used self-report questionnaires to assess self-forgiveness, shame-proneness, and guilt-proneness.	Test of Self-Conscious Affect for Socially Deviant Populations (TOSCA-SD; Hanson & Tangney, 1996)	Ghana	Self-forgiveness was positively associated with guilt-proneness and negatively with shame-proneness. Shame-proneness was higher in female participants than males.

Shanahan et al. (2011) Are you looking at me, or am I? Anger, aggression, shame and self-worth in violent individuals.	To investigate the relationship between unhealthy anger, shame, and self-worth in individuals who had committed a violent offence.	Medium secure unit and a prison	44 male offenders who had been convicted of a violent offence. 22 participants were from prison (aged between 21 and 56 years old, average age 35.3 years). 22 participants were from medium secure unit (aged between 26 and 55 years old, average age 38.9 years). All participants' violent offence must have been driven by anger.	Quantitative Cross-sectional design Used self-report questionnaires to measure irrational thinking, clinically dysfunctional anger, shame, self-esteem, and expression of anger.	The Internalised Shame Scale (ISS; Cook, 2001).	UK	Shame was positively correlated with anger and irrational beliefs. Participants with higher levels of anger had higher internalised shame. Shame and self-esteem were negatively correlated with each other. There were no significant differences between the mentally disordered offenders and prisoners.

Stuewig et al. (2009) The moral emotions, alcohol dependence, and HIV risk behavior in an incarcerated sample.	To examine the relationship between shame, guilt, and symptoms of alcohol-dependence to pre-incarceration HIV risk behaviours.	Jail	368 pre and post-trial male inmates. Average age 31.2 years.	Quantitative Cross-sectional design, as part of ongoing longitudinal study. Used self-report questionnaires to measure alcohol dependence, shame-proneness, and guilt-proneness.	Test of Self-Conscious Affect for Socially Deviant Populations (TOSCA-SD; Hanson & Tangney, 1996)	US	Shame and guilt were moderately correlated. There was an interaction between shame and symptoms of alcohol dependence. In participants with low alcohol dependence, shame-proneness was negatively related to risky sexual behaviour.

Stuewig et al. (2010) Shaming, blaming, and maiming: functional links among the moral emotions, externalization of blame, and aggression.	To assess the mediators between moral emotions and aggression.	Jail	507 pre- and post-trial inmates, aged between 18 and 69 years old. 70% male. Average age 32. All participants charged with at least one offence. Mostly serious offences.	Quantitative Cross-sectional design, as part of ongoing longitudinal study. Used self-report questionnaires to measure shame, guilt, externalization of blame, empathic concern and perspective taking, and verbal and physical aggression.	Test of Self-Conscious Affect for Socially Deviant Populations (TOSCA-SD; Hanson & Tangney, 1996)	US	Shame was positively correlated with eternalization of blame, empathic concern and perspective taking. No direct relationship found between shame and aggression. There was an indirect relationship between shame and aggression through externalisation of blame.

Tangney et al. (2011b) Assessing jail inmates' proneness to shame and guilt. Feeling bad about the behavior or the self?	Sought to address three overarching questions: 1. Can shame and guilt-proneness be measured in an inmate population? 2. What is the relation of proneness to guilt and shame. 3.What is the relevance of gender and race in the experience of shame and guilt.	Jail	550 pre and post-trial inmates, aged between 18 and 69 years old. 379 male 171 female Average age 32 years.	Quantitative Cross-sectional design, as part of ongoing longitudinal study. Used self-report questionnaires to measure shame-proneness, guilt-proneness and externalization of blame, empathic concern, perspective taking and personal distress, psychological and behavioural problems, and self-esteem.	Test of Self-Conscious Affect for Socially Deviant Populations (TOSCA-SD; Hanson & Tangney, 1996).	US	Shame-prone inmates had more psychological symptoms, were more likely to blame others, and had more alcohol and drug problems than non-shame-prone participants. Age was not related to shame-proneness. Shame-proneness was positively related to self-reported antisocial personality and criminogenic cognitions. There was little evidence that shame acts as an inhibitory function to

predictors of recidivism.

Female inmates had higher scores of

shame-proneness than male inmates.

White inmates scored slightly higher than Black inmates on shame-proneness.

Tangney et al. (2014) Two faces of shame: the roles of shame and guilt in predicting recidivism.	To assess whether shame acts as an inhibitor of immoral or illegal behaviour.	Jail	476 pre and posttrial inmates. 67% male 33% female Average age 33 years.	Quantitative Longitudinal study Used self-report questionnaires to measure shame proneness, guilt proneness, and eternalisation of blame. Data were collected at two time points - initial incarceration and one year post release. Recidivism was measured through self-report and searching official records for recorded arrests.	Test of Self-Conscious Affect for Socially Deviant Populations (TOSCA-SD; Hanson & Tangney, 1996).	US	Shame-proneness did not predict post release criminal behaviour. Shame proneness predicted recidivism via its relation to externalisation of blame.

Wright & Gudjonsson (2007) The development of a scale for measuring offence-related feelings of shame and guilt.	To develop and validate a preliminary measure of shame and guilt about a crime.	Forensic psychiatric unit.	60 adult males detained within forensic specialist unit. Most participants had committed a violent index offence.	Quantitative Repeated survey design Used self-report questionnaires to measure shame and guilt, state shame and guilt, shame and guilt proneness, and attribution of blame in relation to offence. Participants completed the attribution of blame measures again a month later.	The Offence-Related Shame and Guilt Scale (ORSGS; Wright & Gudjonsson, 2007) and The Test of Self-Conscious Affect -3 (TOSCA-3; Tangney et al., 2000) and The State Shame and Guilt Scale (SSGS; Marschall et al., 1994)	UK	There is an overlap between shame and guilt. However, they represent distinct emotional responses to an offence.

Wright et al. (2008) An investigation of the relationship between anger and offence-related shame and guilt.	To explore the relationship between shame, guilt, and anger.	Forensic psychiatric unit.	60 adult males detained within forensic specialist unit. Average age 39.6 years. The majority of participants had committed a violent index offence.	Quantitative Cross-sectional design Used self-report questionnaires to measure shame related to their index offence, and anger.	The Offence-Related Shame and Guilt Scale (ORSGS; Wright & Gudjonsson, 2007).	UK	Offence related shame is associated with elevated levels of anger difficulties.

Quality Appraisal

The quality of the research included in the review is considered below. A summary table of the quality appraisal, using rating outcomes from the CEBM tool, can be seen in Appendix A. The most common limitations across studies were in relation to having samples lacking in power, not being clear as to whether the sample was representative, and not controlling for confounding variables. Whilst all studies were assessed as having limitations, none were excluded from the review on the grounds of poor quality.

Study Design

In accordance with the eligibility criteria of the review, all the papers utilised a quantitative design. All papers used self-report questionnaires to assess and measure shame and other constructs relating to their study aims; however, they employed different methodological designs. All methodology chosen was appropriate given the aims of the research. Most studies, 15 in total, used a cross-sectional design, either in a stand-alone study or as part of a larger longitudinal study. This means that whilst these studies could report levels of participants' shame and other constructs such as anger, PTSD symptoms, guilt and depression, the findings could not determine a causal relationship between shame and other measured constructs.

Tangney et al. (2014) used a longitudinal study design to measure questionnaire responses during incarceration and one-year post-release. Their findings showed that participant responses remained stable over time. They reported a good response rate post-release (70%), suggesting that their findings were likely to be generally applicable. Wright and Gudjonsson (2007) used a repeated survey design where they asked participants to repeat a single self-report measure a month later, however, they had an all-male small sample and so the results may not be generalisable across genders.

Participants and Setting

In terms of sample size, there was a notable variation across the papers and participant numbers ranged from 37 (Merecz-Kot et al., 2020) to 550 (Tangney et al., 2011b), with half the studies having 100 or fewer participants. Merecz-Kot et al. (2020) did discuss their small sample size and noted that owing to their low participant numbers, their findings should only be treated as a preliminary report. They also referred to their small sample making it impossible to conduct some analyses into the coexistence and interaction of their studied phenomena. Surprisingly, none of the studies used power calculations to determine if their sample size was adequate to achieve statistical power.

Most participants were recruited from prison. Some of the studies included participants from forensic psychiatric hospitals (Fuller et al., 2019; Morrison & Gilbert, 2001; Wright & Gudjonsson, 2007; Wright et al., 2008) and one group of participants were recruited from a young offender institute (Farmer & Andrews, 2009). Whilst most papers did not report on whether their sample was representative of the wider population, making it difficult to make comparisons or determine the generalisability of their findings, two papers did. For example, Farmer and Andrews (2009) displayed a table comparing their male young offender sample with the population of remanded young adult males, indicating that their sample was largely representative of the wider population in relation to their criminal profile. Similarly, Milligan and Andrews (2005) reported that their sample of sentenced female inmates had a similar demographic profile and conviction variables to the whole population of women prisoners at the point at which the data were collected.

The papers included research from both Western and non-Western cultures. However, six papers did not report the ethnicity or race of their sample (e.g. Farmer & Andrews, 2009; Fuller, 2019; Merecz-Kot et al., 2020; Morrison & Gilbert, 2001; Wright & Gudjonsson, 2007; Wright et al., 2008). With the exception of the Milligan and Andrews (2005) paper, in which 81% of the participants were described as being ‘Caucasian’, the other papers

demonstrated a diverse sample in regard to ethnicity. For example, Tangney (2011b) reported that 44% were African American, 36% were Caucasian, 9% were Latino, 3% were Asian, 4% were “Mixed”, and 4% were “Other”.

All studies provided information on age and gender of participants. Most studies provided additional information on index offence and educational level. Some studies provided further information on the number of prior offences, length of hospital admission or custodial sentence, marital status, religion, mental health diagnoses, and socio-economic status. Eight studies did not provide specific information on participants’ index offence or number of prior convictions. The limited accounts of participant details in some studies means it is difficult to ascertain how generalisable the findings are, for example, for certain types of offences. Furthermore, it also limits the opportunity to identify how shame may be experienced differently for some ethnically minoritised groups.

Data Collection and Analysis

All but one of the studies used purposive sampling to recruit participants, which is acceptable for non-experimental research (Etikan et al., 2016). Eligible participants were approached and invited to take part in the research after receiving information about the study. Morrison and Gilbert (2021) reported using random sampling from a population of male offenders in a high security forensic hospital. However, whilst they did report inclusion criteria, they did not report how participants were randomly selected. Mossière and Marche (2021) advertised their research in correctional institutions by stating that they were looking for people to discuss their thoughts and feelings about their crime. Individuals who were involved in the criminal justice system and expressed an interest in the study were then approached by the researcher. All the studies reported inclusion and exclusion criteria which generally included requiring the ability to speak/understand English (or the local language), not deemed too risky to participate safely, and able to engage in an interview. Additionally, Morrison and Gilbert (2001) specified that participants must have a diagnosis of

Psychopathic Disorder, and Shanahan et al. (2011) had an inclusion criterion which meant that all participants must have committed a violent offence which was driven by anger.

Self-report questionnaires were used to capture participants' experiences of shame and other constructs of interest. Mostly, these were administered via either individual semi-structured or structured interviews. Two papers did not report how questionnaires were administered to participants (Dearing et al., 2005; Farmer & Andrews, 2009). Merecz-Kot et al. (2020) asked prison psychologists to distribute surveys to 100 prisoners. They reported a response rate of 47%, but due to incomplete responses and mistakes they could only include data from 37 participants in the analysis. Two studies administered questionnaires to multiple participants to complete in a quiet room at the same time in order to reduce time and staff burden (Garofalo & Velotti, 2021; Osei-Tutu et al., 2021). Morrison and Gilbert (2001) were the only study that mentioned counter-balancing the order in which measures were given to participants to reduce order effects. Osei-Tutu et al. (2021) stated that the questionnaires used in their study were validated in Western cultures, and so it is not clear how applicable their use is in non-Western populations.

In general, the analyses used in the studies were well described and appropriate for the research question and aims. The studies with a cross-sectional design all used correlations, with some using additional t-tests (Farmer & Andrews, 2009; Merecz-Kot et al., 2020; Shanahan, 2011) or regressions (Fuller et al., 2019; Mossière & Marche, 2021; Muziki et al., 2022; Osei-Tutu et al., 2021; Stuewig et al., 2009) to analyse the data. Although correlations and regressions can make predictions regarding the relationship between variables, they cannot determine causality (Tabachnick & Fidell, 2007). However, it is important to note that as none of the studies conducted a power analysis to determine their sample size, results should be interpreted with caution. Tangney et al. (2014) used a mediational model in their longitudinal study, which allowed them to assess whether eternalisation of blame mediated the link between shame-proneness and recidivism.

Measures, Biases, and Confounding Factors

A range of standardised validated measures of shame were used across the papers, assessing different aspects of shame in line with the research question and aims. All the papers reported psychometric properties of the shame measure they used, and discussed reliability, validity, and consistency. When non-English language versions of the measures were used, their psychometric properties were also discussed (e.g. Garofalo & Velotti, 2021; Merecz-Kot et al., 2020). Whilst all the studies used validated measures of shame, it is important to note that there were all measuring different aspects of shame and so this may have influenced the reported findings, in addition to making it difficult to make direct comparisons across the studies. This is especially true as most of the studies only used one measure of shame, making it hard to ascertain whether their findings would have been applicable to other aspects of shame.

Self-report data carries risk of bias, and some argue that it should not be used alone (Althubaiti, 2016). The self-report questionnaires used in the studies were likely to be particularly vulnerable to social desirability bias and difficulty with being objective. As shame can motivate some individuals to hide or withdraw, it may be that the participants who agreed to participate in the research experienced less shame or had different coping styles in their experience of shame. Furthermore, it is also possible that participants did not respond truthfully or tried to present themselves in a powerful or confident way (Schier et al., 1978).

It is likely that there were confounding factors, such as individual or cultural characteristics, which could have affected participants' ratings of shame. Out of 17 studies, only three controlled for confounding variables in some way. For example, Farmer and Andrews (2009) controlled for depression and defensiveness, Milligan and Andrews (2005) controlled for age and ethnicity in their sample, and Osei-Tutu et al. (2021) controlled for sex and age. Whilst most studies did not attempt to control for confounding variables which could have influenced their findings, some papers did discuss potential confounding variables

which may have been present in their study. For example, Mossière and Marche (2021) acknowledged previous research demonstrating sex differences related to shame (De Boeck et al., 2017), and noted that they did not control for complex trauma or other cultural considerations in their study. Similarly, Fuller et al. (2019) acknowledged that they did not control for mental health difficulties, offence-specific behaviour, or age. Whilst Farmer and Andrews (2009) did control for depression and defensiveness in their study, they also acknowledged that they did not control for ethnicity, familial and cultural factors, or the effects of exposure to prison. The potential confounding influence of the effects of incarceration was also acknowledged by Muziki et al. (2022), although not controlled for in their study. Merecz-Kot et al. (2020) discussed how personality differences, particularly indicators of personality disorder, could also be a confounding variable in the experience of shame.

Ethical Issues

Regarding ethical considerations, eight studies did not report that they had ethical approval to conduct their research. Whilst the remaining studies did clearly state that they had ethical approval, only three (Fuller et al., 2019; Mossière & Marche, 2021; Muziki et al., 2022) went beyond this to describe how the research was explained to participants, how participants were supported if they became distressed, and how participants were debriefed after the study.

Summary of Findings

As the included studies varied in their main focus and aims in relation to shame, the findings have been grouped into the following categories: prevalence of shame; shame and guilt; shame and anger; shame and psychological difficulties; shame and harmful behaviours; shame and psychopathy; shame, criminogenic factors and recidivism; and the impact of shame on psychological interventions. The findings of several studies are reported across more than one of these categories.

Prevalence of Shame

There was a high prevalence of shame in offender populations reported across the studies. There were also differences in the experience of shame amongst different groups, as reported in the findings of several of the studies. Different levels of shame between offenders and non-offenders were reported by Farmer and Andrews (2009) who found that their young offender sample had lower levels of shame-proneness, characterological shame, and bodily shame than undergraduate participants. In comparing prisoners and mentally disordered offenders, Shanahan et al. (2011) reported that there was no significant difference in shame between the two groups.

Two studies reported on shame and age. Muziki et al. (2022) found no statistically significant differences in shame between young and adult mothers who had committed filicide. These findings were also consistent with Tangney et al. (2011b) who found that age was not related to shame-proneness in their large sample of male and female inmates. Osei-Tutu et al. (2021) and Tangney et al. (2011b) both found that shame-proneness was higher in female participants than male participants. Tangney et al. (2011b) was the only study to analyse shame in different ethnicities and reported that White inmates scored slightly higher on shame-proneness than Black inmates.

Regarding differences in shame for different types of offences, Mossière and Marche (2021) reported that offences that were more reactive in nature were associated with higher levels of offence-related shame. Farmer and Andrews (2009) found no significant differences in shame between individuals imprisoned for violent offences and those for non-violent offences. Similarly, Osei-Tutu et al. (2021) found that type of offence did not moderate the association between shame-proneness and self-forgiveness.

Shame and Guilt

None of the studies specifically looked at the relationship between shame and guilt as one of their main research aims. However, several studies examined the relationship between

the two emotions as part of their analysis. Fuller et al. (2019) found that shame and guilt were significantly correlated with one another when the scores from the guilt measure and shame measure were analysed. Stuewig et al. (2009) also found that shame and guilt were moderately correlated in their study exploring shame, guilt, and alcohol dependence amongst male inmates. Similarly, Muziki et al. (2022) found that guilt was strongly correlated with shame in their sample. Mossière and Marche (2021) examined offence-related shame in justice-involved adult males and found that shame and guilt were positively correlated with each other. Whilst Wright and Gudjonsson (2007) did find that there was an overlap between shame and guilt, they stated that they represented distinct emotional responses to an offence.

Shame and Anger

Several studies reported conflicting findings in relation to shame and anger. Farmer and Andrews (2009) explored the relationship between shame and anger in young male participants in a young offender institute. They found that anger and shame-proneness were not significantly correlated in participants. However, they did find a significant positive association between bodily shame and anger reaction and proposed that this distinction can be explained by angry reactions to criticism and anger temperament. Shanahan et al. (2011) explored shame in participants from a prison and forensic medium secure unit. They conducted correlational analyses and found that state anger was positively correlated with shame. When correlations were conducted looking at other aspects of anger in a separate questionnaire, they found that shame was correlated positively with irrational beliefs. They hypothesised that if an individual's primary emotional disturbance is one of shame, it may activate an unhealthy response of anger to protect the individual from further immediate shame.

Anger was also found to be related to higher levels of internalised shame. Milligan and Andrews (2005) found all three shame scales were significantly correlated with trait anger and anger-out (the tendency to express towards others). However, neither

characterological nor bodily shame was significantly correlated with anger-out, and behavioural shame showed a significant but weak correlation. There were strong correlations between trait anger and anger-out, and between characterological and behavioural shame. Muziki et al. (2022) found that shame was significantly correlated with anger when they assessed the relationship between negative emotions and wellbeing in mothers who had committed filicide. Wright et al. (2008) was the only study which looked at shame specifically related to an offence and found that offence-related shame was significantly associated with elevated levels of anger difficulties.

Shame and Psychological Difficulties

Many of the studies reported findings related to shame and various psychological difficulties. Shanahan et al. (2011) found that shame and self-esteem were negatively correlated with each other, thus participants with higher levels of shame had lower levels of self-esteem. Taking these findings with their findings regarding reactions to anger, they also found that those low in self-esteem and high in shame had higher levels of anger arousal. In relation to depression, Farmer and Andrews (2009) reported that no significant association was found between shame and depression in young offenders. This was in contrast to their non-offender sample, where shame was significantly correlated with depression in undergraduates.

Merecz-Kot et al. (2020) investigated the relationship between shame and PTSD symptoms in imprisoned perpetrators of motor vehicle accidents. No association was found between the tendency to experience shame and symptoms of PTSD. However, the researchers do note that their findings were only in relation to a specific type of offence as all participants had been sentenced due to motor vehicle crimes. Mossière and Marche (2021) looked at shame and intrusive memories as a frequent symptom of PTSD and found that shame was positively correlated with intrusive memories. Shame contributed the most unique variance in

the prediction of intrusive memories over and above guilt, stress, and the reactive nature of the offence.

In their study of female offenders, Milligan and Andrews (2005) found that shame was significantly related to self -harm. Furthermore, bodily shame had the strongest independent relationship with self-harm and was significantly related to childhood sexual abuse. Tangney et al. (2011b) examined shame-proneness and found it was associated with a range of factors in their inmate sample. Their results found that shame-prone inmates reported more psychological symptoms than non-shame-prone inmates, in response to questions assessing anxiety, traumatic stress, obsessive-compulsive symptoms, and depression.

Shame and Harmful Behaviours

Two studies found a significant relationship between shame and substance abuse. Dearing et al. (2005) administered questionnaires to assess drug and alcohol use, and shame and guilt-proneness, in participants who were serving at least four months in jail. Bivariate and semi-partial correlations demonstrated that shame-proneness was positively associated with alcohol and drug problems, but not frequency of use. Thus, shame proneness was most strongly associated with substance dependency; however, frequency of alcohol and marijuana use was not significantly related to shame. Stuewig et al. (2009) explored shame and alcohol dependence in participants. Bivariate correlations showed that shame and 'guilt-free' shame were significantly positively related to alcohol dependence.

Stuewig et al. (2009) also investigated shame and guilt in relation to risky sexual behaviour and intravenous (IV) drug use. Bivariate correlations showed that shame was negatively related to the number of sexual partners. They found that the higher the shame-proneness, the fewer the number of sexual partners. In contrast, risky sexual behaviour did not correlate significantly with either shame or the shame residual. The authors also performed logistic regressions to assess the interaction between moral emotions and alcohol

dependence as predictors of whether participants had injected drugs with a needle in the past six months. Results showed that shame did not predict recent intravenous drug use.

Shame and Psychopathy

Two studies explored shame in offenders with psychopathy, which is defined as a form of personality pathology characterised by interpersonal, affective, lifestyle, and antisocial features (Hare & Neumann, 2008). Morrison and Gilbert (2001) found that secondary psychopaths, who tend to have higher levels of anxiety and lower self-esteem, had significantly greater levels of internalised shame than primary psychopaths, as well as greater levels of shame overall. Those diagnosed with psychopathic disorder were also found to have more internalised shame than non-psychopathic individuals. Garofalo and Velotti (2021) found associations between externalising shame coping strategies and psychopathic traits. Additionally, internalising shame coping styles were negatively related to different psychopathic traits.

Shame, Criminogenic Factors, and Recidivism

Regarding criminogenic risk factors, two studies found significant findings in relation to the role of shame. Stuewig et al. (2010) found that although there was no direct relationship between shame and aggression, path analysis showed that shame significantly predicted both physical and verbal aggression through an indirect relationship with the externalisation of blame. Tangney et al. (2011b) found that shame-proneness was positively related to self-reported antisocial personality traits, and criminogenic cognitions.

In regard to recidivism, Tangney et al.'s (2011b) study found little evidence that shame inhibits predictors of recidivism. In a later study, Tangney et al. (2014) used a latent variable representing criminal recidivism during the first year after release and found that shame-proneness did not predict post-release criminal behaviour. However, a mediational model demonstrated a significant positive mediated effect on recidivism via externalisation of blame. Thus, the authors propose the "two faces" of shame whereby shame can present a risk

factor for reoffending through a defensive pathway *and* shame can reduce reoffending risk through a prosocial pathway.

The Impact of Shame on Psychological Interventions

Only one study looked at how shame may impact on psychological interventions. In their study involving a sample of male forensic patients, Fuller et al. (2019) conducted correlational analyses to explore the relationship between shame, guilt, motivation, and readiness to engage in treatment. They found that shame-proneness was not significantly correlated with motivation or readiness to engage in psychological treatment. However, a small but significant correlation was found between offence-related shame and self-reported treatment readiness.

Discussion

This review aimed to explore the quantitative literature investigating shame in individuals detained in forensic institutions. Following the collation and critique of the findings, this review will now consider the findings in relation to the wider literature and existing theories of shame. Clinical and research implications, as well as limitations of this review, will also be discussed.

Summary of Findings

In summary, the studies in this review found that shame was an emotion experienced by many of the participants. In the studies that did analyse the relationship between shame and guilt, the two emotions were found to be significantly correlated with each other. Previous research has suggested that shame and guilt often occur together but have different cognitive profiles (Tangney & Dearing, 2002), and this was supported by Wright and Gudjonsson (2007), who found that despite the overlap between the two emotions there are distinct emotional responses in relation to committing an offence. This seems to be an important distinction to acknowledge within an offender population where individual shame

and guilt reactions to committing an offence may have very different consequences for the individual, and their rehabilitation and recovery.

Shame was found to be significantly associated with anger in all the studies examining the relationship between these two phenomena, except for the Farmer and Andrews (2009) study which found that anger and shame were not related. However, the participants in the Farmer and Andrews (2009) study were aged between 18 and 21, and it may be that younger offenders are more likely to minimise their shame as a defence against the humiliation and embarrassment often associated with it (Miceli & Castelfranchi, 2018).

The finding that shame and anger are related is important because anger can act as a risk factor for offending (Mills et al., 2003; Novaco, 2011), and particularly violent offending (Tangney et al., 2011a). Whilst the reasons for the relationship between anger and shame is likely to be multi-faceted, Velotti et al. (2017) suggest that an inability to regulate emotions such as shame may lead to a secondary reaction of anger. Furthermore, offenders may be particularly motivated to avoid shame, especially as many are likely to have experienced adverse shame-inducing life events such as poverty and abuse (Oudshoorn, 2016). Offenders may therefore use anger as an attempt to reduce their shame and portray a powerful sense of self to others (Gilligan, 1996).

As discussed in the introduction, previous literature has shown that shame is associated with a range of psychological difficulties. Several of the studies in this review had similar findings within an offender population; and shame was found to be related to low self-esteem (Shanahan et al. 2011), intrusive memories (Mossière & Marche, 2021), self-harm (Milligan & Andrews, 2005), and psychological symptoms (Tangney et al., 2011b). Whilst these findings are perhaps unsurprising given that hostile or critical views of the self can result in low self-esteem and self-harm (Forrester et al., 2017), and increase vulnerability to depression (Orth & Robins, 2013), these findings are concerning as prisoners with mental health problems are at an increased risk of suicide, violence, and victimisation (Fazel et al.,

2016). Furthermore, a recent systematic review found that offenders who experience mental health difficulties are subject to more negative stigmatised attitudes, which can have an impact on several areas of their life including their recovery, treatment, and employment options (Tremlin & Beazley, 2022). This is especially important as several of the studies in this review showed that shame is linked to harmful behaviours such as alcohol and substance abuse, which can have a negative impact on an individual's future opportunities and recovery (Crapanzano et al., 2019).

This review also highlighted how shame is associated with several criminogenic risk factors which could increase recidivism risk. Recidivism rates are higher amongst offenders who have received a custodial sentence than those who have received a community-based order (Petersilia, 2011) and figures estimate that between a third and a half of people released from prison reoffend within two years (Yukhnenko et al., 2020). Thus, as shame has been implicated as being a potential predictor of recidivism, acknowledging the potential role of shame may be helpful in considering treatment and rehabilitation options available to prisoners and individuals in forensic hospitals.

Limitations of this Review

This review only included quantitative studies. Whilst this ensured the studies were exploring shame and not guilt, this excluded qualitative research which may have provided valuable findings in relation to the aim of the review. Similarly, the review was limited by the exclusion of papers which included participants from community forensic settings. The forensic population is a heterogenous group of individuals, and this exclusion made it impossible to make comparisons between individuals detained in institutions, and those living in the community. Whilst their experiences of shame may be similar due to their commonality in committing an offence, it may be the case that individuals report their shame differently due to their current incarceration or the impact of being incarcerated itself.

Furthermore, the papers in this review included research from a broad range of settings, countries, and offender groups, which may limit the generalisability of findings. Whilst comparisons of papers could be made in relation to shame and different constructs assessed in the studies, it is likely that the experience of shame differs between countries, and most probably between Western and non-Western cultures. All participants in the review were detained in forensic institutions, however, direct comparisons between participants' experience of shame in prison compared to forensic hospitals could not be made as most studies included participants from only one setting. Furthermore, studies either included a specific group of offenders; for example, individuals with psychopathy or who had committed filicide, or did not separate different types of offences in their analysis. This made it difficult to make comparisons between how shame may be different in different groups of offenders.

Shame is a complex term, in addition to being a subjective experience, which makes it difficult to define. The studies in this review used a broad range of measures which assessed different aspects of shame. Due to this, direct comparisons of different types of shame, for example offence-related shame or external shame, were unable to be made in relation to the themes discussed earlier in the review. Furthermore, the limited scope of this review meant that assessing the measures of shame, and their usefulness in research within this population, was not possible within the remit of this review.

Clinical Implications

Many participants in this review experienced high levels of shame, suggesting that shame is a common experience among individuals within forensic institutions. Whilst there is typically a lot of focus on guilt within the criminal justice system and forensic settings, acknowledging the prevalence of shame amongst those who have offended is also important and may offer implications for clinical practice.

Shame was found to be associated with a range of psychological difficulties. Clinicians working with individuals in prisons, and particularly forensic hospitals, who are experiencing mental health difficulties may benefit from measuring the individual's level of shame and considering the implications for treatment and therapy options. Thinking about how shame may impact on the therapeutic relationship, motivation and willingness to engage in therapy, and relationship with other emotions such as anger, may improve treatment outcomes.

As shame was found to be associated with a range of criminogenic risk factors linked to recidivism, treatment and rehabilitation models should consider targeting shame. Focusing on reducing shame or the impact of shame as part of the intervention, rather than the acknowledgment of guilt, may reduce reoffending and improve recovery. Additionally, clinical psychologists could play an important role in ensuring that forensic services adopt shame-sensitive practice whereby shame is acknowledged and understood at an individual and organisational level, shaming policies and practices are recognised and avoided, and shame is addressed in a safe, non-judgemental way (Dolezal & Gibson, 2022).

Areas for Future Research

It is recommended that further research should be conducted to expand on the findings of this review. There is some suggestion in this review that there may be differences in shame in different ethnic groups (Tangney et al., 2011b). It is therefore important that future research explores the shame experiences of ethnically minoritised individuals. This is especially important given the over-representation of individuals from BAME backgrounds in the criminal justice system (Uhrig, 2016; Walker, 2020). Furthermore, the participants in this review were mostly male and many of the papers purposely excluded females from their study. Given the inconsistent findings regarding potential gender differences in shame, future research exploring the experiences of shame amongst female offenders would be beneficial.

As the cross-sectional studies in this review found that shame was associated with anger and other criminogenic risk factors which could increase recidivism, future research utilising a longitudinal design would be beneficial in exploring whether these relationships are maintained over time. Additionally, shame is likely to be a highly subjective individualised experience and influenced by a range of factors, and thus future research employing qualitative methods would allow for a greater understanding of the experiences of shame in individuals who have offended. Using an approach such as Interpretative Phenomenological Analysis (IPA) would allow for an in-depth exploration of the experience of a particular group of offenders.

Future research focused on the measurement of shame within forensic populations would be beneficial. Whilst there are a range of measures available to assess different aspects of shame, the development of a measure which captures different aspects of shame within one questionnaire would allow for more opportunities to make comparisons. Furthermore, being able to pull apart the potential causes of shame and the interaction between them could help to inform clinical practice by being able to identify whether it is the offence, being sent to prison, the stigma of having mental health difficulties, or other factors, which cause the most shame.

Conclusion

The aim of this review was to examine shame in individuals detained in forensic settings. The literature in this area was varied and often focused on different aspects of shame, as well as the impact of shame. The quantitative studies used a range of self-reported measures to assess shame, but all seemed to be applicable for use in forensic populations. Shame was found to be associated with anger, psychological difficulties, harmful behaviours, and criminogenic risk factors. The studies suggested that guilt and shame appeared to be related within this group of individuals, which was consistent with previous findings. The

studies in this review highlighted how shame is associated with a range of psychological difficulties with individuals who have offended. However, limited research has been conducted looking at shame specifically in offenders with mental health difficulties. Thus, research would benefit from exploring forensic patients' experience of shame. Using qualitative methods would allow for an in-depth analysis of the experiences of this group of individuals and would add an important contribution to the literature in this area.

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Section B

Title: Exploring the Experience of Shame for Men in Secure Forensic Services: An Interpretative Phenomenological Analysis

Word Count: 7968 (plus 152 additional words)

Potential Journal: The Journal of Forensic Psychiatry & Psychology

Abstract

Introduction: Shame is a common human experience and has been linked to substance abuse, psychological difficulties, and criminogenic risk factors in forensic populations. However, little qualitative research has been conducted exploring the experience of shame for individuals who have offended, particularly those detained in secure forensic hospitals.

Method: A qualitative design was used. Semi-structured interviews were conducted with nine men who were currently detained in either a low or medium secure hospital. Transcribed interview data were analysed using Interpretative Phenomenological Analysis.

Analysis and Results: The analysis resulted in four group experiential themes: experience and feeling; causes and contributors; impact and consequences; helpers and hindrances. Sixteen sub-themes were generated from the data.

Discussion: Participants recognised shame as a painful experience which had negatively impacted on their relationships with others, their physical and mental health, and led to social avoidance and withdrawal. Recognising and making sense of their shame helped to reduce the impact, in addition to being open and connecting with others. The strengths and limitations of the research are reviewed. The clinical implications for forensic inpatient services are considered in relation to developing shame-sensitive practice with the view to improving outcomes for patients.

Keywords: shame, forensic, mental health, offender, secure forensic services

Introduction

Forensic mental health services provide care and treatment for people with mental health difficulties, personality disorders, learning disability, and other complex needs who have committed an offence, or are deemed at risk of causing harm to others (Crocker et al., 2017). Secure forensic inpatient settings, where individuals who typically have a history of serious violent offending are detained, aim to improve the mental health and recovery of patients[1], as well as reduce the risk of recidivism to protect the public (Seppänen et al., 2018).

In England, forensic psychiatric inpatient care is provided at three different levels of security: high, medium, and low; and patients often move between hospitals with different levels of security. Patients typically tend to remain in forensic secure care far longer than in general psychiatric inpatient care (Sharma et al., 2015), with up to 27% of patients staying over 10 years (Holley et al., 2020; Rutherford & Duggan, 2008). Furthermore, length of admission often exceeds the typical length of imprisonment for the same offence (Trebilcock & Weaver, 2012).

Many people detained in secure settings have experienced multiple traumas (Bianchini et al., 2022; McKenna et al., 2019), and have severe and complex mental health problems (Mann et al., 2014). There is also a high prevalence of substance abuse (Eagle et al., 2019). Furthermore, forensic patients are subjected to many restrictions and limitations, both during their admission (Soininen et al., 2016) and after discharge (Latham & Williams, 2020). These experiences, in addition to the stigma of being detained in such services (Mezey et al., 2016; West et al., 2018), suggests that forensic patients are likely to experience high levels of shame.

[1] For the purposes of this paper, individuals detained in secure hospitals will be referred to as *patients*. The author recognises that this term has medical model connotations, however, is reflective of the language used within forensic inpatient settings and the existing literature.

Shame

Shame is commonly defined as an intense emotion involving negative evaluations of the self (Benetti-McQuid & Bursik, 2005; Tangney & Dearing, 2002). Lewis (1971) proposes that shame is experienced in response to a moral transgression whereby social or group norms are violated, resulting in an individual becoming concerned with how they are seen or judged by others (Dolezal & Gibson, 2022). An individual feels shame when they believe others consider them to be flawed in some way, or when they perceive themselves to be inadequate, inappropriate, or immoral (Dolezal, 2015).

Lewis (1971) first differentiated between the emotions of shame and guilt, which are both considered to be self-conscious emotions involving self-reflection and self-evaluation (Tangney & Tracy, 2012). Whilst both emotions involve a degree of self-criticism, shame involves criticism related to the self, whereas guilt focuses on behaviour (Teroni & Deonna, 2008), making shame an intensely painful experience (Gilbert, 1998). Compared to guilt, which is believed to motivate reparative action (Tangney & Dearing, 2002), shame is typically considered to be a maladaptive emotion because it encourages people to behave in dysfunctional and unhelpful ways. For example, when an individual experiences shame caused by a moral transgression, they are more likely to respond with anger and avoidance, rather than empathy and attempts to repair through apology (Tangney, 1991).

Shame and Mental Health Difficulties

A wealth of literature has demonstrated how shame is linked to various mental health diagnoses such as depression (Kim et al, 2011; Matos et al., 2013), anxiety disorders (Fergus et al., 2010; Gilbert & Miles, 2000), PTSD (Leskela et al., 2005; Saraiya & Lopez-Castro, 2016), eating disorders (Keith et al., 2009), and schizophrenia (Suslow et al., 2003). Shame plays a key role in conscience and self-identity, and it is therefore unsurprising that shame can damage an individual's sense of self (Kaufman, 1989), impact on relationships with

others (Hasson-Ohayon et al., 2012), and can lead to other psychological difficulties such as poor self-esteem (Elison et al., 2014; Garofalo et al., 2016).

Shame may affect psychological functioning in several ways. Firstly, the experience of shame itself may have a direct impact on a person's wellbeing and functioning (Scheel et al., 2014). Experiencing shame often leads to feelings of inadequacy, worthlessness, and a sense of being alone (Hahn, 2009), and may therefore play a key role in the development of mental health problems (Vizin, 2015) or exacerbate existing mental health symptoms. Secondly, the multiple dimensions of stigma related to mental health (Rössler, 2016; Suba et al., 2021) may result in an individual feeling shame, or increased feelings of shame, due to being diagnosed with a mental health problem.

Shame, Violence, and Aggression

In addition to being a common feature in poor mental health, shame has been indicated as playing a pivotal role in aggression and violence. Gilligan (2003) suggests that early experiences of victimisation such as physical abuse, sexual abuse, or neglect can lead to overwhelming shame and low self-esteem. He proposes that violence is used to rid feelings of shame and humiliation, and to replace them with the opposite feelings of pride and self-respect. This could be particularly relevant for men who, compared to women, may be especially motivated to not show weakness (Berdahl et al., 2018) and to convey a sense of toughness and strength (Vandello & Bosson, 2013). Multiple studies have shown that individuals who are prone to experience shame have an increased tendency towards anger and hostile behaviour which is related to violent offending (Bennett et al., 2005; Harper & Arias, 2004; Howells, 2011; Tangney et al., 2011a).

Shame is often experienced when an individual feels criticised by another (Gilbert, 1998). In circumstances where the individual may believe this criticism to be valid, they may try to defend against these feelings by externalising blame towards the critical other, resulting in violence (Tangney et al., 1996; Tedeschi & Felson, 1994). A further theory of how shame

can lead to violence is proposed by MacDonald and Leary (2005). They suggest that because shame is often linked to social pain it can trigger a threat-defence mechanism, such as a flight or fight response, which can lead to a panic response and maladaptive aggression much in the same way that physical pain can.

Shame and Forensic Populations

As a group, individuals who have offended have typically experienced multiple traumatic experiences throughout their lifetime, (Karatzias et al., 2018; Maschi et al., 2011) and are usually experienced from a younger age and for long periods of time (Facer-Irwin et al., 2019). Research with male prisoners has demonstrated that they have experienced high rates of physical and sexual abuse during childhood (Harlow, 1999; Wolff et al., 2009), as well as emotional abuse and abandonment (Wolff & Shi, 2010). Experiences of abandonment and social rejection also often occur during adulthood (Wolff & Shi, 2012). In addition, interactions with the criminal justice system and forensic services, which are often stigmatising and shaming, can reinforce feelings of abandonment and of being rejected from society (Howell et al., 2022). These difficult experiences are likely to result in a high prevalence of shame within general forensic populations.

Research has shown how shame can have implications within forensic populations. For example, Hosser et al. (2008) found that shame-proneness in young prisoners was related to recidivism risk. Furthermore, shame may inhibit individuals engaging in offender treatment, as individuals often avoid others and hide socially (Hosser et al., 2008; Proeve & Howells, 2002). This could therefore have real implications for both offenders' recovery and risk to others. Whilst shame has been linked to a range of psychological difficulties in the general population, studies have also demonstrated that shame is linked to psychological distress in offenders specifically, and linked to low self-esteem, intrusive memories, and self-harm (Milligan & Andrews, 2005; Mossière & Marche, 2021; Shanahan et al., 2011).

Rationale and Aims

Due to the double stigma of having mental health difficulties and committing an offence, individuals detained in secure forensic services are likely to experience high levels of shame. However, to our knowledge, no qualitative research has been conducted to explore the experience of shame for forensic patients. Increasing our understanding in this area could help to inform effective and appropriate interventions aimed at improving mental health and quality of life, improved relationships with staff, and reduced risk of recidivism. This may result in better quality of care and outcomes for patients within forensic secure services. As there is a high proportion of men in forensic inpatient settings (Ministry of Justice, 2019), and potential gender differences in how shame is experienced (Osei-Tutu et al., 2021; Tangney et al., 2011b), this study focused on exploring the lived experience of male forensic patients.

The current study aimed to explore the following questions:

1. What are male forensic patients' experiences of shame?
2. How do male forensic patients describe the causes of their shame?
3. How do male forensic patients make sense of their experiences of shame?

Method

Design

A qualitative research design was chosen to address the research questions. Semi-structured interviews were used for data collection and analysed using Interpretative Phenomenological Analysis (IPA) (Smith et al., 2022). This method aims to provide a detailed examination of an individual's lived experience, how they have made sense of these experiences and the meanings they give to them, as well as allowing for similarities and differences across the whole group to be examined (Smith et al., 2022).

IPA involves different levels of interpretation. One level involves staying grounded in the individual data, whilst another level involves going beyond this to a more interpretative and psychological level (Smith, 2004). A key element of IPA is the interpretation of the data and acknowledges the 'double hermeneutic' of the researcher's interpretation of how participants have tried to make sense of their experiences (Eatough & Smith, 2017).

Epistemological Position

This research was conducted from a critical realist position (Bhaskar, 1975), which is compatible with IPA as it assumes that whilst an individual's reality does exist, this can only be accessed and viewed through the lens of the individual's own perspective of their 'reality' (Shaw, 2010). Critical realism also proposes that an individual's lived experience must be understood through the interaction with the researcher and how the researcher interprets these experiences through their own lens (Smith & Osborn, 2015).

Participants

Purposive sampling was used to recruit participants. Participants were men who were currently detained in either a low or medium secure ward in a forensic hospital in the South of England. All participants met the inclusion criteria displayed in Table 1.

IPA recommends that a small homogenous sample should be used, with 6 to 10 participants suggested as a reasonable sample size for doctoral research (Smith et al., 2022). A total of nine participants took part in the study. Whilst participants were detained under different levels of security they had committed similar offences and were likely to have similar histories and were therefore deemed to represent homogeneity. A further three patients had initially agreed to participate but later declined to take part on the day of the interview. Participant demographics are displayed in Table 2.

Table 1

Inclusion and Exclusion Criteria

Inclusion	Exclusion
• Male • Detained in a secure hospital • Has been convicted of an offence or demonstrated risky behaviours • Has been diagnosed with a mental health difficulty • Has capacity to give informed consent • Is able to speak and understand English at a level sufficient to be able to engage in an interview	• Is unable to safely take part in an interview due to risk to self and/or interviewer

Table 2

Participant Demographic Information

Participant*	Ethnicity	Age	Length of Hospital Admission	Index Offence	Mental Health Diagnosis	Section	Ward Security Level
Anthony	White British	46	2 years and 6 months	Attempted murder	Schizophrenia	37/41	Medium
Ryan	Mixed British	27	2 years and 10 months	Robbery	Schizoaffective disorder	37/41	Medium
Daniel	White British	34	4 years and 9 months	Attempted GBH	Paranoid schizophrenia	37/41	Medium
Victor	White British	52	27 years and 1 month	GBH	Paranoid schizophrenia, Dissocial personality disorder	37/41	Low
Matthew	White British	39	16 years	Manslaughter	Paranoid schizophrenia	37/41	Low
Derek	White British	44	12 years and 8 months	GBH	Mixed personality disorder	37/41	Low
Kenneth	Black British	60	2 years and 8 months	Robbery and common assault	Depression with psychosis symptoms	37	Low
John	White British	57	2 years and 6 months	Alleged GBH with intent	Delusional disorder	3	Low
Aaron	White British	23	6 months	Alleged attempted murder	Bipolar affective disorder	3	Medium

**Pseudonyms are used to protect anonymity.*

Procedure

Recruitment

Clinicians working in secure units were informed about the study by the researcher's supervisor, who was a clinical psychologist working within the service. A poster (Appendix B) was also displayed on the wards. Clinicians identified patients who met the inclusion criteria and gave them a brief information sheet about the study (Appendix C). Patients who expressed an interest in learning more about the research were then invited to read the longer information sheet (Appendix D) and given the opportunity to ask any questions. If the patient confirmed they wanted to participate in the research, the clinician asked for consent to give their name to the researcher and an interview date was agreed.

Data Collection

Semi-structured interviews were conducted in a room separate from the main ward. At the start of the interview participants were reminded that the interview would be recorded, and to the limits to confidentiality. They were also given the opportunity to ask any questions before signing the consent form (Appendix E). An interview schedule (Appendix F), containing open-ended questions, was used flexibly to guide the conversation. Prompt questions were used to garner further detail or reflections.

Interviews lasted 40-65 minutes and were recorded on a dictaphone. All participants were given a £15 shopping voucher to thank them for their time. Demographic data were later collected by an assistant psychologist who had permission to access participants' electronic patient records.

Data Analysis

Data were analysed following IPA procedures (Smith et al., 2022). The process is outlined in Table 3.

Table 3

Interpretative Phenomenological Analysis Process

Step	Process
1	Transcribe interview verbatim. Read and re-read transcript to develop familiarity and immerse self in the data.
2	Make exploratory notes on the transcript, noting anything of interest.
3	Construct experiential statements from exploratory notes.
4	Make sense of any connections across experiential statements and generate personal experiential themes (PETs).
5	Name the PETS and consolidate into a table.
6	Repeat steps 1-5 with each transcript in turn.
7	Look for patterns of similarities and differences across the whole data set of PETs and create a set of group experiential themes (GETs).
8	Create table of GETs and subthemes.

Reflexivity and Quality Assurance

It is important that researchers who are conducting qualitative research recognise their values, interests, and expectations (Elliot et al., 1999), and how these may influence how the research is conducted, understood, and analysed. Therefore, the researcher engaged in several processes to assure quality and transparency of the research. This included taking part in a bracketing interview prior to commencing data collection. Notes made during the interview (Appendix G) were consulted and reflected upon during the research process to try and mitigate the effects of any of the researcher's preconceived ideas and biases on the data collection and analysis (Tufford & Newman, 2010).

The researcher also considered her own position as a white British female who was currently training to be a clinical psychologist. The researcher had no lived experience of being involved in forensic services or the criminal justice system but did have her own experiences of shame and had previously worked within a forensic secure setting. It was acknowledged that these experiences and positioning may influence her relationship with the

research. Supervision was used throughout the process as a space to reflect on the researcher's position and the potential influence of this on how the interviews were conducted, how participants responded during the interview, and how the data were analysed. Drafts of the analysis were shared and discussed in supervision. A reflexive diary (abridged version in Appendix H) was used throughout the process to aid ongoing reflection.

Ethics

Ethical Approval

This study was reviewed and given favourable opinion by Haydock Research Ethics Committee and was approved by the Health Research Authority (REC reference 23/NW/0083) (Appendix I).

Ethical Considerations

Whilst there were no obvious risks of taking part in the study, talking about experiences of shame could potentially be distressing or cause agitation. At the beginning of the interview participants were reminded that they did not have to talk about anything they did not feel comfortable with. The interviewer explained to participants that if they become upset during the interview they could take a break, talk about a neutral topic, do a breathing exercise, or stop the interview. After the interview participants were asked how they found the experience, and a brief handover was given to nursing staff on return to the ward. Ward staff were aware of where the interview was taking place and expected time of return to the ward. The interviewer carried a personal alarm which could be activated if she felt at risk at any point.

Analysis and Results

Analysis of the findings from the nine participants revealed four group experiential themes (GETS) and 16 sub-themes (Table 4).

Table 4

Overview of Group Experiential Themes and Sub-themes

Group Experiential Themes	Sub-themes
Experience and Feeling	Intolerable and Painful
	Heavy and Chronic
	Uncontrollable and Inescapable
	Hidden and to Remain Hidden
Causes and Contributors	Breaking Rules and Expectations
	Judgements from Others
	Feeling and Being Different
	A Sense of Failure
Impact and Consequences	Impact on the Relationship with Others
	Mind, Body, and Soul
	Withdrawal and Isolation
	A Desire to Escape
Helpers and Hindrances	Understanding, Acceptance, and Meaning-Making
	Increased Vulnerability
	Honesty and Openness
	Connecting with Others

Experience and Feeling

This theme captures participants' descriptions of how shame is felt and experienced.

Intolerable and Painful

Participants spoke about shame being a painful and unpleasant feeling, and used words such as *"horrible"*, *"aversive",* and *"negative"* to describe how shame felt to them. There was a sense that shame felt intolerable and needed to be expelled in some way.

"it's just negative, shame is just negative. [….] You shouldn't be harbouring shame. You need to get rid of it. It's a cancer" – Anthony.

The use of the word *cancer*, likening shame to an illness or disease, really emphasises the pain and discomfort of shame. Additionally, the metaphorical use of cancer with its negative connotations, suggests that even the word shame conjures up aversive feelings. This was reflected in how other participants described how shame felt to them.

"oh, it's intense, it's just like I've got to make noise to make it stop because it's unbearable"- Derek.

Other participants spoke to the emotional and mental pain that accompanies shame, at times comparing it to a physical pain, also reflecting what an unpleasant feeling it is.

"*I guess the pain you feel, […].not physical pain, but emotional pain, it can be quite terrible and it makes you feel really bad"* – Victor.

Heavy and Chronic

Participants spoke about shame being something that sits within them and with them for a long time, seemingly referring to the weight of shame. Victor and Kenneth described shame as a deep-rooted heavy feeling, which cuts to the core of their being.

"Well, shame, it's like it cuts through all the layers that protect you and goes right to the core, and what we are inside. It's like that sort of weight of shame goes right to the centre of you" – Kenneth.

For some participants, there was a sense that their shame was a constant presence in their life. For Aaron, this was something he had not realised until being in hospital.

"Being in this place, you're alone more, you're thinking more about yourself. I never realised I was living with this burdensome shame" - Aaron.

Uncontrollable and Inescapable

Participants reflected on shame being something which they had felt unable to escape or avoid. For some, there was a sense that shame had been in the driving seat and had

controlled many aspects of their life. For Daniel, it seemed his shame had been lurking in the shadows and always tried to "pull him back", no matter what he tried.

> *"But it always has a way of pulling you back in again. Something happens and you're like- it's like you try and let go of it. You try and get away from it. But it always pulls you back"* – Daniel.

There was a sense of inevitability in how participants spoke about shame, and some felt that their shame was unavoidable and was going to live with them forever. Derek felt he would always feel similarly about his shame, however, Matthew felt that whilst shame was likely to remain a part of his life, his relationship to it may change.

> *"I think it'll always be there […] I don't think it will go away. And if it does, I don't think it's going to go away because of anything I consciously do. Maybe it'll just sit more in the background in the future. I don't know"* – Matthew.

Hidden and to Remain Hidden

All participants spoke about shame being a hidden feeling, and something which is not shared or spoken openly about with others. Ryan spoke about how shame is rarely mentioned in court proceedings, compared to guilt.

> *"'Ashamed' is a weird word to me. I don't think I've heard people use it that much. They don't say in Court, "Do you feel shame for what you did?" They wouldn't say that. They say, "are you guilty?" or "are you remorseful?"* – Ryan.

There were differences in participants' views about why people keep shame to themselves. For Anthony, shame is kept hidden as people do not fully understand it. Kenneth felt that people are reluctant to share it because of the potential destruction it can cause.

> *"Shame… It's like it's a word that I never use to be honest because if it's sort of destructive, or like powerful, people tend to hide it"* – Kenneth.

It seemed that some participants deliberately kept shameful feelings hidden from others. John felt very strongly that shame must not be shared, as if that was the only way to cope with it.

> *"Well, the main thing is to keep it internal, and if it's kept internal then it can be dealt with"* – John.

Others spoke about going to great lengths to try and keep their shame hidden. For example, Derek had used various ways to 'mask' his shame. Matthew spoke about this in relation to the group processes in an all-male hospital ward, where men must keep their shame hidden, suggesting that there could be dire consequences otherwise.

> *"this is a men's unit […], we don't talk about stuff like that, for all sorts of reasons. It's like we just want to get along and have an easy life, and one of the ways to do that is just to go along with each other's bullshit. And if you don't, it can be really difficult"* – Matthew.

Causes and Contributors

This theme relates to what participants identified as the causes and contributing factors of their shame.

Breaking Rules and Expectations

Participants spoke about their shame being caused by breaking the rules or expectations in some way, and as Kenneth put it *"it's the knowledge of having crossed the line".*

For some participants this was related to breaking the rules of a group of people who are important to them, for example their family and friends. Others spoke about breaking the rules of society. Victor reflected on his past experiences in various forensic settings and how people who have broken the law usually experience more shame.

> *"I've seen people experience shame on the outside, and experience shame on the inside. And I've been inside quite a lot, and to various different levels of security, and*

I think most people who have actually done something against society usually experience more shame" – Victor.

Some participants spoke about shame in relation to specific types of offences, suggesting that there is a hierarchy of shameful acts within society. Ryan spoke about those who have committed sexual offences, who he believed *do* and *should* feel ashamed.

"You've got sexual offences [..] who feel ashamed. I think they should feel ashamed about it. That's just a hard one. I don't really relate to them. I try not to engage with them as much. And maybe they understand that and that's why they are kind of recluse" – Ryan.

Judgements from Others

Participants recognised that judgements from other people made them feel ashamed and made existing feelings of shame worse. Some participants described feeling worried about people's reactions if they found out about their offence, which Daniel feared could lead to being *"ridiculed and excluded".*

Some participants spoke about their experiences prior to being in hospital. There seemed to be something about their behaviour or actions being visible and known to others, and people's negative perceptions about that, which caused the most shame.

"Drugs for example [….] they've been a big part of my upbringing, and risk taking, and stuff like that. And I think that's added to my shame, as well. You know? Certain things, when people look at you like, "Oh, you're a junkie," you know, you get really shameful about it" – Victor.

John expressed his concern about being discharged from hospital. He described a sort of anticipatory shame about other people knowing that he had been in hospital and how they might feel about, or react, to him.

"Yeah, well, I'll be having to tell people basically where I've been and inevitably what I've done so it's going to be very difficult" – John.

Feeling and Being Different

Many of the participants spoke about experiencing shame due to feeling or being different to other people. For some of the participants, these feelings started from a young age, although there was a sense that this was something that had continued throughout their life.

> *"Probably when I went to secondary school, I found myself quite lower on the social hierarchy than I was at primary school, through my own decisions. I guess that started my feelings of shame"*– Aaron.

Some participants spoke about abuse or bullying they had experienced during childhood and how it had made them feel different. Derek described feeling *"totally and utterly ashamed of everything"* and how as a child he had compartmentalised aspects of his life, perhaps as a way of trying to minimise his shame.

Being diagnosed with a mental health problem had made some participants feel different. Matthew spoke about feeling 'othered' throughout his life by dressing in gender non-conforming clothes and having different interests to others. Being given a diagnosis of schizophrenia perpetuated his feelings of being different and *"wrong"*.

> *"when you come into hospital and you get diagnosed with schizophrenia, they don't say, "Oh, your body's broken," they say, "You're broken. You are. There's something wrong with you." And the more you believe that about yourself it more it reinforces these feelings of shame"* – Matthew.

A Sense of Failure

There was a sense that participants felt a lot of shame at having 'failed' in some way. Several participants spoke about breaking their own moral code when they had experienced psychosis and committed an offence, which as John put it, meant that he had *"failed so profoundly on the most basic and primordial level".*

For some participants, the sense of failure came from their life not turning out as they had hoped or expected it to. Being in a forensic hospital seemed to reinforce those feelings due to frequent reminders that they were living a very different life to people who were not in hospital.

> *"every day is a constant reminder that if I hadn't committed that crime, then the chances are that I too would've been married and had children like my brothers and sisters and be living a normal life"* – Kenneth.

Impact and Consequences

This theme encapsulates participants' views on the impact of their shame, and the consequences for different aspects of their life.

Impact on the Relationship with Others

Many of the participants spoke about how their experience of shame affected their relationships with others in a negative way. Derek spoke about some of the ways his shame had made it difficult to get close to other people: *"Yeah. Lies. Telling little lies. Drinking too much. Not letting people get close, stuff like that".*

Aaron felt that shame made it difficult for him to be honest with other people and to form healthy relationships. He frequently referred to "honesty", perhaps reflecting his fears about not being acceptable to people if he was his true self, and that it felt easier to not seek relationships with others.

> *"It's quite exhausting to always put up a front and pretend you're someone who you're not, and if that's every time that you converse and you're not honest with other people, it feels like you can't be honest with other people if you're shameful"* – Aaron.

Some of the participants felt that their own sense of shame made it hard to communicate with other people, especially when talking to people in the moment. It seemed

that for some participants, shame was always a part of the relationship and interaction with others, creating a barrier to true connection.

> *"There are a few people around who I can talk to, but even them […] I find it difficult to open up to them. Because no matter what the conversation, or which direction you take, there's always that underlying issue in the background…"* - Kenneth.

Mind, Body, and Soul

Shame had affected participants both mentally and physically. Many of the participants spoke about the impact of shame on their body, and Anthony reflected on what happened to him when he was first admitted to hospital.

> *"it can affect you physically, like literally you can lose weight, it can affect your skin, you know everything, your heart rate"* – Anthony.

Matthew also spoke about how shame affects him physically, and how it is particularly noticeable in his posture. He spoke about this being a recognisable feature of many of the patients in hospital. Whilst this posture of shame appeared to be an attempt to hide, it seemed to make people more exposed.

> *"I have this experience of shame about my life, which means I go around with my head down. And I can look out my window at people walking around with an escort, and I can tell who's the patient and who's the staff, by their posture. And it's all about shame"* – Matthew.

Some participants described the psychological feelings of shame which impacted on their mental wellbeing, and how they felt about themselves. Aaron said shame made him feel he was *"flawed"* and *"a bad person".* Victor also reflected on how shame had made him feel about himself and others.

> *"It changed the way I would look at people, I suppose, and how I feel about people. It changed the way I feel about myself towards other people […] It really does stop you doing those things, if you're, like, blocked with shame"* – Victor.

Withdrawal and Isolation

Shame had led to many of the participants feeling isolated and alone. Participants frequently spoke about wanting to "hide away" or to "run and lock themselves away". Music was mentioned by several of the participants as something they listened to when hiding in their rooms, perhaps indicating a desire to block out the outside world, or to help create a sense of safety.

> *"if I'm ashamed [….] I'm going to be hiding in my room. Lock myself in my room. Loud music. Embarrassed to come out"*– Daniel.

Aaron and Victor did not use words like "run" or "hide", but instead spoke about a more subtle feeling of withdrawing from life when experiencing shame. They seemed to be speaking to a sense of longing for a normal life, whilst acknowledging that shame prevents that from being a reality.

> *"It's not an overwhelming feeling of 'Oh, God, I'm so shameful'.. Not for me anyway. It just causes me to withdraw […] It's more like it stops me from living how I want to live. So, I'm reclusive to old friends and to family members. I don't live a proper life, a normal life. So, that's the bad thing about it"* – Aaron.

A Desire to Escape

Some participants spoke about how they had used substances to try and escape their feelings of shame. Derek spoke about daydreaming as his way of trying to escape.

> *"From a very young age, I used to have like a daydream world [….] I would sit and get drunk, just daydream all night. And that became my life for months on end sometimes, just daydreaming"* – Derek.

Others spoke about how shame had led to them self-harming as a way of coping, and for both Victor and Derek, this had resulted in them trying to take their own life. Whilst John did not resonate with shameful feelings making him want to end his life, he did comment on

this being something experienced by other people, as if this was sometimes the inevitable cost of shame.

> *"I mean how many people commit suicide because they can't deal with the shame or whatever it is?"* – John.

Helpers and Hindrances

This theme captures participants' views on things which have been helpful and unhelpful when they have experienced shame.

Understanding, Acceptance, and Meaning-Making

Participants expressed how important they thought it was to become aware of their shame, and for many of the participants this seemed like the first step in being able to understand their shame and move on from it. However, some acknowledged how difficult this was, and at times appeared conflicted in their commitment to this process.

> *"I think most people should acknowledge if they're feeling shameful. So, for me anyway, if I were- which I am doing. If I was to acknowledge shame, it's a daunting process. Because there are so many things I have to think about"* – Aaron.

Several of the participants had tried to make sense of their experiences and to accept them. For Matthew this meant exploring his "psyche", and whilst he described finding this helpful, there was also a sense that some of his experiences were too painful to explore.

> *"There's this whole core of stuff in my psyche that isn't very nice […] And I've tried to explore it a bit […] It's a bit like fumbling around in the dark in the woods. I think I've done enough, and now I'm quite happy to go around, carry my shame around, and just get on with my life"* – Matthew.

For John, separating himself from his offence by acknowledging that he was mentally unwell when it happened had helped him reach a place of acceptance. This process of separating his 'true self' from his 'mentally unwell self' appeared to make shame more tolerable for him.

"it made me realise that … I had separated myself from that event, that that's not me, that's not who I am, that's not the way I carry on" – John.

Increased Vulnerability

Many of the participants spoke about how shame had made them more vulnerable. Some participants reflected on how this meant that people could use their shame against them or, as Kenneth explained, *"It's like once you expose that, then it doesn't take much for somebody else to destroy you".* John explained that this was something he had experienced since he was a teenager.

"I did three months in a juvenile's offenders when I was 15 and to this day people still use it against me […] I just hardened off to the tactic of people trying to shame me over it" – John.

Daniel and Derek both reflected how vulnerability was linked to their feelings of shame, but also how they had tried to combat that vulnerability. Whilst both participants shared some of their vulnerability during the interview, they very quickly then spoke about "not caring" or "not getting a vulnerability out". This seemed to demonstrate how hard it is to be truly vulnerable with shame and was played out during the interviews.

"Being vulnerable would be showing shame, wouldn't it? You know, about things that affect me, being scared, telling people you can't cope. You know, [….] because you won't get a vulnerability out of me" – Derek.

Honesty and Openness

Almost all the participants spoke about how being open and honest with others was helpful in both reducing their shame and improving their mental wellbeing. For others, there were some upsides and downsides to this. For example, Daniel's description of "letting loose" may suggest that at times he has not made a deliberate choice to be as open as he has been, and that he may be experiencing some regret whilst remaining hopeful that it could help him.

"I've just kind of let loose […] And I just uncover everything about myself […] But I guess I'm expelling my own anguish and, hopefully, healing and getting over it and moving on" - Daniel.

Some participants spoke about how speaking with hospital staff or in therapy may help them work through their feelings. For Victor, it appeared that talking to professionals who can provide a space and put some of his feelings into words is what would be helpful. Others spoke about a sense of reaching a point where they could no longer hide their shame. Derek described feeling as if he had no choice but to start being honest about what he was going through, but how ultimately this was good for him.

"So I literally, rather than cover it up, I was stuck in a bed with broken legs, broken back, and I just cried for about four days. I couldn't hide it anymore. I couldn't be a geezer. I couldn't do none of it, because I was just lying there and I couldn't pretend […] And it was the best thing for me. I just cried for days and days and days, and I didn't care" – Derek.

Connecting with Others

Participants described times when they connected with others who had experienced similar things to them. John found talking with another patient helped to give him an outside perspective of his own thoughts and feelings and appeared somewhat surprised that this had been helpful.

"There are some patients that I've spoken to and that's been interesting their experiences, yeah, that gives you an external view of the same thing that I'm going through, so it is quite interesting" – John.

Matthew spoke about how he had been able to connect with another patient, after both finding out the topic of this research was shame. There appeared to be a sense of connection through both agreeing to participate in the research, almost as if that gave them 'permission' to talk about it with each other.

"I've got a friend here […] and shame is the huge thing that has defined his life, with tragic consequences. But I've never heard him talk about that until the other day […] I've had moments like that with people, and it can be really nice. [….] But a lot of the time, in these places, everyone just has to go around wearing a mask" – Matthew.

Kenneth reflected on his life before being in hospital, and how he sought and found a connection with others through shame.

"I started exploring drugs and meeting people or going out looking for people who had the same detachment from society in general. Most of the people I met, they all had their skeletons in the cupboard […] it's like at first you don't really relate or understand. But the longer you spend with them, it's like the more you begin to see what the person is behind the mask" – Kenneth.

Discussion

This research aimed to explore how shame is experienced by male forensic patients, the causes of their shame, and how they made sense of these experiences. Participants highlighted how shame was an incredibly painful experience for them and was something that most of them had experienced throughout their life but kept hidden. They also reflected on what they felt had caused or contributed to their shame, and how shame had impacted on their lives.

Many of the participants spoke about how their shame was related to their difficult upbringings, which led to them feeling different and ostracised in some way. Previous studies have shown how individuals who have offended are likely to have experienced multiple traumatic and adverse events throughout their life (Reavis et al., 2013; Turner et al., 2021), and it is recognised that shame is often an emotional after effect of trauma (Dolezal & Gibson, 2022). Furthermore, some research suggests that early experiences of shame may be

stored in memory and used as a reference point in which to self-identify later in life, increasing vulnerability to psychopathology (Pinto-Gouveia & Matos, 2011).

The impact of shame was widespread, and participants spoke about how shame had affected their relationships with others, their mental and physical health, and had led to social withdrawal and isolation. Some participants had tried to cope with their shame by using alcohol and substances, daydreaming, and self-harm. Shame is an incredibly painful and unpleasant experience (Gilbert, 1998) and individuals often try to avoid the feeling (Lewis, 2003). Therefore, these coping strategies may be interpreted as participants' attempts to defend against the pain of shame through repression (Banmen, 1988), to try and minimise further judgment from others, or to reduce vulnerability.

The impact of shame, and the strategies participants used to cope with their shame, are important findings as maladaptive coping techniques such as substance use and self-harm are risk factors for violence and mental health difficulties (Claro et al., 2015; Pickard & Fazel, 2014). In addition, participants frequently spoke about wanting to hide or lock themselves away, which the literature suggests is a common reaction to experiencing shame (Tangney, 1992). However, social isolation and a lack of positive social relationships with others can have a devastating impact on both physical and mental health (Brandt et al., 2022; Cacioppo & Cacioppo, 2014). Withdrawing may also impact on patients' ability to engage in therapeutic interventions during their time in hospital, possibly leading to poorer outcomes and negative consequences (Cann et al., 2003; Palmer et al., 2008) including increased risk of recidivism (McMurran & Theodosi, 2007).

Shame theories propose that external shame occurs when an individual violates social norms in some way (Ferguson et al., 1991) and the moral transgression is known to others (Gilbert, 1998; Smith et al., 2002). Participants spoke about experiencing external shame when they had broken rules or expectations, particularly when they had felt judged by others. Participants also appeared to have experienced internal shame (Tarrier et al., 1998), as feeling

different to others or having failed in some way elicited feelings of shame. There was a sense that participants experienced a lot of shame due to being detained in a forensic hospital, with some expressing concern that this would continue after discharge. Research has suggested that the stigma associated with having a mental health diagnosis or being labelled as an offender can be extremely shaming (Bidwell & Polley, 2023; Sabu et al., 2021; Vigo, 2016). Consequently, themes around feeling "different" and "failing" may have been inadvertently reinforced by the forensic mental health system.

There were differences between participants' views about what helped reduce their shame and what made it worse. Understanding their shame and making sense of it was often described as an important first step for participants, to enable them to work through and move on from their shame. Additionally, openness and connection with others seemed important to participants, although it was recognised that this did increase feelings of vulnerability. Van Vliet (2009) proports that making connections is key to overcoming profound shame as it leads to greater self-acceptance and acceptance of others, and this may help to make sense of participants' reported experiences. Furthermore, it is proposed that self-compassion is the antidote to shame (Sedighimornani et al., 2019), and thus the process of participants acknowledging their shame, making sense of it, and accepting it may have helped to increase their self-compassion.

Strengths and Limitations

The experiences of shame for male forensic patients have not previously been explored in a qualitative study. Therefore, this research provides important insights into how shame is experienced and understood by this group of individuals.

IPA approaches aim to provide an in-depth examination of the experiences of a small homogenous group of people, and whilst it is anticipated that the findings can be transferred from one group to another, it is difficult to make wider generalisations. All nine participants in this study were from hospitals in the same geographical area, which means that the

experiences they described may be specific to these participants. Furthermore, participants were aware that they would be interviewed on the topic of shame before agreeing to participate. This may have meant that individuals with a better awareness of their shame, or more open to talking about their experiences, were more likely to participate in the research.

Participants were aware that they were being interviewed by a trainee clinical psychologist, and many of them mentioned having previous experiences with psychologists. This may have altered what they felt able to share or perceived as relevant to share during the interview. For example, some participants may have said things they believed they were 'expected' or 'should' say to a psychologist, whereas others may have held back on what they discussed due to previous negative experiences.

Finally, individuals from Black and Minoritised Ethnic (BAME) groups were under-represented in this sample, especially as Black people are overrepresented in secure forensic services (Ministry of Justice, 2022). Therefore, the findings from this study may not fully reflect the experience of individuals from BAME backgrounds whose experience of shame may be different, given they are at increased risk of detention in forensic inpatient settings, have longer stays within secure services, and have higher rates of readmission (Arya et al., 2021).

Clinical Implications

Findings emphasised how shame was a common, painful, and vulnerable experience for participants and had negatively affected their life in many ways. Furthermore, the stigma associated with being detained in a forensic hospital and judgements from others were identified as contributing to participants' shame. It is important that these findings are acknowledged and addressed within secure forensic services so that shame, and the impact of shame, is considered at a policy, organisational, and individual practitioner level. Developing shame-sensitive practice which aims to acknowledge, avoid, and address shame at all organisational levels (Dolezal & Gibson, 2022) is likely to be especially important within

forensic inpatient settings as participants highlighted the interplay between trauma and shame, how forensic services can be shaming, and how shame impacts on their behaviour and presentation in hospital.

Staff training aimed at increasing staff's understanding of shame, and the impact of shame for forensic patients, may improve the care offered to patients. For example, staff may have a better understanding of potential reasons for patients withdrawing, using substances, or engaging in aggressive behaviour, as well as potentially reducing staffs' judgements about offences. Paying particular attention to patients when they are first admitted to hospital, as this is likely to be a time of increased shame, may help to identify those at risk of withdrawal and social isolation which are risk factors for poor mental health and aggression (Ferguson et al., 2005; Rohde et al., 2015).

As participants spoke about the importance of sharing and connecting with other patients, group interventions involving psychoeducation about emotions and shame may help to reduce stigma and offer opportunities for connection and engagement. Incorporating compassion training based on compassion-focused therapy (CFT) principles may also help to improve self-acceptance and reduce feelings of shame (Gilbert, 2017). However, caution would be required as participants acknowledged that shame often increases feelings of vulnerability.

Clinical psychologists working with forensic patients should consider the role of shame within psychological formulations and to guide interventions, especially as shame has been linked to a range of psychological difficulties. Participants also spoke about the importance of meaning-making in reducing the impact of their shame. Thus, offering patients opportunities to understand and make sense of their experiences in a safe, non-judgemental way, whilst acknowledging that shame is difficult to talk about, is likely to be important.

Participants spoke about shame in relation to previous traumatic experiences. Therefore, offering individual psychological interventions such as CFT could help

participants address their shame by making sense of their offending and behaviour through a trauma lens. Previous studies have shown promising findings regarding CFT as an effective intervention for people who use forensic services in reducing shame, violence, and anger (Taylor, 2017; Taylor, 2021; Thomas, 2019).

Areas for Future Research

There are several ways that future research could expand and build on the findings from this study. To increase the generalisability of findings, future research using quantitative methods could be conducted on a larger sample of male forensic patients using questionnaires based on themes from this study. Furthermore, quantitative research could compare results from different groups, for example female and male forensic patients, or for individuals who have committed different types of offences. Further qualitative research exploring shame in different groups of offenders, such as female forensic patients, prisoners, or individuals from a BAME background would also be beneficial.

Future research could use a longitudinal approach to investigate the relationship between shame and being detained in a secure hospital. Measuring forensic patients' shame at the point of admission, mid-way through their admission, and on discharge from hospital would provide further information on the experience of being in a forensic hospital and feelings of shame. Investigating the impact of different variables such as engagement in psychological therapy, accessing peer support, and group interventions, may complement this work.

Conclusion

The current study explored male forensic patients' experiences of shame. Participants described shame as a painful, inescapable feeling that was hidden from others. The causes of shame were identified as being due to breaking rules and expectations, judgement from others, feeling different, and feeling as if they had failed in some way. Participants

recognised that shame had impacted on their life in many ways and had negatively affected their relationships with others, their mental and physical health, and caused them to become socially isolated. Participants had tried to escape their shame, which had resulted in them engaging in substance use, self-harm, and attempts to take their own life. Participants felt that recognising their shame, making sense of it, and accepting it had helped to minimise the negative impact, whilst also acknowledging the vulnerability that accompanies shame. Additionally, they recognised that connecting with others, and being open and honest, helped them deal with their shame.

The findings from this study suggest that the experiences of shame for men detained in forensic secure services are considered, and a shame-sensitive culture is adopted within services to improve outcomes for patients. Implications for clinical practice include offering staff training to improve understanding of shame for men detained in forensic services, group interventions based on self-compassion to increase understanding and provide opportunities for connection, and the importance of considering shame within psychological formulations and individual interventions. Future research would benefit from further exploration of the experience of shame for different individuals detained in secure forensic services, including both qualitative and quantitative research.

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Section C

Appendices of Supporting Information

Appendix A

CEBM Table

The Centre for Evidence Based Medicine (CEBMa, 2014) Critical Appraisal of a Cross-Sectional Study tool

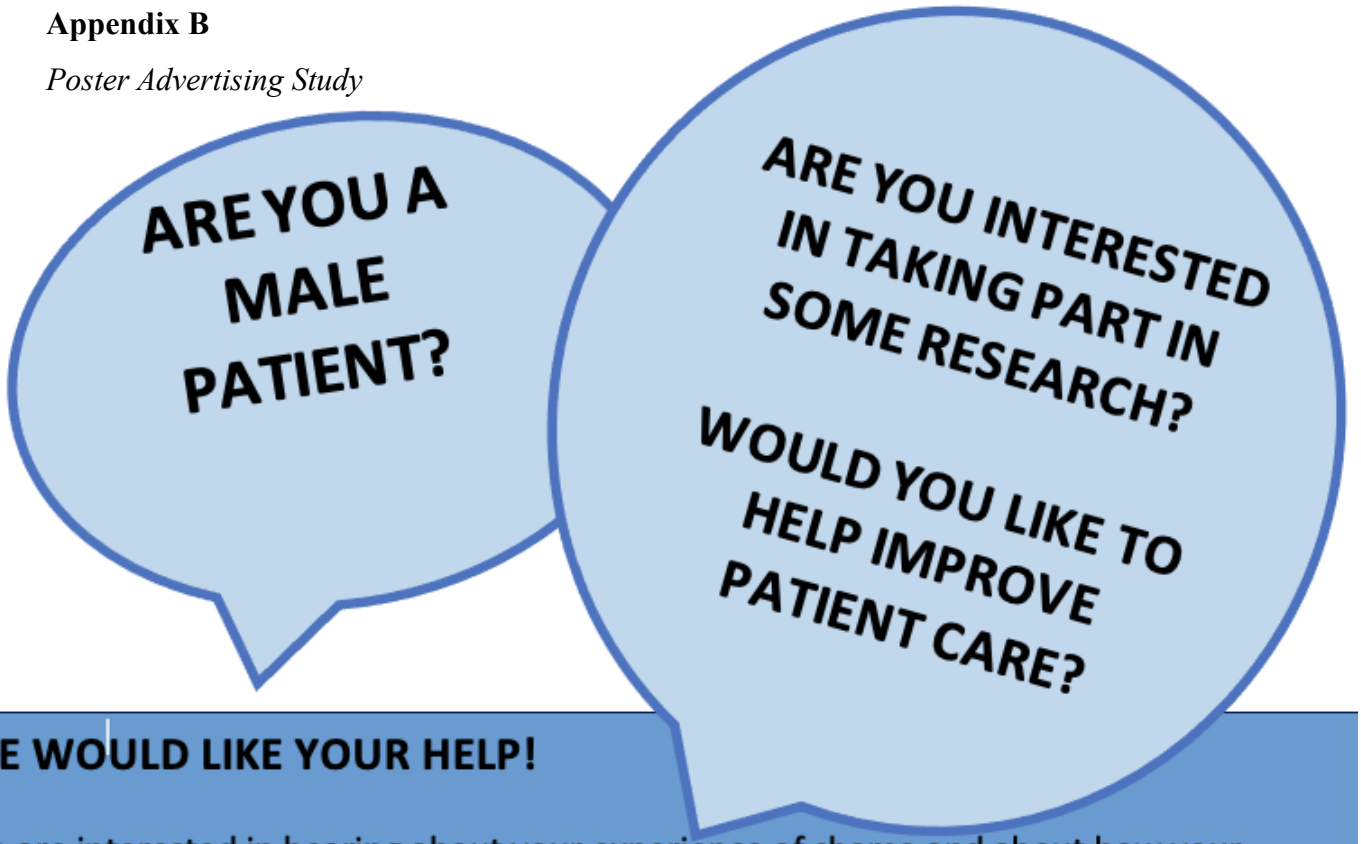
Study	Dearing et al. (2005)	Farmer & Andrews (2009)	Fuller et al. (2019)	Garofalo & Velotti (2021	Mereczkot et al. (2020)	Milligan & Andrews (2005)	Morrison & Gilbert (2001)	Mossière & Marche (2021)	Muziki et al. (2022)
Clearly focused question?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Study design appropriate?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Method of selection of the subjects clearly described?	No	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Selection bias in the sample?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Representative sample?	Unclear	Yes	Unclear	Unclear	No	Yes	Unclear	Unclear	Unclear
Sample size based on power calculations?	No	No	No	No	No	No	No	No	No
Satisfactory response rate?	Unclear	Unclear	Yes	Yes	No	Yes	Yes	Yes	Unclear
Measurements valid and reliable?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Statistical significance assessed?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Confidence intervals given	No	No	No	No	No	Yes	No	Yes	No
Confounding factors?	Yes	Yes (controlled for some)	Yes	Yes	Yes	Yes (controlled for some)	Yes	Yes	Yes
Applicable results?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

The Centre for Evidence Based Medicine (CEBMa, 2014) Critical Appraisal of a Cross-Sectional Study tool

Study	Osei-Tutu et al. (2021)	Shanahan et al. (2011)	Stuewig et al. (2009)	Stuewig et al. (2010)	Tangney et al. (2011)	Tangney et al. (2014)	Wright & Gudjonsson (2007)	Wright et al. (2008)
Clearly focused question?	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Study design appropriate?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Method of selection of the subjects clearly described?	Yes	Yes	Yes	Yes	Yes	Yes	No	No
Selection bias in the sample?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Representative sample?	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear	Yes
Sample size based on power calculations?	No	No	No	No	No	No	No	No
Satisfactory response rate?	Yes	Unclear	Yes	Unclear	Yes	Yes	Yes	Unclear
Measurements valid and reliable?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Statistical significance assessed?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Confidence intervals given?	Yes	No	No	No	No	No	No	No
Confounding factors?	Yes (controlled for some)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Applicable results?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Appendix B

Poster Advertising Study



WE WOULD LIKE YOUR HELP!

We are interested in hearing about your experience of shame and about how your experiences may have affected you in different ways.

We don't know much about this at the moment, but we would like to learn more so that we can hopefully help improve patient care in the future.

Would you be willing to share your experiences with us in an interview that would last approximately 30- 60 minutes?

YOU WILL RECEIVE A £15 VOUCHER FOR YOUR TIME

If you think you might like to take part in this study and would like further information please email:

Sarah Flaherty-Hutchins
Trainee Clinical Psychologist
Sf504@canterbury.ac.uk
OR
speak to a member of staff

Canterbury Christ Church University

Appendix C

Participant Brief Information Sheet

Canterbury Christ Church University

Do you want to help with some important research and help improve patient care?

- Hi. My name is Sarah, and I am a trainee clinical psychologist. I am inviting you to take part in a research study. I am not a member of staff at this hospital and this study is separate from your hospital care.
- Shame is a common human experience and is a difficult emotion which often makes us feel bad about ourselves. In this study we are interested in learning about how shame is experienced in men who are receiving care in a forensic hospital. At the moment we do not know much about this, and we would like to learn more.
- You do not have to take part. If you say no it won't affect your care in hospital.
- To take part in this study you will be asked to take part in an interview with me. The interview is likely to last at least 30 minutes.
- In this interview we will talk about your experiences of shame. You do not have to tell me any details about anything that is uncomfortable to you.
- You will be given a £15 voucher for taking part in the interview.
- If you think you might be interested in taking part in this study, please tell someone in your care team.

THANK YOU

Appendix D

Participant Long Information Sheet

INFORMATION SHEET

Study title

Exploring male service users' experience of shame in forensic inpatient settings.

Lead researcher Sarah Flaherty-Hutchins **(**Salomons Institute for Applied Psychology)
Principal supervisor Dr Rachel Terry (Salomons Institute for Applied Psychology)
Secondary supervisor [redacted]

Introduction

Hi. My name is Sarah and I am a trainee clinical psychologist at Canterbury Christ Church University. I am inviting you to take part in a research study. I am not a member of staff at this hospital and this study is separate from your hospital care. Please read this information sheet to find out more about the study before deciding if you would like to take part. It is important that you understand why this study is being done and what taking part would involve for you.

What is the purpose of the study?

This study aims to explore shame in men who are receiving care in a secure hospital setting and how they make sense of their experiences of shame. This is something that is currently not well understood. We hope that by learning more about this topic we can better understand the experiences of service users in forensic inpatient settings and improve their care.

Why have I been invited to take part?

You have been invited to take part as you are currently receiving care in a secure hospital setting.

Do I have to take part?

No, participating in this study is voluntary so you do not need to take part if you do not want to. If you agree to take part, then I will make sure you understand what is being asked of you and then ask you to sign a consent form, or provide verbal consent. Even if you initially agree

to take part in the study, you can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have. If you have already taken part in the interview, you will have 10 days to let me know that you wish to withdraw. You do not have to give a reason why you no longer wish to be part of the study, but we will keep any information about you that we already have. If you feel unsure about taking part in the study, you may find it helpful to talk through with a member of staff. If you decide that you do not want to take part in this study for any reason, your care will not be affected in any way. This means you will not be treated differently whether you decide to take part or not.

What will happen to me if I take part?

We will agree a time to meet at the hospital. We will go to a private, quiet room for a one-to-one interview. This is likely to last for at least 30 minutes. The interview will be audio recorded so that the information from the interview can be written up afterwards. The audio recording will be deleted as soon as the interview has been written up. The audio recording of the interview may be transcribed (written up) by an external transcription company. If this happens, the company will have to sign a confidentiality agreement before they listen to the recording. At the start of the interview, I will tell you a bit about an emotion called shame. Then, I will ask you some questions about your experience of feeling shame, how you feel about it and how this may affect your day-to-day life. You will also be able to ask me any questions if you wish. You do not have to tell me anything that is uncomfortable to you.

We will also collect some information about you from your file, for example how long you have been in hospital, the section you are under, your mental health diagnosis, any convictions, your age, and ethnicity.

Payment

By taking part in this research, you will receive a £15 voucher to thank you for your time. You will be emailed the voucher after you have participated in the interview. To receive the £15 voucher, you must have participated fully in the interview.

What will I have to do?

If you agree to take part, we will organise a time to meet. If you consent, we will collect some information about your life. I will ask you to sign a consent form, or provide verbal

consent, before we start the interview, and I will ask you to answer the questions I ask you as honestly as possible.

What are the potential disadvantages and risks of taking part?

As you are being invited to take part in an interview you may be asked some further questions to expand on your answers. It might be that you find some of the questions difficult to answer. We understand that you might not have talked to anyone before about the things we will talk about in the interview. This means taking part in this study might make you feel distressed, upset, or angry in some way. If this happens in the meeting you can stop answering questions or have a break. We will let the nursing staff and clinical team know that you have taken part in the research so that they can offer you support if needed. We will not share any of your answers with them and it will not affect your ongoing care pathway. If you do find anything distressing, I can support you with these feelings before leaving the room, if you would like to. If you continue to feel distressed after the interview I will talk to the ward staff about this so that you can be supported with this when you are back on the ward.

What are the possible benefits of taking part?

It is possible that you might find it helpful to talk about your experiences of shame. However, we do not know if this study will help you directly, but we are hoping to find out more about the experiences of people who are in forensic hospitals, to learn important information about your lived experience of shame and how this may affect your life.

What will happen to my information?

We will need to use information from your interview and from your clinical records for this research project. This information will include your initials, NHS number and name. People will use this information to do the research or to check your records to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/
- by asking one of the research team (Sarah Flaherty-Hutchins, Dr Rachel Terry, Dr XXXX)
- by sending an email to Dr Fergal Jones (fergal.jones@canterbury.ac.uk)

We will follow all ethical guidelines in place from the university and the NHS. Your clinical team will be told if you have agreed to take part in this research project, but we will not share any details with them. This means they will not know any of your answers and your care will not be affected in any way by the answers you give. However, there are some instances where information about you may need to be shared with others. For example, if you tell us about a criminal offence or if you tell us something which makes us think there is a risk of harm to yourself or to others, we will need to share this with your clinical team and possibly other authorities, such as the police. It may be that your clinical team decide to share this information with the trust's safeguarding team. If we need to do this, we will always talk to you about this first so that you know we will be sharing this information with others.

What will happen to the results of the research study?

Once you have completed the interview, we will give you some information about how you can withdraw your answers if you no longer want to be involved in the research. This will give you the latest date that you will be able to do this. The results of the study will be written up in partial fulfilment of my Doctorate in Clinical Psychology. Some of the findings from the study may be published in an academic journal. Direct quotes from the interview may be used in publications. Anything written up will be anonymous. No names of participants or identifying information will be used. You will be able to get a copy of a summary of the findings if you wish. You can do this by providing your email address on the consent form. If you do not have access to email, you can tick on the consent from that you agree for the findings to be sent to your named nurse, who can then pass this on to you if you are still in hospital when the results have been written up.

What if there is a problem?

Any complaint that is made about how you were treated during this study or any harm that you may have suffered will be addressed.

If you have a concern about this study you should ask to speak to the lead researcher, Sarah Flaherty-Hutchins, in the first instance who will try and address your concerns as soon as possible (contact details at the end of this document). If you remain unsatisfied with this and would like to complain formally you can contact Dr Fergal Jones, Research Director, Salomons Centre for Applied Psychology, Canterbury Christ Church University 1 Meadow Road, Tunbridge Wells, TN1 2YG – fergal.jones@canterbury.ac.uk, tel: 01227 927110.

Who is sponsoring or funding the research?

This research is being funded by Canterbury Christ Church University.

Has the study been reviewed and approved?

All research conducted within the NHS is looked at by a Research Ethics Committee, which is a group of independent people who are looking to protect your interests. This study has been reviewed and given favourable opinion by Haydock Research Ethics Committee and been approved by the Health Research Authority (REC reference 23/NW/0083).

Further information and contact details

If you would like to ask any questions or have any concerns about the study or to find out some more information, please contact the lead researcher Sarah Flaherty-Hutchins by emailing sf504@canterbury.ac.uk

THANK YOU

Appendix E

Participant Consent Form

CONSENT FORM

Study title: Exploring male service users' experience of shame in forensic inpatient settings.
Name of researcher: Sarah Flaherty-Hutchins

Please initial each box and sign below:

- I confirm I have read (or had read to me) and understand the information sheet for the above study. I have been given the opportunity to consider the information, ask questions, and have had any questions answered satisfactorily. ☐

- I understand that my participation is voluntary and that I can withdraw from the study without giving a reason. I understand that I must withdraw from the study within 10 days after taking part in the interview for my data to not be used. ☐

- I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from Canterbury Christ Church University and from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐

- I understand that all members of the research team (Sarah Flaherty-Hutchins, Dr Rachel Terry, Dr Hannah Gray) will have access to my data during the study. ☐

- I have been informed that there is the possibility that I may experience some emotional discomfort during participation and am aware of how I can get help and support with this if this happens. ☐

- I agree to take part in the above study. ☐

- I would like to receive the results of this study and will provide my email address below so that the results can be emailed to me. ☐

- I would like to receive the results of the study, but do not have access to email. Therefore, I agree for the results to be emailed to my named nurse to give to me instead. I understand this can only happen if I am still in hospital when the findings have been written up. ☐

Name of participant: _____

Signature: _____

Date: _____

Email address:

_____

Name of person taking consent: _____

Signature: _____

Date: _____

Appendix F

Interview Schedule

Interview Schedule

Introduction:

- Briefly cover the information from the Participant Information Sheet.
- Give participants time to ask any questions, check they understand what they are being asked to do and ask them to sign the consent form.

Say: Thank you for agreeing to take part in this interview. I really appreciate you taking the time to meet with me today. The aim of this interview is to gain an in-depth understanding of your experiences of shame. There are no right or wrong answers and I am interested in your thoughts, feelings and reflections. Please be as open and honest as possible. This might be a difficult topic for you to talk about. However, you do not have to tell me any details about your offence, experience of mental health difficulties or difficult things that have happened in your life. I may not say much as I am mostly interested in hearing your views. If you do not understand a question or would like me to explain more, please let me know. Just to remind you that as a thank you for engaging in the interview fully, you will be given a £15 voucher for your time.

Finally, this is likely to be a difficult topic to talk about. You might not have spoken about these things to anyone before. I would like to remind you that if you become distressed or upset during the interview then we can stop and take a break, talk about something else for a bit or do some breathing exercises. I will also tell the ward staff that you have taken part in this interview so they can continue to offer you support when you are back on the ward.

Warm up questions before starting interview

- So, how are you today?
- What have you been up to before this?
- How long have you been in hospital?

Questions:

Provide the participant with some images/prompts about shame to help explain the difference between shame and guilt

Say: just before we start, I would like to show you a couple of images which might help to explain what we are going to be talking about today. Shame and guilt are feelings that everyone gets from time to time. Often people think ‘guilt’ and ‘shame’ are the same thing, but they’re not. An example of how they are different might be that if you feel guilty about something you might think “I did a bad thing”. However, if you feel ashamed about

something you might think “I am a bad person”. Today I would just like you to answer questions about shame, and not guilt. Does that make sense? Do you have any questions about what I’ve just said before we start

Section 1. General experiences

- What does shame mean to you?
- What have been your experiences of shame as a child?
- What have been your experiences of shame as an adult?
- How do you feel about yourself when you experience shame?
- How do you think your family, friends or other people feel about you when you experience shame?

Possible prompts: *can you tell me about a time/times you have felt shame? How has that/those times affected you? How do you feel about shame? What do you do when you experience shame? How do you behave?*

If the participant is struggling to think of anything, say: Research suggests that children often experience shame when they hit their sibling, lie to their parents, or steal something. This may make them feel like a they’re a bad person.

Section 2. Beliefs about shame

- Do you think you experience more or less shame than an average person?
- Why do you think that?
- Has your experience of shame changed over time?
- If so, in what ways?

Possible prompts: *what do you think people in general would say about shame? What about specifically for men? What about people who have been diagnosed with a mental health difficulty? What about people who have committed an offence? How does that idea make you feel?*

Section 3. Your relationship with others

- Do any of these experiences of shame affect your relationships with others?

Possible prompts: *what about before you were in hospital? What about your relationship with family? With your friends? What about during your time in hospital? With staff? With other patients? What makes it harder? What makes it easier?*

Section 4. Your experience in hospital

- Do any of these experiences of shame affect you in hospital?

Possible prompts: *what about your treatment in hospital? What about your progress in hospital? How you spend your time in hospital? Is anything harder for you due to these experiences? Is anything easier? Do feelings of shame make you more or less likely to want to take part in different treatments available?*

Follow up question: Is there anything else you would like to tell me about your experiences or to talk about that I haven't asked you today?

Debrief:

- Thank the participant for their time and ask them what they are doing for the rest of the day.
- Recap the information in the Participant Information Sheet and remind the participant what will happen to the results and who to contact for further information.
- Remind them of my contact details if they want to discuss anything further or to withdraw their data.
- Ensure there is someone on the ward they can talk to if they need to.
- Give them time to reflect on the interview. How did they find it? Do they have any questions?
- Thank them for their time and tell them how to access their £15 voucher via email.

Appendix G

Bracketing Interview Notes

What is your previous experience or interest in this area that is relevant to the research?

Previously worked in a forensic learning disability service prior to training. Noticed that shame was not something that came up much in MDT clinical discussions but did come up in direct work with clients (even if clients didn't have the ability to communicate this themselves). Focus seemed to be more on guilt than shame – recognition that shame might be unspoken due to the emphasis on whether someone is guilty of an offence or not and desire not to want to show any sort of vulnerability. Curious about impact of previous traumatic experiences, being labelled as an "offender" and staff's attitudes/behaviour towards clients on how shame is experienced. Interested in working in this area and keen to undertake research which could help contribute to the literature.

How might your previous experiences working with this population impact your assumptions, pre-conceived ideas, and biases?

Knowledge about the types of offences people have committed and assumption that people who have engaged in such behaviours "must" feel shameful about that – what does it mean about that person if they have harmed others and don't feel shame? What does it mean about me if I become focused on that? It's possible that they may relate more to thinking and talking about guilt than shame – what to do if that comes up in the interview when I want to know about their experience of shame not guilt? Assume that people will likely find it difficult to talk about shame – what might this mean for the interview if people don't talk much or talk about things other than shame? Aware that being interviewed about shame might increase their shame – what does this mean for what might happen in the room? Will people become defensive? Think that shame comes from multiple domains, not just one – assume that they then might have had multiple experiences which has caused them shame. I assume that shame might impact on them in lots of different ways – might be a different perspective from them – how might they feel about my interpretation of their experiences? Assume that the general public might belief that this group of people "should" feel shame for what they have done. Possibility that beliefs about shame come from narratives about what types of offences are worse etc and that might impact on how people feel about their own shame.

What are some of my GRACES and how might this influence the research?

Keeping in mind my positioning as a white British female who will be interviewing men (how might this influence how able participants feel to talk about their experiences with me). Aware of how Black men are overrepresented in forensic service and my difference as a White person, but also whether/if many people from BAME backgrounds will participate in the research. Keeping my own position as someone who has not received a mental health diagnosis or who has been involved in the criminal justice system – will I be seen as an "outsider" or viewed as someone who is "part of" the hospital system – what does this mean for what might come up/what participants might be willing to share? Participants might make assumptions about me due to age/background/ethnicity/class and may therefore think that I "won't get it" and be less willing to share their experiences (particularly difficult ones) with me.

What are my personal values and beliefs about this particular group of people?

Belief that this is a group of people who have had a lot of bad things happen to them – a lot of trauma and lots of shame. Believe that people have the right to good quality care, compassion, and empathy no matter what they have done. Think that shame is probably not often considered much within forensic services where the focus is on guilt and would like to be able to contribute something to the literature which could improve quality of care for patients.

What are any concerns you have about undertaking this research?

Awareness of power (as a researcher who has done a lot of reading about the subject of shame which has informed my thinking and influenced what I think might come up). Also my power as someone training as a clinical psychologist and undertaking doctoral training (academic background which likely to be different from participants)- might they think I "know it all" or "could not understand" their experiences. Concerned that men may be less likely to open up with me – worried about people being quiet during the interviews and how that might go – my own worries about not getting enough data but also not trying to push my own agenda. Worried that people may go off topic (eg talk about guilt rather than shame) – noticing my own frustration if that happens and what to do to get the interview 'back on track' and focused on shame – but also be in keeping with IPA where interviews are supposed to be participant-led. How might my own behaviour during the interview if that happens influence what happens – eg cutting the interview short, asking more or less questions, appearing distracted or disinterested. My own insecurities about being a researcher and not therapist – conducting interviews for research purposes and not for therapy – likely to have my own questions/ desire to find out more if I was in a different context. Concern about what might happen if people get angry/shout/become upset – feel more confident in my ability to handle this in a therapy context but how easy will this be to do in a forensic setting where I have never met the person before?

Appendix H

Abridged Research Diary

22nd April 2023 – Confirmation of ethics approval

I have just had email confirmation that my research has been approved by the NHS ethics committee. It feels like such a relief, and the whole process wasn't as bad as I was expecting. It feels like things are starting to move now, although there is still a long way to go. Now, just to get approval from the R&D department.

19th July 2023 – Site visit

I visited the hospital site today to have my key induction. I really enjoyed walking around the hospital, and it has made the whole process seem much more real now. It was lovely to hear how much the psychology team are on board and they seem really interested in the research. They have been really supportive in helping to identify potential participants and will let me know if any confirm, so that I can get interviews booked in. I do feel slightly worried that people won't sign up to participate, or that they will change their mind at the last minute, but I am sure that everyone has similar worries!

4th August 2023 – Post-interview reflections

Drove 200 miles to the hospital site and back today. Feeling exhausted but so pleased to have done 3 interviews in one day. All the interviews were very different but really interesting. I found myself feeling very nervous and was probably quite awkward during the interviews. Was very aware that I wanted to ask follow up questions based on what participants said, but also didn't want to 'lead them' in any way – I have done lots of reading around "how to do IPA" yet still felt really unprepared. Felt slightly strange interviewing in a research capacity, rather than asking questions during a therapy session which I feel much more comfortable with. Noticed that I was interested a lot in what participants said, but felt at times I shouldn't follow up with some questions as they weren't related to the research questions (and were probably more about my own interest in a therapeutic capacity). I noticed myself feeling sad at some of the experiences people had had during their life. I also noticed myself feeling shocked quite a few times at how quickly people went into talking about things they had done in the past, sometimes it took me off guard and took me a while to get back on track with the interview. Participants spoke much more than I thought they would, so I feel like I got lots of data which is great. I also noticed my own judgements about what I thought people would talk about in relation to their shame (i.e their offence) and being surprised that quite often people talked about other things and spoke very little about shame regarding their offence. I hope the rest go just as well. I should hopefully have some more interviews booked in in the next few days once the assistant psychologist has been able to speak with some more potential participants.

7th August – Transcribing

I have started transcribing so that I can keep on track as I go. Forgot how much I dislike transcribing, even though its really interesting listening back. Definitely feel like the first day

of interviews was a warm up, and listening back there are definitely things I can improve and will need to hold in mind for future interviews. For example, I need to be more comfortable with silence as the participants are more likely to offer up more if I allow them space. Also to not be afraid to go back to points they have made at a later time. I have noticed feeling annoyed at myself for not picking up points that I wish I had now I have listened back to the tape but have made some extra notes about things I have learnt to take into future interviews. At times it felt like shame 'showed up' in the room in various ways- this is something to keep in mind and come back to during the analysis.

29th December 2023: Starting the analysis

I have been able to have a bit of a break from the MRP over Christmas and have started on the analysis. It feels good to have had some time away from it all but I want to get started on the analysis to give myself time to do it justice. This is the part I have been dreading. I have read through my IPA book, and read some blogs, to remind myself about the IPA process. Think I have a rough idea in mind about how to approach the analysis, but it still seems like a huge task. I have started with the first transcript and have done the coding and developed the personal experiential statements for the transcript. Still not sure I am doing it right, but just trying to really immerse myself in what the participant is saying and to note it down. For some participants, I wonder whether they are talking about guilt rather than shame. I guess they are intertwined in some ways (which is backed up by the literature) but I also think that guilt is a lot easier to talk about than shame and so I wonder whether that was happening in the room at times.

3rd January 2024: Analysis

This is taking ages!! I had allocated lots of time to do the analysis, but it is taking even longer than I thought. I am working through each transcript in turn but I am feeling really overwhelmed by it all. Keep feeling conflicted between thinking I am not doing enough interpretation of what participants are saying to also thinking that I am going too deep and not sticking close enough to the data. I seem to have got a good system in place and cutting out the personal experiential statements and then having them out in front of me has really helped me to move things around as my thinking develops and changes. Once I am almost completely happy with my themes grouped in paper I have started to type them into tables on my laptop. I have noticed that I am still moving things around even then. I think (and hope!) that this is all part of the process though.

16th February 2024 : Writing up

I have started writing up and am feeling more confused than ever. I have never done IPA before, and I don't know if I am actually "doing IPA" or not. I feel like I have lots of thoughts in my head about what participants might mean, or what they might be trying to say, but it's difficult to make sure that comes through on paper. I have done thematic analysis before, and I feel like I am doing this analysis much more in depth than that, but still I am doubting myself. I feel like I still have time to refine things, and I am glad I started the analysis as early as I did. I think I will submit my first draft of my analysis to my supervisors and discuss with them. It will be helpful to have an extra pair of eyes over the data again, especially as once you are "in" the analysis, it can be hard to think clearly at times – it all

feels very overwhelming. I am so grateful to all the participants who were so willing to be open with me and really hope I can capture their experiences and develop the best themes to capture this. Despite the stress and anxiety, this has been a really interesting project in so many ways. After reflecting back, I really do feel like people were being open and honest during interviews. Some mentioned not really thinking much about shame before, but they wanted to go away and think some more about it after the interview. I feel like people really thought about what they wanted to share before they came to the interview, and it felt as if people were being really honest and vulnerable with me at times, which is such a privilege.

Appendix I

Ethical Approval Documentation

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Appendix J

Victor's (Participant 4) Coded Transcript

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Appendix K

Victor's (Participant 4) Personal Experiential Theme Table

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Appendix L

Example of Group Experiential Theme Development

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Appendix M

Summary Report for Ethics Panel and R & D Department

Feedback Report

Research Summary

Title: Exploring the Experience of Shame for Men in Secure Forensic Services: An Interpretative Phenomenological Analysis.

Background: Shame has been linked to various mental health difficulties and violent behaviour. Previous studies investigating shame within the general forensic population have found that shame is associated with an increased recidivism risk, reduced engagement in offender treatment, and psychological distress. Individuals detained in secure forensic services are likely to experience a high level of shame due to previous traumatic experiences, and the "double stigma" of committing an offence and having a diagnosed mental health problem. There is a high proportion of men in forensic secure care, and potential gender differences in the experience of shame. However, to date, research exploring the lived experience of men who are detained in forensic secure services is limited.

Aims: The study explored the experience of shame for men in secure forensic services and aimed to answer the following research questions:

1. What are male forensic patients' experiences of shame?
2. How do male forensic patients describe the causes of their shame?
3. How do male forensic patients make sense of their experiences of shame?

Method: Semi-structured interviews were conducted with nine men who were detained in either a low or medium secure hospital. Interviews were analysed using Interpretative Phenomenological Analysis (IPA). This qualitative methodological approach allows for a detailed examination of participants' lived experience. Interviews were conducted in person in a room separate from the main hospital ward. Participants were given information about the study and asked to sign a consent form prior to interview. All participants received a £15 voucher to thank them for their time.

Analysis and Results: Analysis of the data revealed four group experiential themes in relation to shame. These were: experience and feeling; causes and contributors; impact and consequences; helpers and hindrances. Findings demonstrated how shame was a common experience for participants and negatively affected their life in many ways. Participants identified things that were helpful and not helpful in reducing and coping with their shame.

Conclusions: This study offered insight into the experiences of shame for men in secure forensic services. Participants felt shame was a painful experience for them, was something they had carried for most of their lives and was something they kept hidden from others. Shame had affected participants' mental and physical health, their relationships with others, and had led to social isolation and self-harm. Participants felt that developing an

understanding of their shame, making sense of it, and connecting with others helped to reduce the negative impact of shame. This study had implications for clinical practice, and it is important that a shame-sensitive culture is adopted within forensic secure services to improve outcomes for patients. This includes offering training for staff, developing group interventions based on self-compassion principles, and ensuring that shame is considered within psychological formulations and individual therapeutic interventions. Future research could build on findings from this study and would benefit from exploring the experience of shame for individuals detained in secure forensic services, including females, and those from ethnically minoritised backgrounds.

To all the participants who took part in this study – thank you so much for your participation and involvement in this research.

Appendix N

Summary Report for Participants

Feedback Report

Research Summary for Participants

Title: Exploring the Experience of Shame for Men in Secure Forensic Services

Thank you very much for taking part in this project and I hope you found it interesting. Here is a summary of what I found for all the interviews I did- do feel free to talk it through with a member of the psychology team if you would like to.

Background *(what do we already know about this topic?)*

- Shame has been linked to various mental health difficulties and violence.
- Previous studies investigating shame within the general forensic population have found that shame is associated with an increased risk of reoffending, psychological distress and can reduce likelihood of taking part in treatment programmes.
- Individuals in secure forensic services are likely to experience a high level of shame due to previous traumatic experiences, and the "double stigma" of committing an offence and having a diagnosed mental health problem.
- There is a high proportion of men in forensic secure care, and potential gender differences in the experience of shame. However, to date, there is not much research exploring the experience of men in secure hospitals.

Aims *(what did we hope to find out from this study?)*

This study explored the experience of shame for men in secure forensic services and aimed to answer the following research questions:

1. What are male forensic patients' experiences of shame?
2. How do male forensic patients describe the causes of their shame?
3. How do male forensic patients make sense of their experiences of shame?

Method *(what did we do to conduct this study?)*

- Interviews were conducted with nine men who were in either a low or medium secure hospital.
- Interviews were analysed using Interpretative Phenomenological Analysis (IPA). This is a type of research method which really explores participant's real life experience.
- Interviews were conducted in person in a private room.
- All participants were given information about the study and asked to sign a consent form before the interview started.
- All participants received a £15 voucher to thank them for their time.

Analysis and Results ***(what did we find out from this study?)***

- The interviews were analysed by the lead researcher of the study.
- Due to the type of research method used, things that participants said were grouped together into 'themes' by the lead researcher. These themes may reflect similarities or differences in what participants said.
- This type of research method also means that the researcher interpreted what participants said in some way. This means that the researcher may have tried to 'make sense' of what was said, even if participants didn't use those exact words.
- Four main themes were developed from the interview data from participants. These are shown in the table below. Sixteen sub-themes were also developed from the data.
- Overall, shame was a common experience amongst participants and had negatively affected their life in many ways. Participants also spoke about things which were helpful and not helpful to reduce and cope with their shame.

Group Experiential Theme	Sub-theme
Experience and Feeling	Intolerable and Painful Heavy and Chronic Uncontrollable and Inescapable Hidden and to Remain Hidden
Causes and Contributors	Breaking Rules and Expectations Judgements from Others Feeling and Being Different A Sense of Failure
Impact and Consequences	Impact on the Relationship with Others Mind, Body, and Soul Withdrawal and Isolation A Desire to Escape
Helpers and Hindrances	Understanding, Acceptance, and Meaning-Making Increased Vulnerability Honesty and Openness Connecting with Others

Conclusions ***(what are the main points we can take away from this study?)***

- Shame was a really painful experience for participants and was something often kept hidden from other people.
- Shame was something that most participants had experienced throughout their life. Shame felt really hard to escape.
- Some of the things that were described as causing shame were: breaking rules and expectations, judgements from other people, and feeling different to other people.
- Many of the participants spoke about feeling as if they had failed, and this brought them a great deal of shame.
- Shame had affected participants' lives in many ways, including their relationships with others, their mental and physical health and had led to social isolation and avoidance. For some, feelings of shame had led to substance use and attempting to end their own life.

- Opportunities for understanding, accepting and making sense of shame were often important first steps in moving on from shame. Additionally, being open and honest and connecting with others were identified as being helpful, however participants spoke about the increased vulnerability associated with this, which brought about its' own difficulties.

Practice Implications ***(how can things be improved based on what we have learnt from this study?)***

- Forensic services should think about people's experiences of shame at all levels of a person's care.
- Staff training should aim to increase staff's understanding of shame, and the impact of shame for people who are detained in secure hospitals.
- Developing group sessions about emotions and shame, and opportunities for connection with other people.
- Consideration of the role of shame within psychology sessions to think about people's experience of shame, and offering a safe, non-judgemental space for people to understand and make sense of their experiences.

Finally, again I would like to say thank you for your participation and involvement in this research. If you would like any further information regarding the findings please do not hesitate to contact me.

Sarah Flaherty-Hutchins
Trainee Clinical Psychologist
Salomons Institute for Applied Psychology
Canterbury Christ Church University

Appendix O

Journal Information for Publishing

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