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AN INVESTIGATION INTO SHAME IN FORENSIC SERVICES

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Summary of Major Research Project

Section A:

This narrative review aimed to synthesise and critique the literature regarding the impact of shame on female offenders. Eight studies were included, which comprised a mixture of qualitative and quantitative papers. Five themes were found across these papers; relationships, recidivism, substance misuse, societal stigma and self-regulation. The studies were critically appraised and the implications of the quality of these papers on the findings was described. Findings were considered in relation to prior literature and theory, and the implications of the review were discussed. Ideas for future research were suggested, including the importance of investigating the relationship between shame and recovery.

Section B:

An Abbreviated Grounded Theory investigation aimed to understand the relationship between shame and recovery for forensic service users. Eleven participants from three forensic settings (low secure, medium secure and community) completed semi-structured interviews. From these interviews, a tentative model of the relationship between shame and recovery was constructed. This included exploring when shame might hinder recovery and when shame might actually be helpful for forensic service users on their recovery journey. Theoretical and clinical implications from the findings were discussed, as well as suggestions for future research.

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Section A: An Investigation Into the Impact of Shame on Female Offenders

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Abstract

Shame is a prevalent emotion in criminal justice system populations, particularly for women. Shame is known to impact on aspects of offender's life such as wellbeing and recidivism, however currently there are no reviews aiming to understand the impact of shame for female offenders. This review therefore aimed to understand the current literature around the impact of experiencing shame on females under the care of criminal justice services. This review took a narrative format and synthesised both qualitative and quantitative papers. Eight papers were found and five themes were identified as commonalities for female offenders experiencing shame; relationships, recidivism, substance misuse, societal stigma and self-regulation. A critical appraisal of all studies was conducted, and the implications of this quality discussed. Together it could be seen that shame impacted on several areas of female offender's experiences. Clinical and research implications of the review were discussed, as well as directions for future research. Due to the difficult impact that shame can have, interventions to help female offenders cope with shame were discussed. Future research should further explore the impact of shame for female offenders, particularly in terms of implications for recovery. More research should also investigate the impact of shame cross-culturally.

Key words: Systematic Review, Shame, Females, Offenders, Forensic

Introduction

Shame

Tracy and Robins (2007) describe shame as a difficult emotion associated with feelings of pain, worthlessness and negative self-evaluation. Shame has been investigated in a number of contexts; predominantly university populations and the general population. It should be noted that shame refers to a different construct than guilt. Guilt refers to the feeling of having done something bad, whereas shame refers to the painful emotion of feeling as though one is a bad person (Lewis., 1971; Lutwak et al., 2003; Schmader & Lickel., 2006; Tangney et al., 1996). Lewis (1971) was the first person to posit this definition and it is widely adopted in forensic literature. Other researchers have since extended this definition in order to understand the implications of shame. Some suggest that while guilt typically leads to prosocial behaviour, shame does not; they suggest that shame leads to behaviours which do not promote reparative action (Stuewig et al., 2010; Tagney et al., 2011; Macey et al., 2017). However, Gilbert's (1992) evolutionary model suggests that while anti-social behaviour is possible in response to feeling shame, prosocial and reparative behaviour is also possible. Gilbert's (1992) model allows for shame to be explored openly rather than through an assumption of shame having negative consequences, thus this understanding frames the current review, and Gilbert's ideas will be explored in more depth below.

Shame is a universal human emotion (Gilbert & Andrews., 1998; Gilbert., 2007) however there is evidence to suggest that shame is experienced and responded to differently in different cultures (Goetz & Keltner., 2007). In Western cultures, shame is often seen as a negative emotion, whereas collectivist cultures can experience shame as a positive emotion, and one that motivates change (Sheikh., 2014). Shame is an emotional state, where-as Shame proneness is a related and relevant construct commonly used which refers to our tendency to view ourselves as flawed, bad or unworthy (Tangney., 1990); our tendency to feel shame.

A Theoretical Perspective on Shame in Criminal Justice Services

Criminal justice services encompass a wide range of services including prisons and probation teams. Forensic mental health services are also a type of criminal justice service, and they care for and treat individuals with a serious mental health diagnosis who are considered a risk to the public and who typically have a criminal history (Nedopil., 2009). Shame is an emotion that is known to be prevalent in these populations (Lateef et al., 2023). One reason for this may be due to the level of trauma experienced in this population. Trauma and experiences of abuse and neglect are higher in forensic populations, and there is evidence that shame is a common emotion in response to trauma and abuse (Dyer et al, 2017). Shame is therefore an experience that is likely central to offender's experiences, thus, understanding the experience of shame in this population is critical.

Understood through a Compassion Focused Framework, humans are predisposed to be sensitive to threat in order to survive (Gilbert & Andrews., 1998; Gilbert., 2007). Part of this threat response includes shame, as a functional emotion to keep us safe by motivating us to maintain social relationships and alerting us to the threat of the loss of these relationships. However this threat system is often overactive in the modern age, leading to this threat response being common. Gilbert's (1997) Social Rank Theory suggests that shame serves a role in encouraging us to respond in one of three ways to attempt to maintain our social relationships; displaying power to the group, for example through aggression, submitting to the group or changing behaviour to be more socially desirable. The first way of responding (displaying power to the group) may lead to offending behaviour through aggression, suggesting one pathway through which shame may contribute to offending behaviour.

There are also factors impacting shame which are unique to forensic settings and occur subsequent to admission to services, such as individuals coming to terms with their offence or previous anti-social behaviour. This process may include denial, minimization,

justification, and rationalisation (Drennen & Aldred, 2012). Braithwaite's Reintegrative Shaming Theory (Braithwaite., 1989) suggests that the way in which individuals are shamed by society and the criminal justice system will impact their outcomes. If rehabilitation is prioritised, and the criminal act is shamed rather than the person, this tends to lead to less recidivism. However, if the individual is stigmatised and shamed, then this may lead to higher rates of recidivism. Individuals in the criminal justice system typically face increased stigmatisation from the community which can contribute to increased shame (Leeming and Boyle., 2013; West et al., 2014) and may increase the risk of recidivism.

In summary, the impact of shame on offenders appears to be mixed in the literature. Offence-related shame can promote a motivation to make reparations (Ferrito et al., 2012; Fuller et al, 2019). However, shame can impact negatively on therapeutic processes (Dearing & Tangney, 2011). Experiencing higher shame has also been linked to a higher likelihood of re-offending (Hosser et al., 2008). Investigation of the impact of shame is thus imperative in order for services to manage and support offenders experiencing shame.

Shame and Mental Health in Forensic Services

Experiencing mental health difficulties can also further contribute to shame due to the perceived stigma from the community regarding mental health issues (Larkings et al., 2017). Therefore, it is important to consider mental health and psychological factors when investigating shame.

There are some models of mental health recovery which specifically consider shame and can be applied to a forensic mental health context. Vogel-Scibilia et al (2009) suggest a psycho-developmental model of recovery which parallels Erikson's stages of development (Erikson., 1963). They suggest that understanding mental health recovery through this lens can be helpful. The 'Hope vs Shame' stage of this model is particularly relevant. The model proposes that individuals move through the 'Hope vs Shame' stage by building relationships,

skills and independence, as well as understanding how life may be different from prior expectations. This suggests that working through feelings of shame can be a key part of recovery. However, shame can be a difficult emotion to talk about in mental health settings. This may in part be due to difficulty identifying shame, or feeling that shame must be internalised or kept secret (Brown., 2006). One study found that staff supporting individuals did not respond or changed the topic when service users brought up experiences of shame (Vuokila-Oikkonen., 2002). As this can be a subject which can be difficult to discuss, it is important for services to have an awareness of the potential impact that shame can have on offenders.

Female Experiences of Shame

There may be gender differences in how shame is experienced and expressed (Osei-Tutu et al., 2021; Tangney et al., 2011) and the impact of gender on shame is important to consider. There is research to suggest that the relationship between gender and shame may be related to type of trauma experienced (Wetterlöv et al, 2021). In community samples, Tangney and Dearing (2002) found that females experienced more shame than men. Additionally, Benetti-McQuoid and Bursik (2005) found that women with typically female gender roles experienced higher levels of shame-proneness. Although, individual's gender roles also influenced shame proneness for men and women, with traditionally feminine gender roles being associated with a higher tendency to feel shame for both genders studied. Research regarding female offenders experiencing shame is still developing. However, research suggest that for female offenders, one way that shame develops is through not feeling as though they are living up to society's expectations of them (Dodge & Pogrebin., 2001). This is in relation to factors such as society's expectations of being a woman, a mother and a responsible citizen. These societal expectations of female offenders can also contribute to portrayals in the media and justice settings. For example, women in the USA who have

killed can be more likely to receive the death penalty than men for certain crimes (Messing & Heeren., 2009), suggesting potentially harsher perceptions of crimes for women in some instances.

Implications

The literature suggests that shame is an important construct to understand in offender populations. It also suggests that proneness to shame may be higher in females than it is in males. Due to the significant effect shame could have on female offenders and their outcomes, it is important to understand more about this area.

Rationale

While reviews have been conducted regarding shame in forensic services (Macey et al., 2017) as well as shame as an experience in women and the psychological approaches targeting it (Miller-Prieve., 2016), there is not yet a review providing an overview of the impact of shame on female offenders. It is important to understand the current literature in this area due to the large impact that it can have on their wellbeing and quality of life. It is also important for service leads to be able to understand the impact shame has on female offenders, in order for services to be structured in a way that promotes wellbeing and reduces recidivism, thus reducing costs placed on the criminal justice system and improving female offender's quality of life.

Aim

The aim of this review is to understand the current literature regarding the experience and impact of shame for females in criminal justice system services. In terms of the impact of shame, this refers to any part of a service user's life which has been made different or influenced directly as a result of experiencing shame. While shame will not be the only factor that influences aspects of a service user's life, this review is looking at areas which can be seen to be in some way impacted due to experiencing shame. Due to shame being thought to

vary cross-culturally (Goetz & Keltner., 2007), it was important that this review aim to include cross-cultural studies. Additionally, due to a dearth of literature regarding females in forensic mental health services specifically, this review is investigating the experience of females across all areas of the criminal justice system.

Method

Search Strategy

Three relevant databases were searched in October 2023; Psychinfo, Web of Science and Scopus. Relevant journals such as the Southwest Journal of Criminal Justice were also hand searched, as well as the reference lists of the identified studies. The search terms were Shame or "moral emotion" or "moral injury" AND Forensic or prison or inmate* or "forensic hospital" or "secure hospital" or "high secure hospital" or "medium secure hospital" or "probation" or "parole" or "incarceration" or "jail" or "detention facility" or "correctional institution" or "imprisoned" or "in custody" or "behind bars" or "Forensic Personality Disorder Service" or "Offender personality disorder pathway" or "Forensic Personality Disorder" or "felony" or "felony charges" or "offender*" or "offending" AND female* or girl* or women or woman. Only English language accessible studies were used and grey literature was excluded. The search process involved searching in abstracts before reviewing the titles and abstracts to access suitability. After this screening process, the full text articles were accessed and reviewed for relevant studies. A PRISMA diagram can be found in Figure 1 (Page et al., 2012).

Eligibility criteria

Inclusion Criteria

Inclusion criteria consisted of studies with female adults in contact with the criminal justice system (for example prison, forensic hospital, parole), and could be from any country

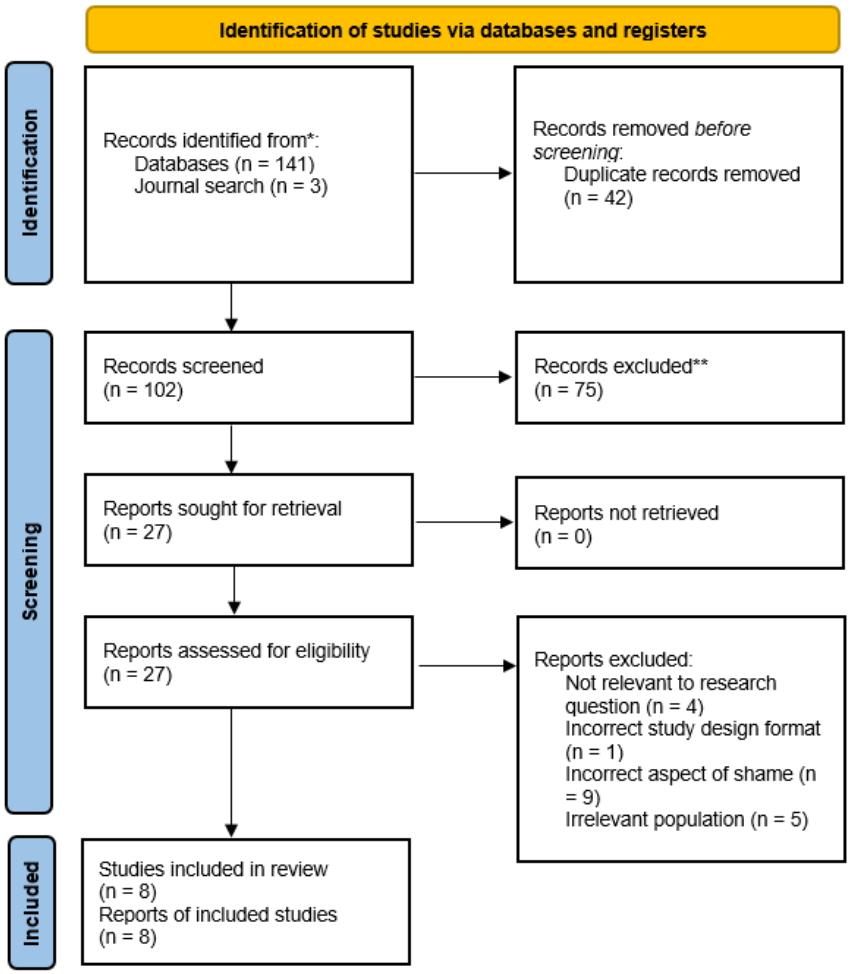
over any time period. These inclusion criteria were kept as open as possible due to the lack of research in the area. Criteria comprised studies which included female participants as the only participants or which investigated females as a distinct subgroup. The studies were required to investigate the experience and impact of shame.

Exclusion Criteria

Exclusion criteria involved studies in which females were investigated in combination with men, without considering them as a separate group. This is due to this review focusing specifically on the experiences of females. This review also excluded studies

Figure 1

PRISMA Diagram (Page et al., 2021)



only investigating the development of shame, and not discussing the impact of shame, due to the review aiming to understand the impact of shame specifically. Research on children and adolescents was excluded, again due to aiming to understand the experience of adult women specifically. Any other format of document other than journal articles were excluded, and grey literature was excluded due to focusing on peer-reviewed articles. A full list of exclusion reasons can be seen in Table 1.

Quality Assessment

Quality assessment tools were used to critically review the papers. The three qualitative papers were reviewed using the Critical Appraising Skills Programme (CASP)

Table 1

Exclusion Criteria and Descriptions of Criteria

Exclusion Reason	Description
Not relevant to research questions	Studies which do not relate to the question, including studies which do not explore shame in enough depth to be included in the review
Inadequate study design	Studies which do not examine a construct through participant research. Any format which was not a journal article, including book chapters or grey literature was excluded.
Irrelevant population	Non-forensic participants, studies in which female gender was not examined as an independent group or compared as a separate group
Different aspect of shame	Any studies which did not explicitly investigate the experience and impact of shame, for example studies which purely focused on the development of shame rather than the impact of shame.

criteria for evaluating qualitative research (CASP, 2006). Three cross sectional studies were assessed using the Appraisal tool for Cross-Sectional Studies (AXIS tool; Downes et al., 2016), one longitudinal study was assessed using the Critical Appraisal Skills Programme

(CASP) checklist for cohort studies (CASP., 2016) and the pre-post measure study was assessed using the Quality appraisal Tool for Before-After (Pre-Post) Studies With No Control Group from National Heart, Lung, and Blood Institute (NIH, 2014). Critical appraisal tools for all papers can be found in Appendix A. These critical appraisal tools were chosen due to their ability to facilitate the evaluation of research in a consistent and structured way. While critical appraisal tools are useful for assessing important areas of study quality, they are known to have limitations (Crowe & Sheppard., 2011). Therefore these tools will be used as a guide to the areas to appraise, and will be extended upon. Due to the limited research in this area, no studies were excluded based on poor quality, however the possible implications of any poor quality research was discussed.

Synthesis and Structure

The findings of the papers were synthesized in line with Mays et al's (2005) guidance on writing narrative reviews which include both qualitative and quantitative literature (Mays et al., 2005). This method of synthesis was chosen due to its ability to synthesise a variety of literature. Due to this being a scarcely researched area, it was important to aim to gather information from different modalities in order to attempt to provide a comprehensive view of the research area. This is important in public sector and health settings, as policies and service management often require the synthesis of different evidence, which a narrative review allows (Mays et al., 2005). This involved synthesising data about the impact of shame on females in criminal justice services and identifying and drawing together themes from the data.

In order for this review to synthesise the data into themes, the papers were initially read multiple times for familiarisation, before identifying themes present across the studies. The primary areas focused on by each paper were identified, and then grouped into themes which were present across more than one paper. These themes were not pre-determined,

instead they emerged from the data. The themes were developed upon as the process progressed (Appendix B). Synthesising data is necessary in order to develop a complete understanding of the current knowledge base around a topic. Themes are discussed below in turn, with critical evaluation of the relevant studies conducted in order to understand any strengths or limitations which may impact on the conclusions drawn.

Reflexivity

The researcher acknowledges potential biases and has considered how to minimise these. The researcher worked in a forensic service in a previous job role in which shame was discussed with service users. Therefore the researcher may have preconceived notions and biases which may impact on this review. In order to reduce potential bias, measures have been taken; a bracketing interview with a colleague researching a similar area was completed in order to make conscious the researcher's expectations and experiences. This included acknowledging the researcher's expectations that shame would impact in various ways on female offenders. This process allowed the researcher to be conscious of biases as they present themselves, and take action to minimise them.

Findings

Overview

A total of eight studies were identified, including three qualitative studies and five quantitative studies. A total of 528 female offenders were included in the studies overall. An overview of the studies is provided in Table 2, and explored further below.

Critical Appraisal Overview

To help provide some context to the findings of the literature review, consideration has been given to quality of the papers, informed by the quality appraisal tools and issues more broadly. Information about the specific criteria met by each paper according to the

critical appraisal tools can be found in Appendix C, and are summarised below in relation to each theme. Limitations of the research which were not covered by the critical appraisal tools were also important to consider. Female offenders as a group can be difficult to reach due to females making up a minority of individuals in services. The consequences of this are that often recruitment of this group is difficult and sample sizes of studies are smaller, thus conclusions are not as easily generalisable. Shame as an emotion is inherently difficult to discuss. Shame causes one to feel flawed and is often linked to the urge to hide away, thus expecting participants to be willing and able to disclose information about shame further limits the recruitment pool. It is likely that only a certain type of person would volunteer for

Table 2

Overview of Studies

Author and Date	Title	Setting and Population	Participants	Aims	Design and Method	Findings	Country
Cooper-Sadlo et al (2019)	Mothers Talk Back: Exploring the Experiences of Formerly Incarcerated Mothers	Formerly incarcerated mothers recruited from a post-incarceration support group	12 formerly incarcerated females	To explore how formerly incarcerated mothers negotiate their experiences	Transcendental phenomenological approach Semi-structured interviews	Women described the shame they experienced in relation to not being able to fulfil mothering duties Experienced shame for 'abandoning' their children, and this impacted how able they felt to return to the mothering role Acceptance and forgiveness helped with recovery Rejected the labels of "addict" and "felon"	USA
Jackson et al (2011)	An Examination of Guilt, Shame, Empathy and Blaming Among a Sample of Incarcerated Male and Female Offenders	Adult female offenders in a Woman's Reception and Diagnostic Centre in Missouri and adult males in a Reception and Diagnostic Correctional Centre in Missouri. All participants were due to be released in the next 120 days. All attended Impact of Crime on Victims Course	124 respondents (97 females and 27 males)	To test if a victim awareness course led to participants experiencing a significant emotional change. To investigate differences in males vs females and violent vs non violent inmates in development of shame, guilt, blaming and empathy. To investigate whether offenders levels	Multiple Analysis of Covariance (MANCOVA)	Participants in ICVC program did not experience differences in shame from pre to post measures. Offenders with more shame were more likely to place blame in the victim and society, whereas those with more empathy were not as likely to blame the victim No gender differences between pre and post measures or parents/non-parents Violent offences had significant impact on reduced empathy and increased society blaming Female inmates were found to be more likely	USA

		(ICVC)		of guilt, shame and empathy influenced their likelihood of blaming others, and the impact of other factors on this (male vs. female, children vs. no children and violent vs. nonviolent).		to negatively appraise themselves for their crime Non-violent inmates who were parents experienced more empathy and guilt compared to violent inmates who did not have children (who experienced more shame)	
Kreis et al (2016)	Relational Pathways to Substance Misuse and Drug-Related Offending in Women: The Role of Trauma, Insecure Attachment, and Shame	Women with previous criminal conviction over 18, from substance misuse treatment services	7 female participants with past criminal justice involvement (primarily in court ordered substance use treatment promgramme)	To understand how substance misuse interacts with crimiongenic needs such as dysfunctional relationships in increasing the risk of re-offending. To explore whether insecure attachment and relationship disconnections may be involved	Qualitative design using a social constructionist version of Grounded Theory (Abbreviated) Semi-structured interviews	Once starting drug use, individuals were rejected or detached themselves from family due to shame (avoiding painful feelings of shame). Shame got in the way of asking family for help. Shame both preceded and was a consequence of substance misuse, and led to difficult relationship dynamics and drug related offending. People often used their families to financially support drug use through 'misrepresenetation'. This led to shame and disconnection Loss of family meant that they began offending to fund their drug habit Intimate partner relationships were	Scotland

						connected with shame. Loss of children due to chaotic lifestyle exasperated shame. Discussed that shame is a typical consequence of trauma, and shame may be defended against by using coping strategies. Created a model in which traumatic experiences/dysfunctional parenting led to insecure attachment, which then led to shame. This then led to a complex interplay of factors, including substance misuse and offending	
Milligan and Andrews (2005)	Suicidal and other self-harming behaviour in offender women: The role of shame, anger and childhood abuse	Female inmates in a medium sized prison in Midlands, UK	89 female inmates	To investigate the impact of abuse, shame and anger on self-harming behaviour	Correlation Analysis and Hierarchical Logistic Regression	Demonstrated a significant association between shame and self-harm in female offenders. Relationships were found between shame, anger and childhood abuse, and suicidal/self-harming behaviours	UK
Nikartas and Tereškinas (2022)	Women's pains of punishment: Experience s of female offenders serving community sentences in Lithuania	Women serving community sentences in Lithuania	13 women under the probation service, sentenced for violent crimes, theft and drug possession and distribution	To understand the relationship between systemic oppression structures and vulnerable individual's experiences To reflect and analyse social injustice and	Qualitative (did not specify analysis method) Semi-structured interviews	Community supervision led to experience of shame Rather than shame emerging due to restrictions it was more about being a 'sentenced person', as they felt separated from society and its norms Ashamed of crime and feared judgements from	Lithuania

				marginalised individual's suffering Investigate the role of punitive power, social inequality and deprivation		others Shame caused them to hide their sentences Shame limited social ties, fear of shame caused them to reduce social circles Fear of shame and condemnation caused them to keep their crime a secret A burden of shame felt like it was put on them	
Osei-Tutu et al (2021)	Self-Forgiveness Among Incarcerated Individuals in Ghana: Relations With Shame- and Guilt-Proneness	Medium secure prison in Ghana	310 incarcerated individuals in medium security prison in Ghana, males (83.87%) and females (16.13%), grouped separately	To investigate the associations between self-forgiveness and guilt and shame in an incarcerated population in Ghana. This was to extend the investigation done in non-incarcerated western samples	Cross-Sectional study Pearson and Point-Biserial Correlations, and a Moderated Multiple Regression Analysis	Self-forgiveness was significantly negatively correlated with shame proneness, however was not moderated by type of offence Shame proneness was higher in females	Ghana
Tangney et al (2011)	Assessing Jail Inmates' Proneness to Shame and Guilt: Feeling Bad About the Behavior or the Self?	Participants recruited from a 'county jail' in which they were enrolled in a longitudinal study surrounding moral emotions and recidivism	550 participants (379 male and 171 female)	To extend the current literature around associations with shame and guilt proneness in adult offenders. Examining the relationship between guilt and shame proneness and factors associated with	ANOVA, and correlational analyses	Shame did not provide an inhibitory function in terms of recidivism Findings were generalisable across gender Shame-proneness was not found to be protective and was significantly associated with risk factors for recidivism Females scored significantly higher on shame than men Shame was more associated	USA

				recidivism, as well as investigating the impact of gender and ethnicity on this. Also examined the reliability and validity of the Test of Self Conscious Affect–Socially Deviant Version (this part was not included in review)		with impression management for women Those with higher shame found self-control more difficult, and shame had a stronger relationship with self-control for women	
Tangney et al (2016)	Changes in Inmates' Substance Use and Dependence from pre-Incarceration to One Year Post-Release	Urban detention centre	305 participants (71% male, 29% female)	To understand how substance use changes from pre to post imprisonment for inmates	Longitudinal study of substance misuse from point of incarceration to post release	Significant decrease in substance use from pre-imprisonment to post-release Shame proneness did not did not predict substance use or dependence generally. However, shame proneness was related to a sharper decrease in cannabis use Shame did not predict changes in frequency or dependence for 'hard' drugs.	USA

studies exploring shame, and qualitative studies particularly may require a person who would like to discuss shame in depth. These factors together limit the external validity of the studies and thus the review, as the individuals studied may not be representative of the population. Due to the difficulty accessing information about this particular construct in this population, the current review has included studies across a wide range of forensic settings. While this is a strength in terms of attempting to understand the impact of shame across criminal justice settings, a consequence is that information may be difficult to synthesise coherently across varied settings.

Themes

Five themes were identified from the studies (Table 3). These themes included the impact of shame on relationships, recidivism, substance misuse, self-regulation, as well as the connection of shame to societal stigma and the consequences of this. Each theme was explored in depth, with the below findings following a structure of exploring the findings regarding each theme, critically appraising the papers which explore that theme, and summarising what can be concluded about the theme in light of the quality of the literature.

Relationships

Relationships were identified as a key area which was impacted upon by shame, with three papers discussing the impact of shame on relationships (Cooper-Sadlo et al., 2019; Jackson et al., 2011; Kreis et al., 2016).

Design. Two of the studies used a qualitative design; a Transcendental Phenomenological Approach using semi-structured interviews (Cooper-Sadlo et al., 2019) was used to explore the experience of formerly incarcerated mothers, and a social constructionist version of Grounded Theory (Kreis et al., 2016) was used to investigate pathways to substance misuse and offending for women, including the role of shame. One study used a quantitative design; A Multivariate Analysis of Covariance (MANCOVA)

Table 3

Areas Investigated in Studies, Grouped into Themes

Theme	Cooper-Sadlo et al (2019)	Jackson et al (2011)	Kreis et al (2016)	Milligan & Andrews (2005)	Nikartas & Tereškinas (2022)	Osei- Tutu et al (2021)	Tangney et al (2011)	Tangney et al (2016)
Relationships	Shame related to being a mother in prison, and the impact of this	Investigated shame and being a parent	Described shame related to drug use impacting relationship dynamics					
Recidivism			Shame as a factor in drug related offending				Investigating shame's role in recidivism	
Substance Misuse			Investigation of the role shame plays in drug use				Substance misuse in those prone to shame	Shame as predictor for drug use
Societal stigma	Impact of shaming labels on women	Shame and blaming society			Impact of shame on societal circles			
Self-regulation	Impact of shame on self-forgiveness			Shame impacting self-harm		Impact of shame on self-forgiveness	Shame and self-control	

(Jackson et al., 2011) was used to investigate the role of guilt, shame, empathy and blaming in offenders before and after completing a correction based Impact of Crime on Victims Course (ICVC).

Findings. The identified research suggests that being a mother in prison may be central to experience of shame (Cooper-Sadlo et al., 2019; Kreis et al., 2016). Cooper-Sadlo et al (2019) described narratives regarding the ongoing struggles in relation to feeling as though they were not fulfilling their mothering duties. Their experience of shame related to feeling as though they had 'abandoned' their children. Even after leaving prison this shame impacted how able they felt to return to the mothering role, thus having implications for these relationships after release. Acceptance and self-forgiveness were sighted as things that helped with reducing shame and trying to recover. Kreis et al (2016) also found that shame was central to the experience of mothers, and was a contributing factor to the chaotic lifestyle which could lead to mothers losing of custody of their children.

Kreis et al (2016) found that shame was also an obstacle in asking family for help for drug using females, and contributed to negative relationship dynamics. Individuals often used their family to financially support their drug habit, which led to shame and also led individuals to reject or be rejected by their family. Intimate partner relationships were also associated with shame for these women. This was part of a wider cycle of shame and drug use which tended to maintain the presence of relationship difficulties.

While predominantly studies have found that being a parent is related to the experience of shame, Jackson et al (2011) found that violent offenders without children experienced more shame than non-violent offenders with children. This suggests that while shame might be related to the experience of having children as a female offender, actually the

nature of individual's offence appears to be a more important factor in regards to shame, and the nature of the crime therefore might have a greater impact on shame and its consequences.

Critical Evaluation. The two qualitative studies were evaluated to be good quality, particularly Kreis et al (2016). Cooper-Sadlo et al's (2019) research was also evaluated to be relatively good quality, however they would have benefited from describing ethical considerations in more depth. They did not mention an ethics committee, and although they stated that informed consent was gained and there were no conflicts of interest, they did not mention details of confidentiality or wellbeing of participants. Due to the sensitive subject matter, it would be beneficial to understand more about how the participant's needs were considered. Kreis et al (2016) and Cooper-Sadlo et al (2019) discuss and account for many areas of possible bias, including examining their own bias and taking steps to reduce this, which is critical in understanding the generation of themes in qualitative research. The quality of Jackson et al's (2011) was also deemed to be good by critical appraisal tools, however it is noteworthy that there was a dropout rate at follow up of 30%. This may potentially bias results, as it is likely that this 30% may be different in some way, therefore biasing results slightly.

Summary. Shame appears to have an impact on the quality of relationships, in terms of how able individuals feel to perform for example mothering duties and interact with their partners. The research suggests that shame can be one of the factors which can cause difficulties in these relationships. While the general limitations of research within this population do apply, the quality of the research appeared reasonably strong, particularly for the qualitative research, therefore it is likely that there is credibility in the findings.

Recidivism

Two studies investigated the impact of shame on recidivism and associated factors (Kreis et al., 2016; Tangney et al., 2011).

Design. Tangney et al (2011) conducted a quantitative cross-sectional study assessing female offenders' proneness to shame and guilt, and the correlates to know risk factors for recidivism, and Kreis et al's (2016) qualitative grounded theory research investigated the role of shame in drug related offending.

Findings. Tangney et al (2011) investigated a number of factors in relation to shame proneness, including factors associated with recidivism. They found no evidence that experience of shame serves an inhibitory function in known predictors of recidivism. Moreover, shame proneness was positively associated with known risk variables. For example, shame proneness was associated with higher substance misuse, impulsivity, self-reported antisocial personality and criminogenic patterns of thinking. Kreis et al (2016) found that shame was a factor in drug related offending for women. In part, this was due to shame preventing women from reaching out to their families for financial support, leading to them to offending behaviour in order to financially support drug use. This research suggests that the way individuals cope with their shame impacts of their actions and likely on recidivism.

Critical Evaluation. Both Tangney et al (2011) and Kreis et al (2016) have been evaluated by critical appraisal tools to be reasonably good quality. Tangney et al (2011) excluded individuals in a forensic unit for individuals experiencing active psychosis. While this is justifiable, it is worth noting that this excludes a key group and may limit generalisability to certain forensic services. It in beneficial that the quantitative and qualitative studies have been undertaken in this area. The quantitative design allows shame to be linked directly to a number of factors associated with recidivism, while the qualitative project provides more detail about the processes by which shame might link to offending behaviour.

Summary. This research suggests that shame may impact on rates of recidivism for female offenders, with one pathway possibly being due to the isolating effects of shame

which can cause individuals to withdraw from their support systems and engage in offending behaviour to serve financial needs. While Tangney et al's (2011) research is not causal, it does support the suggestion between a link between shame and recidivism. Some caution should be taken in applying these findings directly to forensic mental health settings, however these findings suggest a likely connection between shame and recidivism for female offenders.

Substance Misuse

Three studies investigated shame in relation to substance misuse (Kreis et al., 2016; Tangney et al., 2011; Tangney et al., 2016).

Design. One study used a qualitative Grounded Theory design (Kreis et al., 2016), and two used a quantitative design; Tangney et al (2011) used a cross-sectional design investigating factors related to shame proneness, and Tangney et al (2016) used a longitudinal design studying changes in inmates substance use from pre-incarceration to post incarceration.

Findings. While three of the studies in this review (Kreis et al., 2016; Tangney et al., 2011; Tangney et al., 2016) discussed substance misuse, the relationship with shame does not appear to be straightforward. Tangney et al (2011) found that substance misuse was higher in those more prone to shame. However contrary to other studies, Tangney et al (2016) found that shame proneness did not predict substance use, particularly for 'hard drugs'. They did however find a significant finding that shame proneness was related to a sharper decrease in marijuana use. The authors acknowledged that this finding is difficult to interpret and may contradict other research. Rather than shame being a predictor of substance misuse, they found that other demographic variables such as being older, being female and having a higher education were far stronger predictors of reducing use. Kreis et al (2016) conducted an Abbreviated Grounded Theory investigation to understand how different factors, including

shame and relationships, impacted on drug use. They found a pattern by which once women started drug use, they were either rejected by or they detached themselves from family due to the emotional pain which accompanied shame. They found that shame both preceded and was a consequence of drug use, and shame played a role in the initiation of drug-related offending due to lack of family support and resources, as shame reduced how able individuals felt to ask their family for support.

Critical Evaluation. As discussed above, Kreis et al's (2016) research was evaluated to be good quality. In most regards Tangney et al's (2011) study can be seen to be good quality, although the exclusion of actively psychotic offenders should be noted. Tangney et al's (2016) research has also been evaluated positively using critical appraisal measures. It is noteworthy that the evidence of the relationship between shame and substance misuse does not seem to be straightforward, and the three studies provide differing information in regards to the potential impact of shame on substance misuse for women. This is likely due to the three studies using differing methodologies, thus each exploring a slightly different aspect of this relationship.

Summary. The research suggests a possible link between shame and drug use, however this link is not fully understood. The differing findings do not take away from the insights gained from the research, however suggest that further investigation of this relationship is required. Kreis et al's (2016) use of a qualitative methodology allowed detailed exploration of one pathway through which shame and substance misuse are related.

Societal Stigma and Community Interaction

Three studies discussed the relationship between shame and societal stigma (Cooper-Sadlo et al., 2019; Jackson et al., 2011; Nikartas & Tereškinas, 2022).

Design. Two studies which explored the relationship between societal stigma and shame were qualitative; Cooper- Sadlo et al (2019) conducted a Transcendental

Phenomenological study while the qualitative method used by Nikartas & Tereškin as (2022) was not explicitly stated. One study used a quantitative design; A Multivariate Analysis of Covariance (MANCOVA) (Jackson et al., 2011) was used to investigate the role of guilt, shame, empathy and blaming in offenders before and after completing a correction based Impact of Crime on Victims Course (ICVC).

Findings. Nikartas & Tereškinas (2022) explored the impact of shame in women under community supervision. Through interviewing these women, they found that it was the status of being a 'sentenced person' that was the largest cause of shame, rather than for example shame emerging directly from the restrictions. This was due to feeling as though they were separated from the norms of society, and this was shame-inducing. They were not only ashamed of their crime, but were ashamed due to the fear of judgements from others. This shame impacted on their behaviour and life choices. They often chose to hide their sentences from most people and reduce their social circle. Shame therefore caused them to limit their social ties, and fear of shame caused them to keep their crimes a secret, burdening them further.

Cooper-Sadlo et al (2019) found that the labels placed on women by society such as 'addict' and 'felon', could cause shame. They found that women often coped with this shame by rejecting these labels. Jackson et al (2011) found that women with higher levels of shame were more likely to place blame in society and the victim for their crimes than those lower in shame. They also found that females were more likely than males to hold negative self-appraisals for committing their crime.

Critical Evaluation. As discussed above, Cooper-Sadlo et al (2019) was evaluated to be relatively good quality, however did lack some exploration of ethical issues. While the methodology used by Nikartas & Tereškin (2022) had many strengths and the qualitative design was appropriate, it had limitations which might impact its reliability. Detailed

description of the analysis was not provided and it was unclear how the themes and quotes were extracted from the data, making it difficult to replicate and to assess how valid the results may be. The researchers also did not explicitly examine their own role or potential bias, meaning that it is unclear the role they played in the process. However, the results section contained detailed quotes and exploration of themes.

Summary. Together, these studies suggest that one consequence of shame might be that it can cause individuals to distance themselves from society and their community. This in part may be due to fear of further shame and stigma from their community. Higher shame may also cause individuals to blame society or their victim(s) and be less likely to engage with their community. While one of the papers may have lacked methodological detail (Nikartas & Tereškin., 2022), the evidence from the three studies taken together, including quotes from Nikartas & Tereškin's (2022) results, implies that shame may impact on perceptions of and engagement with society and the community.

Self-Regulation

Aspects of self-regulation such as self-forgiveness, self-control and self-harm were investigated in four studies (Cooper-Sadlo et al., 2019; Milligan & Andrews., 2005; Osei-Tutu et al., 2021; Tangney et al., 2011).

Design. Three papers used a quantitative design. Milligan and Andrews (2005) used a Correlation Analysis and Hierarchical Logistic Regression to understand the role of shame and other factors on suicidal and self-harming behaviours. Tangney et al (2011) also used a quantitative design to understand factors associated with shame proneness. Osei-Tutu et al (2021) conducted a cross-sectional study utilising Pearson and Point-Biserial Correlations, and a Moderated Multiple Regression Analysis to investigate the associations of self-forgiveness to guilt and shame in an incarcerated population in Ghana. Cooper-Sadlo et al (2019) used the qualitative method of a Transcendental Phenomenological Approach.

Findings. Self-forgiveness was something that was identified as being difficult while experiencing shame (Cooper-Sadlo et al., 2019). Osei-Tutu et al (2021) found that self-forgiveness was negatively correlated with shame proneness, suggesting that difficulties are present for women in forgiving themselves if they are prone to experiencing shame. They found that shame proneness was also higher in females, and this was not moderated by type of offence. Tangney et al (2011) found that those more prone to shame had more difficulty with self-control, and that shame had a stronger link to self-control in women than men. They also found that shame was higher in females than males. Milligan and Andrews (2005) found that for female offenders, there was a link between shame and self-harm, with those higher in shame being more likely to self-harm. This was part of a wider model which linked childhood abuse with anger and shame, and suicidal or self-harming behaviours.

Critical Evaluation. Osei-Tutu et al's (2021) research was assessed by critical appraisal tools as being reasonably good quality, with a couple of limitations. They did not justify the sample size or discuss measures taken to address and categorise non-responders, or discuss non-response bias. Non-responders can bias findings and conclusions. This is due to the fact that typically only a certain type of individual will respond, skewing data and making it difficult to generalise to the wider population due to concerns regarding external validity. Additionally sources of funding were not stated in Milligan and Andrews's (2005) research, therefore a bias or conflict of interest is possible. As above, Cooper-Sadlo et al (2019) and Tangney et al's (2011) research was assessed to be reasonably good quality.

Summary. While the research under this theme discusses different psychological constructs, the studies can be seen to suggest that shame does likely impact on self-regulatory behaviours such as self-harm, self-control and self-forgiveness. Osei-Tutu et al's (2021) research was the only study identified researching a non-western population, therefore there is likely not enough evidence to make conclusions regarding cross-cultural findings.

Discussion

Summary

This review synthesised five quantitative and three qualitative papers exploring the experience and impact of shame in the female offender population. Several themes emerged related to female offenders' experience of shame; relationships, recidivism, substance misuse, society and stigma, and self-regulation. Predominantly, different papers within themes painted a similar picture of each construct, and built on each other. This could be seen to suggest good validity in terms of the findings. However an exception to this was substance misuse. While most studies agreed that shame was associated with increased substance misuse, Tangney et al (2016) found the opposite. This suggests that more research needs to be conducted to investigate the complex relationship between shame and substance misuse, including mitigating factors.

Additionally, caution should be taken in interpreting the conclusions of this review, due to the variability in study quality. While some papers were evaluated to have good quality, it was difficult to assess others. Some studies did not adequately explain their methods and analysis, therefore these could not be assessed or replicated. In qualitative studies, researchers did not always engage in reflexivity, meaning that it is possible findings may be biased. Some studies also gave very vague descriptions or no description of ethical considerations such as informed consent, confidentiality or conflicts of interest. This raises concern regarding procedures followed in these studies. However it is noteworthy that female offenders are a marginalised and difficult to access group, therefore conducting research with this group can be challenging. While there are some methodological issues, the current research in this area does however provide valuable insights into the experience of shame in this difficult to reach group.

Parallels can be drawn between the findings of this review and theoretical perspectives on shame from previous literature. Gilbert's (1997) Social Rank Theory highlights the importance of shame in guiding social group behaviour. The current findings regarding the impact of societal stigma on shame and subsequent behaviour uggests that shame is a key motivator in social behaviour. Furthermore, the current findings also suggest that shame may contribute to recidivism. This includes those acts which may serve to display aggression or power, in line with Gilbert's (1997) suggestion regarding the function of aggression as a response to shame in order to maintain group membership.

Additionally, Braithwaite's Reintegrative Shaming Theory (1989) suggests that when stigmatisation is high, this can lead to worse outcomes. In the present review, societal stigma was found to be prevalent and impacted on outcomes. When individuals felt stigmatised, this led to consequences such as reducing their social circles, and may have contributed towards blaming society and the victim for crimes. The current review also investigated the impact of shame on recidivism. While this review did not find evidence of the difference between stigmatising shame vs reintegrative shame, it did suggest a link between shame and recidivism. Taken together, the review does suggest that stigmatisation may be linked to further difficulties, in line with Braithwaite's (1989) theory regarding the impact of stigmatisation and shame.

Considering the differing conceptualisations of shame and the behavioural implications of these definitions, this research aligned with Gilbert's (1992) assumptions; in that while many behavioural consequences of shame appear to be negative, this is not always the case. This is in opposition to researchers who suggest that shame only leads to negative consequences such as avoidance (Stuewig et al., 2010; Tagney et al., 2011).

While this research was specifically set in the context of women under the care of criminal justice services, the findings can be seen to fit with other research around the

experience of shame in women more generally. For example Jackson et al's (2011) findings that females were more likely than males to negatively self-appraise themselves for committing their crime, and Tangney et al's (2011) finding regarding shame being higher in females fits with other research in the general population suggesting that females may experience more shame and negative self-appraisal (Benetti-McQuoid & Bursik., 2005; Tangney & Dearing., 2002). Osei-Tutu et al's (2021) research also extends this to suggest that female offenders in Ghana also experience more shame proneness than men.

Nikartas & Tereškinas' (2022) findings regarding the shame being present due to feeling separate from the norms of society and this impacting their interaction with society is supported by other research suggesting that shame can develop through comparison with society's expectations (Dodge & Pogrebin., 2001). It is noteworthy that the majority of the research in in this review was based in Western cultures, and the findings can be seen to align with Sheikh's (2014) suggestion that shame in Western cultures is often seen as negative. This includes the suggestion from this review that shame may be associated with factors related to increased recidivism, which has also been suggested in previous research (Hosser et al., 2008).

Limitations

Limitations of this review include that there was only one reviewer reviewing the papers, meaning that there may be biases present. However, research supervision was used throughout the process, including in decisions relating to the papers included in the review and the organisation of findings, therefore this helped to reduce bias. Additionally, the reviewer engaged in a reflective log throughout the review process in an attempt to reflect on and reduce sources of bias. A bracketing interview was also conducted with the same aims. Another limitation is that due to the limited research in this area, there were relatively few studies to draw on, with differing methodologies and populations. The research looked at a

broad range of offence types and populations. It was important to keep the inclusion criteria broad due to the dearth of research in this area. However, this can make findings difficult to compare and synthesize. Nevertheless, valuable insights were still gained even given the heterogeneity of the research.

One further limitation of this review is that causality cannot be implied from the findings. Often shame is a complex process in its development and its impact, thus separating the factors that cause shame from the factors which result from shame can be difficult. However, this review can be seen to provide information regarding the areas which may be implicated when experiencing shame.

Clinical Implications

This review suggests that there are various areas for clinical and service improvement. Shame may be a more prevalent experience for females than it is for males, therefore considering the implications of shame in female offender services should be a priority. Many of the impacts of shame in this review appear to be negative, for example shame being linked to re-offending, as well as potentially contributing to difficulties in relationships. Thus interventions to reduce shame may be beneficial for women in forensic services. While the evidence discussed is primarily correlational, interventions to reduce shame may improve wellbeing and reduce recidivism. Evidence has been found that interventions such as those targeting trauma symptoms can be helpful in reducing shame and increasing positive outcomes for female offenders (Bridges., 2020). Psychological professionals including Clinical Psychologists would be appropriate to lead these interventions. Many other psychological approaches could also further address shame and allow exploration of the feeling and its impact on subsequent behaviour. Approaches such as Compassion Focused Therapy which intrinsically address shame may be helpful (Irons & Lad., 2017). Interventions such as Cognitive Behavioural Therapy and mindfulness have also been shown

to reduce shame (Gofnett et al., 2020), and these may be appropriate if shame is negatively impacting individuals. In addition to shame being considered in psychological therapy specifically, it would be beneficial for psychologists to facilitate conversations around shame more generally in services, and train other staff to be able to also have these conversations, given the fact that shame is likely a difficult emotion to talk about in services (Vuokila-Oikkonen., 2002). It may be beneficial for conversations to be facilitated with female offenders at different stages of recovery in services, in order to target shame throughout their recovery.

In addition to the implications regarding shame directly, this review suggests that shame may impact on relationships, drug use and self-regulatory functions, thus implications for these areas should also be considered. In order to help female offenders with the impact of shame, interventions in these areas should be prioritised in services. This could be facilitated through interventions such as relationship counselling, substance misuse programs and coping skills sessions. Specifically, interventions such as substance misuse programs could include components directly addressing shame and stigma. Coping skills sessions could help individuals learn techniques to manage emotions, as well as addressing how to cope with shame specifically. Additionally, in line with Vogel-Scibilia et al's (2009) model on working through shame towards recovery, there should be a focus on supporting women to build relationships, skills and independence.

This review found that shame related to being a mother in prison can be a challenging experience and can lead to negative outcomes. This should therefore also be an area in which women in forensic settings are supported with. This could be done through practical interventions led by the service, aiming to facilitate relationships between mothers and their children. There is also a role for Psychological professionals in leading groups, individual interventions or family interventions aimed at targeting any shame, and helping to facilitate

healthy relationship dynamics. There may also a role for Clinical Psychologists in raising awareness more generally about the benefits for women and for society as a whole of focusing on rehabilitation for women rather than punishment.

Research Implications

The information from this review leads to several directions for future research. Firstly, while the current literature gives useful indications regarding the impact of shame on female offenders, more research is needed in this area. Due to the low volume and quality of the research on shame in female offenders, other qualitative and quantitative studies investigating the experience of shame and the impact on their lives is important, including looking for mediating factors for the impact of shame. From the information gained in this review, shame appears to have a significant impact on wellbeing and future actions of female offenders, thus understanding more about this is imperative.

Secondly, more research should be done to consider cross-cultural experiences of shame in female offenders. It has been suggested that shame may be experienced differently in different cultures (Goetz & Keltner., 2007) and have a different impact on an individual's actions. This review aimed to include a range of cultural perspectives, however due to the paucity of research cross-culturally only one study was available from a non-western background and it was not possible for conclusions to be drawn regarding this.

Thirdly, substance misuse was found in various studies to be linked to shame, both as a precursor and consequence of shame. However this finding was not universal. Further research should therefore investigate the complex relationship between shame and later drug use, as substance use may play in a key role in female offender's recovery and reintegration. Both qualitative and quantitative research would be beneficial in order to investigate different aspects of this area.

Finally, this review suggests that when female offenders feel shame, this can impact on community reintegration and recovery. Future research should further investigate the interaction of shame with recovery, as shame has the potential to have a significant impact on an individual's recovery. In particular, qualitative research in this area would be important. Due limited research in this area to date, qualitative research would be beneficial in allowing initial theories to be generated and perhaps for the mechanisms of any relationships to be explored.

Conclusions

This review investigated the impact shame has on female offenders. It has been found that shame has associations with female offenders' experiences in a number of areas; relationships, re-offending, drug use, societal reintegration and self-regulatory functions.

While shame was often associated with negative outcomes, this was not unanimous. Implications from the review were made in terms of clinical outcomes, including prioritising interventions to assist female offenders with the experience of shame and its impact. For example, through interventions aimed at improving relationships, reducing drug use and increasing coping skills. Research implications included needing more research generally regarding the experience of shame in female offenders. Alongside this, research should also focus on understanding the experience of shame in offenders in different cultures.

Importantly, this review highlighted that shame is associated with various outcomes for female offenders, including implications for relationships, substance misuse, recidivism, societal integration and self-regulation. These factors are likely to impact on female offender's reintegration into the community and their recovery. Therefore more research is needed to understand how the experience of shame impacts on recovery in forensic services.

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Section B: A Grounded Theory Investigation Into Shame and Recovery in Forensic Services

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Abstract

An Abbreviated Grounded Theory investigation was conducted to understand the relationship between shame and recovery for individuals in forensic services. The study aimed to investigate how service users experienced shame as well as how they coped with it. It also aimed to investigate any connection between shame and recovery, and what sense service users made of this connection. Semi-structured interviews were conducted with eleven participants across three forensic settings; a community service, a low secure hospital and a medium secure hospital. A tentative model was constructed which explored how shame developed and how it was experienced. The model also described how shame could at times help recovery, and at other times hinder recovery. Coping with shame through strategies such as substance misuse and self-harm helped participants with shame temporarily, however could hinder recovery long-term. Talking to staff was a factor which helped individuals cope with shame and recover. Some participants reported how shame was beneficial in working towards recovery. Implications were discussed, including the role of psychological professionals in facilitating conversations regarding shame with service users and staff, and supporting service users experiencing shame.

Key words: Shame, Recovery, Forensic, Grounded Theory, Mental Health

Introduction

Forensic mental health services provide treatment and support for individuals diagnosed with a serious mental health condition and who are considered a risk to the public. There are varying levels of security for forensic hospitals, and once individuals are discharged, they are often under the care of a community forensic team. Services manage the dual process of treating and supporting vulnerable individuals with mental health difficulties as well as managing risk (Drennan & Aldred., 2012). Forensic services users are detained under a section of the Mental Health Act (MHA), and may be subject to restrictions from the Ministry of Justice.

Theoretical Perspectives on Shame

Shame leads to one believing they are flawed, inferior or worthless (Lewis., 1971). It is distinguishable from guilt in that guilt typically refers to a negative feeling related to a specific behaviour, whereas shame refers to a difficult feeling in relation to the self more generally, in terms of feeling inferior or flawed (Lewis., 1971). Shame can be further categorised into internal and external shame. Internal shame refers to viewing oneself as inferior or worthless, whereas external shame refers to considering that others see one as inferior (Gilbert., 1997). Shame can be prominent in forensic services due to individuals typically having complex trauma backgrounds (Dyer et al., 2017; Feiring & Taska, 2005), and shame can influence outcomes for individuals in forensic services (Hosser et al., 2008). Shame can be triggered by the stigma of mental health issues (Corrigan et al., 2014) and being detained (Akther et al., 2019), as well as shame related to previous offending or anti-social behaviour (Mossiere & Marche., 2012). Shame can be a contributor to as well as a consequence of offending behaviour (Kreis et al., 2016; Mossiere & Marche., 2021), thus shame is important to consider in terms of recidivism (Hosser et al., 2008).

Gilbert's (1997) Social Rank Theory suggests that shame is an evolutionary and necessary emotion which alerts humans to a social transgression and encourages one to respond in a way which will rectify this. This can lead to three types of response; submitting to the group, displaying power to the group by being aggressive, or changing behaviour to behave in a way which is socially desirable (Gilbert., 1997). Gilbert and Miles (2014) suggested that the way that one responds depends on factors such as their previous experiences, current situational environment and physiological states. In a forensic population, service users are likely to have had a history of responding to shame in a way which may be aggressive (Hosser et al., 2008), however this will vary based on individual factors (Gilbert and Miles., 2014).

The Reintegrative Shaming Theory (Braithwaite., 1989) suggests that how an individual is shamed influences likelihood of recidivism. If the criminal act itself is shamed rather than shaming the criminal, and after the criminal has 'redressed' and apologised, the individual is reintegrated back into the community, this is likely to lead to less recidivism. However if an individual is stigmatised this is likely to lead to higher recidivism, perhaps through the process of shame displacement and anger leading to violence. Braithwaite compared the Reintegrative Shaming that often happens in Japan which prioritises rehabilitation and leads to low crime rates, with the high stigmatisation in the US which is associated with high crime rates. While consequent studies primarily focus on the shame individuals feel as opposed to the ways in which the system shames them, research has found that incarcerated individuals who feel more shame may be more likely to re-offend (Hosser et al., 2008).

Gilbert (1997) and Braithwaite's (1989) theories suggest that the impact of shame can be significant. While they comment on the impact of shame on recidivism and pro-social behaviour, the relationship between shame and mental health recovery is not discussed.

Recovery in forensic services does not simply relate to reduced recidivism, but relates to aspects such as improving mental health and personal development. When considering recovery in forensic mental health services, it is important to consider mental health recovery.

Mental Health Recovery

Recovery in mental health is a personal process specific to the individual (Llewellyn-Beardsley et al., 2019), however it is widely accepted that rather than recovery simply meaning freedom from mental illness, recovery involves living a meaningful life (Iwasaki et al., 2010).

Recovery in Forensic Services

'Secure Recovery' refers specifically to promoting recovery in secure forensic services (Simpson & Penney., 2018). Clarke et al (2016) identified six themes important in forensic recovery; hope, health, connectedness, coming to terms with the past, sense of self, freedom, and intervention. Recovery in forensic services also needs to consider individuals coming to terms with their offence (Simpson & Penny, 2018). Drennan and Aldred (2012) describe principles important for recovery in a secure hospital; being involved in life and decision making, relationships, believing in the capacity to grow, and holding realistic hopes. They also describe creating an ethos which fosters respect for the individual human beings in services rather than focusing on the identity of being a patient.

Shame and Recovery

While there are theories regarding shame in forensic services as well as recovery, there is a lack of theoretical knowledge regarding the impact of shame on the recovery journey. There is also a dearth of research examining shame and recovery in forensic mental health services specifically. Therefore, insights from mainstream mental health services will be considered. As service users progress with recovery they typically have more interaction

with the community, which is a positive in many ways for recovery (Roberts et al., 2015). However, some factors related to engaging with the community might increase shame. Larkings et al (2017) found that service users often believe that the community perceives that mental illness is caused by personal weakness. Shame can also arise in interactions with mental health staff and the community (Leeming and Boyle, 2013). Shame and negative experiences as an inpatient have been found to be contribute towards negative experiences after discharge (Eldal et al, 2019). Additionally, social friction and being rejected contribute to experience of shame (Eldal et al, 2019). This research suggests that relationships and community interaction may contribute to shame and this shame may have implications related to recovery after discharge. Vogel-Scibilia et al (2009) suggest that working through shame and maintaining hope may be a key part of recovery in mental health.

While models are in place to support recovery in mental health services, staff may not feel equipped to support individuals in their recovery when it pertains to shame. Vuokila-Oikkonen (2002) found that in an inpatient unit, staff did not respond or changed the subject when patients attempted to discuss shame, which may perpetuate these feelings.

Shame and Recovery in Forensic Services

In terms of investigating the relationship between shame and recovery in forensic services, there are gaps in the literature. Offence-related shame can encourage reparative action (Ferrito et al., 2012; Fuller et al, 2019). However shame may also impact negatively on the therapeutic process (Tangney & Dearing., 2011), so further exploration is important for engaging service users (Fuller et al., 2019; Gilbert., 2010). This project therefore aims to address these gaps in the literature. Recovery is a complex process in forensic services, as there are added factors such as offence related shame and increased stigma from the community. Understanding how recovery and shame are connected is important to investigate due to the impact that shame has on wellbeing, engagement, and rates of recidivism.

Aims and Research Questions

The current research aimed to understand how shame and recovery are related in forensic services. The research did not aim to investigate internal or external shame specifically; it was open to the broad experience of shame which participants may feel. This research focused on forensic mental health services rather than prisons, due to aiming to understand more about recovery specifically in a mental health context. An Abbreviated Grounded Theory approach was used due to its ability to facilitate understanding understudied phenomenon and the building of a theory about the subject, using the perspectives of participants (Charmaz, 2006; Willig, 2008). A Social Constructionist position was taken, which acknowledged the role of the researcher in the process, and aimed to understand participants' constructions of reality, as opposed to building a universal theory (Charmaz., 2006). The research aimed to answer the following Grounded Theory questions:

1. How do service users experience shame in forensic services?
2. How do service users cope with shame over the recovery journey and how does this change?
3. Is there a connection between shame and recovery, from the perspective of service users? If so, what sense do service users make of this connection?

This research is conducted in a National Health Service (NHS) context, therefore it has been designed in a way which considers NHS values; working together for patients, respect and dignity, commitment to quality of care, compassion, improving lives and everyone counts (Department of Health & Social Care., 2023).

Methods

Design

A qualitative design was used, utilising Grounded Theory (Charmaz, 2006). Grounded Theory aims to construct a theory based on participant experiences. Due to the

time and scope of the research, an abbreviated version of Grounded Theory was used. This is a method used by similar projects with comparable scope e.g. Kreis et al's (2016) research, and it aims to construct a 'provisional' theory as opposed to a fully constructed theory (Charmaz, 2006; Willig, 2008). A Social Constructionist philosophical underpinning was used. This Constructionist epistemological positioning refers to the idea that reality is subjective and each participant constructs their own reality based on their experiences. It is important to acknowledge that the researcher co-constructs the knowledge due to their own experiences and assumptions, therefore reflexivity is critical (Charmaz., 2006).

Reflexivity

The researcher may have been influenced in assumptions and understandings due to their experience working in a forensic service previously. Table 1 outlines measures taken to promote reflexivity.

Table 1

Measures Taken to Promote Reflexivity

Reflexive Measures	Description
Bracketing interviews	Conducted bracketing interviews with a colleague researching a similar area in the initial design stages as well as throughout the research. This allowed assumptions and expectations of possible findings to be uncovered and documented prior to gathering data, as well as the research progressed. An abridged bracketing interview can be found in Appendix D
Memo Writing	Used throughout to document subjective understandings and assumptions

Measures

Semi-Structured Interview Schedule

Interviews were used to attempt to understand participants' subjective experience. In line with Charmaz (2006), a semi-structured interview guide was used (Appendix I) which contained open questions about the subject area, and participants were given the opportunity to talk about relevant aspects which were important to them. The schedule was designed to start by asking about less emotionally laden subjects initially such as recovery before building up to discussing shame. To contain the emotional experience, more general questions were used to close the interview. The interview schedule was adapted slightly as the interviews progressed, in order to focus on areas which were identified as important in building the theory (Charmaz., 2006).

Participants

Participants were recruited from three forensic services in England; a mixed gender low secure hospital unit, a male low and medium secure hospital unit, as well as a mixed gender community forensic service. All services were in the same NHS Trust. Inclusion and exclusion criteria can be found in Table 2. Inclusion criteria were kept as wide as possible to gain a heterogeneous sample and a broad range of perspectives. The exclusion criteria was in place to ensure the safety of all parties and ensure that participants were in a stable mental state to give fully informed consent.

The number of participants recruited was determined by recruiting until theoretical sufficiency had been met (Dey, 1999). This included having enough data to develop a theory and demonstrate that this theory was present in the sample. A total of eleven participants were sampled. Demographic and historical data were collected with the participants' consent via local collaborators (Table 3).

Table 2

Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Individuals currently under the care of forensic services, even if they did not have an index offence Individuals aged over 18 Any gender Those proficient in understanding and speaking English	If participants were deemed to unwell or too high risk by their clinicians to participate

Ethics

The research was reviewed and given favourable opinion by the Preston NHS Ethics Committee and approved by the Health Research Authority (Approval Letter in Appendices C & D). All information from participants was stored confidentially and privately, and was anonymised. The data were stored in line with the Data Protection Act. Participation was voluntary and participants were able to withdraw without needing to provide a reason. Verbal and written consent was gathered and participants were able to ask any questions they wished. Consent was given for pseudonyms to be used in quotes from participants in the results section. Participant's wellbeing was prioritised throughout, including providing breaks and debriefs. Two Experts-by-experience were consulted throughout the process to ensure the study was relevant and interesting to the participant group. This included consulting forensic service users during the initial development of the project as well as co-developing the information sheets and interview schedule with them. Forensic service users were recruited through the university Expert-By-Experience network, and through a Peer Involvement network within the Trust recruited from, and they were paid for their time.

Table 3

Demographic Data

Demographic	Description
Age	32-60 (mean = 42.3)
Gender	7 Males, 4 Females
Ethnicity	7 White British, 1 White Other, 1 Mixed – White & Black, 1 Mixed (any other background), 1 Black or Black British - African
Length of time in current service	8 months – 7 years (mean = 22.8 months)
Length of time in forensic services	11 months – 17 years (mean = 61.7 months)
Section of MHA	Three s42, three 37/41, two 47/49, two s3, s45
Mental Health Diagnosis	5 Paranoid Schizophrenia, 1 Schizophrenia, 3 Schizoaffective Disorder, 3 Emotionally Unstable Personality Disorder, 1 Mixed Personality Disorder, 1 Obsessive Compulsive disorder, 1 Depression, 1 Psychotic Disorder [a]
Index Offence	3 Murder, 2 Attempted Murder, 2 Manslaughter, 2 Violence, 1 Arson, 1 Possession of Imitation Firearm, 1 Stalking
Service setting	6 Low Secure, 2 Medium Secure, 3 Community

Note. Counts of index offence types and mental health diagnoses are cumulative and one individual sometimes had multiple

[a] Mental health diagnoses are used for research purposes and have been taken by research collaborators verbatim from their clinical record. The current research prioritises the exploration of subjective experiences rather than reliance on diagnostic labels, however acknowledges the usefulness of these descriptors in a research context

Procedure

Potential participants were identified by local collaborators in the services and permission was sought from their care team for them to take part. Participants were first approached by a member of their care team about the research, and given information about it

verbally and in written form. They were then given time to read the information and consider participating. Participants then met with the main researcher to ask questions and sign the consent form. Participants were given an outline of the type of questions that would be asked before starting, and a 10 minute debrief was provided after the interview. The interview was recorded using an audio recording dictaphone. Participants were advised of who they could approach for support if needed. Following the interview, to thank them for their time, participants were provided with an electronic £10 gift voucher or sweet treats if they did not have an email address. Participants were asked if they would like to be contacted to provide them with a summary of the results of the study after it had been completed. Following analysis, the services recruited from and the ethics panels were provided with a summary of the outcomes of the research (Appendices N and P), as well as the participants who requested a summary (Appendix O).

Analysis

Interviews were transcribed and anonymised by the main researcher, and read through several times to familiarise themselves with the data (Charmaz., 2006). Initial line-by-line coding was then used, aiming to code the action (Charmaz, 2006). Focused coding was then used to consider which codes appeared most frequently or had most significance, which further guided the analysis. Theoretical coding was then used to consider how the codes were related and to move the analytic story in a theoretical direction. This allowed conditions to be specified under which the phenomenon changed and outlined consequences to the phenomenon. This combination of coding allowed the most common and significant codes and the relationships between them to be built into a provisional theory. The main researcher's clinical supervisor independently coded the first transcript and codes were compared to promote inter-rater reliability. Theme validation was also completed by an Assistant Psychologist in one of the services in order to ensure inter-rater reliability of the

themes. This involved them validating the correspondence of codes to themes. Finally, respondent validity (Chiovitti & Piran., 2003) was sought, by meeting with a participant to discuss the findings and provisional theory, and using their input to refine the theory.

Results

Question 1: How do Service Users Experience Shame in Forensic Services?

Attempting to understand participants' experiences of shame was set in the context of understanding individuals who had significant mental health issues, and a history of past violent behaviour which they felt shame about. This shame was described by participants.

Index Offence/Past Violence

Previous violence to others was something that caused participants psychological pain to think about, and seven participants described their experiences related to this:

Gemma:"(index offence) It's attempted murder. And I am beyond shameful about that…. But what right did I have to try and take a life? I had no right. I had no right whatsoever… and the shame inside because of that…"

For most participants the shame tended to start as soon as they started to understand what had happened:

Ed:"When I started to realise what happened and where I am, probably the first feeling was shame. Considering, obviously, what happened (index offence)"

This shame was not experienced exclusively related to experiences which occurred after they became unwell, participants sometimes felt more shame for things they had done before becoming unwell:

Cameron:"The way I behaved when I was young, when I was in the army and stuff, that was very uncouth… I used to beat people up. I used to get into fights, I used to do the kind of things that were um wrong, that makes me feel a bit shameful… so I would say that a

lot of the shame is tied into regretful decisions or choices that I've made that I regret and a lot of that ties into remorse also, so I'm remorseful about the things that I wish I hadn't done"

Additional Causes of Shame

Participants described additional factors which had led to them feeling shame, including traumatic or difficult childhood experiences, stigma about being in a forensic mental health service, and difficult relationships.

Trauma/Difficult Childhood. Two participants described how they had felt shame since childhood, due to experiences growing up. Participants felt that this shame was programmed into them by their parents:

Helen:"I believe that shame stems from childhood, not just adulthood or like teenager years, I think it's pre-programmed in you as you're growing up. That's my experience."

Other participants described how they felt shame specifically about experiences that had happened to them as a child, and this shame had stayed with them:

Gemma:"My mum is an alcoholic. My dad raped a (redacted) child when I was younger. My step granddad sexually abused me when I was a kid. My Nan believed him not me and everyone else just like going on his side and not my side… I used to think that what happened between me and my step granddad was normal … He made me feel like it was something special…. and that's why I feel shame."

Stigma and Shame Felt from the Community. It was felt by six participants that shame was imposed on them by the community. Even when they did not feel they should be ashamed, they felt shamed by others, often regarding their mental health:

Gemma:"You feel bad for everything that you do, you know it's almost imposed on you to feel bad… Sometimes you get shamed for nothing… People ugh people are quick to

judge. And they're quick to embarrass you about it. You know, like, oh look, there's a crazy person. Wakaloo Loo."

Participants felt like this was something that they could not get away from, and that it was obvious to others, leading to shame:

Heather: "Sometimes it's almost like you've got, I don't know, a um a sign on your back saying I'm a mental patient sort of thing, you know? And you feel that people can see that you know? That you've been in hospital etcetera"

Others experienced that others shame them when they were open about their time in hospital:

Dom:"The shame that you've got mental health issues. Because when you meet someone new and that you go. Yeah, my name is (redacted) and I'm at (redacted) hospital. And they're like, oh, mental health issues. And there's a stigma that we're all bad. And that we're all crazy and all out of our mind. … and some people may talk down to you because of it. And then you feel ashamed because you're the one with it."

Difficult Relationships. Four participants described shame in relation to their relationships, such as with their family. They described shame regarding how they felt they had impacted their family:

Heather:"Yeah most of my shame is around my children, because I feel like you know now I've messed up their lives… there's so many different forms of it but most of mine is around my family and stuff. That's probably the worst."

What Shame Feels Like

Participants described the feeling of shame in a number of ways, which are represented in Table 4.

Table 4

Table Representing Participant's Descriptions of Shame

Description	**Quote**
Bad	*Heather:"It is a massive thing and you know, you do believe that you're a bad person and that you know. And that nothing can make you into a good person sort of thing."*
Unloved	*I: "OK what does shame feel like? Gemma1: being unloved."*
Worthless	*Gemma:"And I think, yeah, shame for me is more feeling made to feel worthless."*
Hating yourself	*Heather:"I think shame to me just in my eyes makes me hate myself. And when they say that you're feeling bad, you know it's not just feeling bad it's it's hating yourself, you know? And it's you know, you're living, trying to live while you're hating yourself. It's very difficult."*
Painful	*Ed:"... if it's a friend that you've known for, you know, 20 25 years. From one day to another, and he don't want to, you know, have anything to do with you for whatever reasons. There is a sense of, yeah, pain."*
Heavy	*Gemma:"You feel bad for everything you do…it's heavy. You know, I get it, but it is heavy."*
Like there's something wrong with you	*Helen:"Made to feel like there's something wrong with you and also you're always questioning what's wrong with you."*

Question 2: How Do Service Users Cope with Shame Over the Recovery Journey, and How Does This Change?

Trying to Cope with Shame

Shame was described as an emotion which is painful, and that participants often did not feel equipped to deal with. Participants described a range of ways of attempting to deal with this shame. Often these ways of coping were individual's best way of coping with the painful feeling of shame with the resources they felt they had. These ways of coping appeared to help them cope with shame in the short term, however in the long-term these strategies were not described as bringing individuals closer to recovery. Sometimes they stated these ways of coping made things worse, and maintained the shame.

Drugs and Alcohol. A common theme was coping with shame by using substances. Five participants described it as a way of coping, particularly once people were in the community:

Gemma:"I used to cope by drinking."

Gemma:" when I leave hospital what worries me is am I going to be able to stay off the alcohol? … thinking back on the (shameful) memories when I'm low, and that's why I drink. And I drink until I'm too drunk to care."

Participants recognised that while they tended to use substances as a coping mechanism, it often made it harder to cope long term. Participants also recognised that using substances could get in the way of them trying to recover:

Craig:"And I said I felt really bad doctor on my meds, I really felt bad, I don't know why I even drunk it (alcohol), it made me feel really bad. And he said you see what I mean (Craig), that's not good for you. You don't need to as you could die doing that…"

Detachment from People. Distancing themselves from people who might cause them to feel shame was a theme described by seven participants. While this could be helpful, it had implications later in life that could sometimes make recovery more difficult:

Cameron:"I don't have uh I've not been married, I've not spoken to my parents, well my father, in years, I haven't spoken to my brother in years so there's all sorts of people that would make me feel guilty or shameful, that I've, or angry, or sad, or whatever, or people that I've argued with that just aren't in my life anymore so I feel like it's easier to change and just move forward, but then in a way I'm a bit regretful in that I wish I had children I wish I had been married, I wish my parents and I had a closer relationship so it's kind of swings and roundabouts."

Other participants described detaching from people less as a conscious choice, and more that having people close to you is "too much". They described that that is how they find they are best able to cope:

Gemma:"I like that detachment… No. Acquaintances are nice. You know you can talk to them once a month and that's about fine. I can't be doing all the close (pause) too much sigh (pause) too too much… And as long as you've got yourself, you don't really need anyone else. You know, I've always been that way."

Self-Harm and Suicidality. Two participants described how one way that they cope with the pain that comes from feeling shame is to self-harm:

Heather:"I feel that I've messed up their lives you know and there's nothing I can do to make it any better sort of thing, you know? Um so what I do then is sort of take out on myself by you know self-harming."

They expanded on this to reflect on how feeling this shame and coping by self-harming can make it difficult to think about recovering:

Heather:"… It does affect me, you know. Not wanting to do things and it doesn't…. give me the energy to sort of get out of here because you know in my head is I need to hurt myself. That's all I'm thinking about all the time. Trying to sort of think about recovering and getting out of here is very difficult when you feel like that"

Another participant described how shame made them feel helpless, and caused negative thoughts, including wanting to end their life:

Andre:"Yeah, because it it starts with something really small… it explodes and then before you know it yeah it's gone you know over your head or you think oh what have I done. I can't get out of this. Was feeling hopeless, feeling suicidal. Feeling can't go on so, so negative thoughts."

Ruminating. Ruminating on things that participants felt shameful about was described by three participants as being useful to some extent, however if they ruminated on the shame too much, it could lead to it being harder to cope:

Cameron:"So I think the shame is useful to make you not make the same mistakes twice. But if you just ruminate on it, it can become very dangerous and I think that was why I was very depressed when I was in my 20s. Because I was ruminating on things a lot."

Denial/Avoidance. Three participants described pushing feelings of shame aside rather than dealing with them directly. This appeared to be a way to cope when things were overwhelming:

Steven:"Sometimes you just don't want to have to deal with things, I guess (Laughter) You just want to go to sleep or something."

Gemma:"But it just (pause) I tend to push things aside and not deal with them right there and then."

Question 3: Is There a Connection Between Shame and Recovery, From the Perspective of Service Users? And What Sense do Service Users Make of this Connection?

Shame Can Make it Hard to Recover

Participants described how shame can sometimes make it more difficult to recover, and some participants reported that this is in part due to coping in the ways described above. Another reason that shame can make it more difficult to recover is due to shame making it difficult to express yourself and making you want to hide away, which was described by seven participants:

Andre:"Well, it's shame as well yeah because you feel you don't wanna take part. You wanna hide away"

Andre:"(shame has) been in the background… it did have an impact because it was hard for me to express myself fully the way that I wanted to express myself.

I What impact did that have on being able to recover?

P More like, feeling subdued in that kind of way? Umm. Not be able to do things fully in mind."

Due to experiencing shame, three participants described how this can make it difficult to engage with the community, something that is important in forensic services:

Craig:"I think shame is a type of phobia. Because my shame is when I'm out the door walking along, And I'll be like… like quenched up in the head. Ohh no, they can see I'm unwell."

Need Support to Deal With Shame

There were certain things participants described which could help them feel able to cope differently with the shame and move forward. One thing that was spoken about by almost all participants was having the support of staff which allowed them to talk through things and which helped them cope:

Ed:"Breaking that barrier of shame with the people closest to me helped me quite a lot. To do it step by step. You know start talking in the one to one therapy, or talking to the Chaplin for example, maybe? For spiritual conversation and stuff like that. Obviously (shame) is a feeling I have every time I try to start that conversation, but in the three years it goes slightly, you know, slightly softer in terms of dealing with it, maybe you know, because I started to talk about it with people you know a bit further from my circle if that makes sense."

Participants highlighted that if this is not available, it is harder to recover:

Helen: "I think when I first went to (redacted) they made it worse because I wanted to talk about things and I got told by my like, I think he was like key member or something, he was like my go to man, that I couldn't talk about my index offence with any of the staff that were on the ward, apart from the psychologist and I found that really unhelpful because I I had so many unanswered questions in my head. So really, if you've got an ongoing investigation like I did, you've got no one to talk to."

The right living environment with the right support was described by three participants as helpful for coping with shame and being able to recover:

Andre:"Also depends on where you are having time, because I mean you can be in a bad place, and if you live in a bad place it makes the outlook worse, and what it can be. But if you're in a good place and got good staff and people surrounding you and they can help you along that way as well to have a better, better outlook on things."

Feeling accepted was also noted as key in recovering from shame:

Helen: "But I think sometimes when you're in a certain place, you haven't got the courage to try and work for that love and I did get that from hospital… I got kind of like some kind of acceptance and I got got some kind of acceptance from some of the patients."

Alternative/Helpful Ways of Coping

Ways which were more helpful for coping, both in the short and long term, were identified by participants.

Psychology. Using therapy was described by five participants as important in coping with shame and moving towards recovery:

Ed: "I've been doing the therapies with my previous psychologist in the other hospital and my first psychologist here, so I had the possibility to fully open and you know and receive advice and that has helped me so much… I had the chance to talk about it and deal a bit better with a sense of shame."

Religion. Participants often described a complicated relationship with religion, however three participants who were religious found that it was helpful in coping with shame:

Steven:"Yeah, and I think religion helps. I think maybe like understanding that you're not perfect and that God's there to help and um, yeah. And that you shouldn't be ashamed."

Meaningful Activity. Two participants spoke about how meaningful activities can help with shame and recovery:

Andre:"Activities (impact on shame and recovery) because I think if you're in the age group having been able to work helps as well because it keeps your mind… If if you can't, if you can't work even doing some voluntary work, and that will help people on their recovery journey as well, the people at first say I don't wanna do this, don't wanna do that, feel unmotivated to do things but once you get into it it helps you for the future."

Process/Work Through Shame to Help Recovery

Seven participants explained how, given the right support, shame can actually be helpful for recovery. Three participants descried how shame could motivate them to recover:

Dom:"Them things can help you become a little bit stronger if you do get a bad reaction. No matter what happens in life, its only you that can push forward not anyone else, whether you're doing it 'cause people are taking it the wrong way or whether you're doing it because you want a better life, it makes you stronger. It makes you fight for a little bit more, do you know what I mean? You know it makes you want to do good, if that makes sense."

Helen:"Umm, I think shame is built when it's built into you from an early age makes you strive more and it makes you just put that a little bit more effort in because… it's like you want to feel loved."

Three participants described how shame helped them to learn from their mistakes:

Craig:"If I've done something that I feel shame about but I've learned from it uh I'll be like no, no, I can't say those words like that and I'm like, yeah, I know I'm not gonna be like that to that person anyway."

Three participants also described how shame was necessary in order to work towards recovery:

Gemma:"I told you all the things I feel shameful for … And I can't stop it and I think it's a necessary emotion… it's a necessary emotion"

Dom:"Yeah. To start off with, I felt ashamed that I was going through things. And I could hear people whispering he's gone fucking crazy and that. And them talking about me and that, and I felt ashamed that I was going through that. But it's not, I think that you should feel like that. You should embrace it in a way that you know you can do better and help yourself get through things."

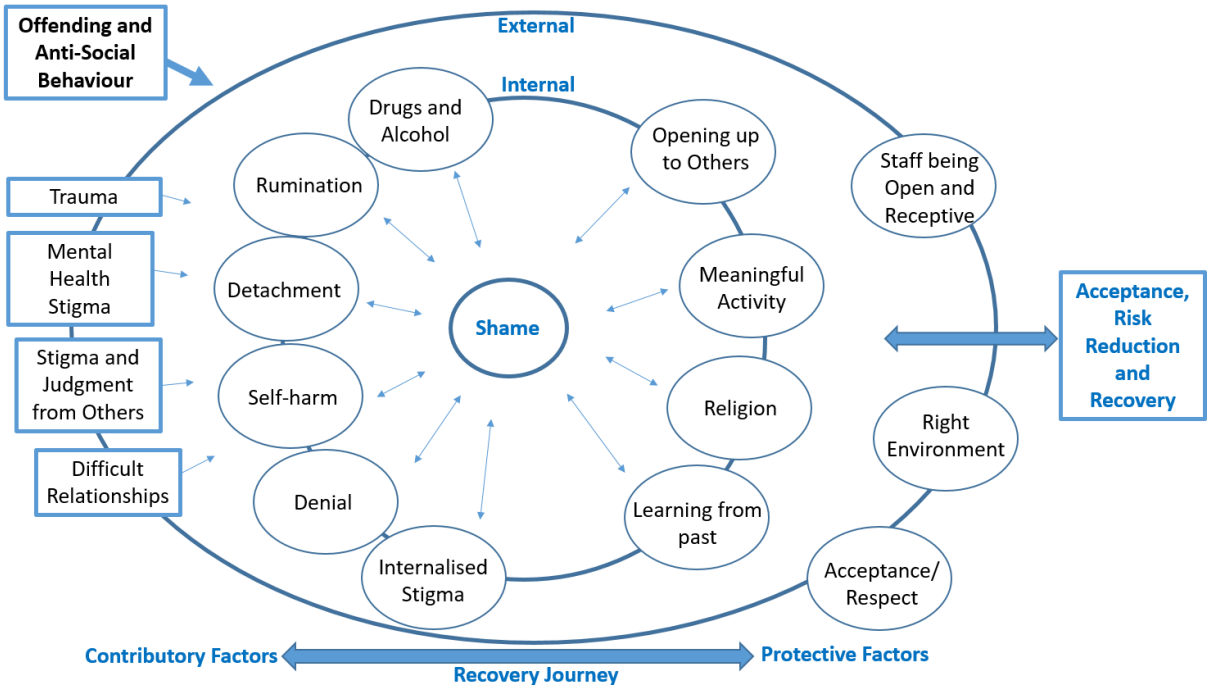
Model

A provisional theory regarding how shame relates to recovery has been developed based on the findings above (Figure 1). The model was set in the context of participants with significant mental health difficulties experiencing shame regarding their offending or

antisocial behaviour history. There were further common factors that tended to lead to shame for participants; including traumatic childhood experiences or difficult experiences with parents, which was described as something which had stayed with them since childhood. Other people's perceptions of them from the community, including stigma related to mental health, as well as in their relationships also triggered shame. Initially after entering forensic services, it appeared that this shame was particularly difficult to cope with. Participants commonly tried to cope with shame in ways which sometimes made them feel better short-term however prolonged the shame long-term. This included using drugs and alcohol, self-harming, denial of shame or ruminating on shame, or detaching from people. These were strategies which most participants had engaged in, and they were described often as perpetuating shame and other difficulties, and making it harder to recover. However, several participants described how their relationship with shame and how they coped

Figure 1

Model of Shame and Recovery



with it changed over time. They changed how they coped with shame, and this had a positive impact on recovery. There were both external and internal factors which contributed to participants making this change. The main factor was staff being present, being supportive and being equipped to have conversations about shame and other emotions. Having the right living environment, as well as things such as religion, activities and psychology also helped people to cope with shame. Participants explained how after they started to cope differently with shame and come to terms with it, they found that shame could be helpful for motivating them to recover. It helped them to learn from the past, and some participants described how they thought working through shame was a key and necessary part of their recovery.

Participant Consultation on Model

In discussion with a participant during the respondent validation stage, they stated that coping with shame and using it to help them recover might be easier when this shame is not being imposed on you by others (i.e. this might be easier for internal shame as opposed to external shame). It is also important to note that different people cope in different ways at different points, and the model is dynamic and not one directional. Some individuals may stay in one section of the model for a while, and progress through the model to recovery at different paces.

Discussion

This research aimed to understand the factors which contribute towards shame and how it is experienced in forensic services, understand how service users cope with shame over the recovery journey, and understand the connection between shame and recovery.

A tentative model of shame and recovery was proposed by analysing interviews with forensic service users using an Abbreviated Grounded Theory Approach, and was set in the context of participants experiencing shame regarding an anti-social or offending past and the

experience of significant mental health difficulties. Childhood trauma, stigma from self and others and difficult relationships also contributed to experiencing shame. A common initial way of coping with shame was coping in ways which may provide short-term relief however perpetuate long-term shame; using substances, detaching from people, self-harming, ruminating and denial. These strategies could make it harder to recover. Many participants then described moving to a healthier way of coping with shame, which aided recovery. This was often prompted by external factors, including staff being able to talk to service users about shame, having the right living environment and feeling accepted. Internal ways of coping were often accessible subsequently, including tolerating shame, engaging in meaningful activity, religion and psychological therapy. These coping strategies helped recovery. Some participants felt shame was necessary as it had helped them to learn from mistakes and motivated recovery. It was suggested during the respondent validity stage that shame serving a helpful and motivating role may be primarily true for individuals who are coping with internal rather than external shame.

Connection to Literature

This model supports aspects of other theories, and extends these to understand more about how shame relates to recovery in a forensic setting. It supports prior research suggesting that shame can be linked to offending behaviour (Mossiere & Marche., 2012), trauma histories (Dyer et al., 2017; Feiring & Taska, 2005; Lateef et al., 2023) and perceived stigma (Gerlinger et al., 2013) as well as rejection from the community (Eldal et al, 2019). This model also suggests that relationships, in particular being a mother while in services, can be strongly related to shame. This has also been found in previous research (Cooper-Sadlo et al., 2019; Jackson et al., 2011; Kreis et al., 2016) and suggests that being a woman and a parent in forensic services can be a difficult experience in part due to shame experienced.

It was also highlighted in the current study that positive relationships were important for coping with shame and moving towards recovery. This extends Clarke et al's (2016) and Drennan and Aldred's (2012) suggestions that positive relationships are important for recovery, and suggests that these theories hold true for coping with shame while recovering. Additionally, it supports prior research citing importance of therapeutic relationships in managing forensic services (Simpson & Penney,. 2018), and suggests that this is also key in managing shame. The current model builds on Vuokila-Oikkonen's (2002) finding of staff not engaging in conversations around shame and suggests that not being able to talk about shame with staff can make shame harder to cope with and may hinder recovery.

Braithwaite's (1989) Reiterative Shaming model suggests that if an individual is stigmatised this can lead to worse outcomes. The current findings extend this to suggest that some shame, particularly internal shame if it does not feel overwhelming, may be helpful in recovery as it motivates recovery, whereas external shame triggered through interaction with the community may lead to difficulty working through shame. The current research also aligns with aspects of Secure Recovery highlighted by Drennan and Alred (2012), including the importance of relationships and respect. From the current model, this can be seen to support individuals to work through shame towards recovery.

In regards to the connection between shame and recovery, the current model supports Vogel-Scibilia et al's (2009) suggestion that working through shame can aid recovery. However, this model highlights that in forensic services this is not straightforward and is something that staff can feel anxious about or unsure of (particularly before court proceedings), and rather than being one directional, it is a complex process by which service users may at times be able to work through shame, and at other times this may be more difficult. It also highlights ways of coping which can help and hinder working through shame towards recovery. Kreis et al (2016) investigated relational pathways to drug use in offenders,

and the role of shame. They found a cycle by which shame was maintained in a cycle with substance use, offending, loss of children, family disconnection and difficult intimate relationships. The current research suggests a similar pattern in the development and maintenance of shame, however furthers this model by identifying potential routes by which different coping mechanisms are developed and individuals feel more able to work towards recovery.

Strengths and Limitations

One limitation of this research is that it may be excluding key service users who would be able to contribute to the theory, as those deemed as high risk were excluded. They may have been at a different and earlier stage of their recovery, and would therefore have unique insights into their experience. The scope of this research did not aim to create a universal theory which can be applied to the entire population. However, due to this exclusion, key perspectives may have been lost that may have extended the theory. Additionally, black men and minoritised ethnicities in particular can be mislabelled as 'high risk' (Coid et al., 2000). This study therefore may have inadvertently excluded some of these individuals. Additionally, the proportion of individuals from the global majority in this study is likely lower than the proportion in forensic services, where black men are over represented (Coid et al., 2000). Contributing factors to this may be distrust of research professionals due to prior experiences and expectations (Bashir., 2023; Das., 2010; Yancey et al., 2006). These individuals may have experiences of shame which are impacted by factors such racism (Johnson., 2020), which would be relevant to the model. However, while in this regard the study may have benefitted from investigating more areas of difference, the study did incorporate a range of different experiences in regards to service users in different levels of security. This is a strength, as it enabled a detailed understanding of different perspectives, and the development of a model which covered multiple stages of a recovery journey.

Another limitation is the small sample size. While the scope of other similar projects have used similar or fewer participant numbers (Kreis et al., 2016), doing this only allows a tentative model to be formed. This is due to the difficulty recruiting in forensic services and shame being difficult to talk about, thereby restricting numbers. However, this model allows a helpful start for research to build upon, and in line with the Social Constructionist epistemology, this research is only aiming to create a theory relevant to the specific setting and individuals sampled (Charmaz., 2006). The research was able to work to theoretical sufficiency and formed a model around how this group of participants constructed their reality.

Another strength of this research is that service users and Expert-By-Experiences were consulted throughout, aiming to ensure that the research would be relevant and helpful to the population. Respondent validity was also used, one benefit of which was being a preliminary way of assessing acceptability of the model to the population.

Clinical Implications

For service users, this research provides a tentative framework and hope for how shame might be helpful for recovery. Coping strategies such as talking to staff and engaging in psychology and activities may help individuals cope with shame. This understanding of shame could also be used by Psychological Professionals and incorporated into service user's formulations, empowering service users to be able to work through shame in a validating way.

This research develops upon the understanding of shame and recovery in the literature, and may allow clinicians to understand more about risk factors related to shame. An improved understanding of the role of staff support and respect in managing shame, helping recovery and reducing risk related behaviours may assist services in managing risk and reducing recidivism. Understanding that behaviours such as using substances and

withdrawing may be related to shame may help services in identifying individuals who may pose a risk to themselves or others. This understanding may help staff to know how to support individuals and reduce risk related behaviour.

The research also highlights implications for staff in forensic mental health services, as staff availability and ability to talk about shame is key. Psychological professionals such as Clinical Psychologists should ensure that staff are trained in a way that they are able to manage emotionally laden conversations, particularly shame, in a way which validates service user's experience and allows them to process the emotion. More specifically, Clinical Psychologists could facilitate training sessions to inform staff about shame and its impact, and facilitate reflective spaces in which staff can bring related issues. Psychological therapists could also incorporate discussions around shame into psychological therapy, for example through using Compassion Focused Therapy (CFT) (Gilbert., 2010). Taylor and Hocken (2021) propose a framework for using CFT in forensic services in a way which addresses shame and could be used to promote recovery.

Forensic services could also benefit from structuring services in such a way that staff are accessible to service users and have the correct training to support them with shame. Services should continue to structure care in a way which appropriately mitigates and discusses risk, which will involve discussing aspects of their past which service users might be shameful about. However, importantly, services should do this in a therapeutic way in which service users feel supported to process shame and change their behaviour, rather than in a way which is stigmatising, as this may lead to more shame and difficulty with recovery.

The model also highlighted religion as key in helping service users to cope with shame and recover, therefore services facilitating the availability of chaplains and religious spaces is important. Social spaces and the availability of meaningful activities on wards, as well as the facilitation of regular visits for friends and family should also be prioritised.

Theoretical Implications and Future Research

This model proposes a new framework for understanding the role of shame in the recovery journey, and suggests how this may change throughout service user's time in forensic services. It extends prior research by proposing a way in which shame might interact with the recovery process in a dynamic way, something which prior to this research was a gap in the literature. It also extends the understanding of risk factors in the context of shame, as individuals may cope with shame in a way that either increases or decreases risk, depending on how the individual is coping with shame.

This research should be extended to understand more about how service users cope with shame. While some relevant factors have been identified, it would be beneficial to understand more about how individuals may move from a place of finding shame extremely difficult to finding that they can cope with it. This will likely not be straightforward, and will involve service users alternating between different ways of coping, however more information about influential factors would be theoretically and clinically beneficial. Longitudinal research and further quantitative research could further develop and test the current model. It would be beneficial for future research to understand how the current model might differ for individuals experiencing internal shame vs external shame. From prior research, shame may be experienced differently in different cultures (Braithwaite., 1989), therefore research should investigate shame and recovery in non-western populations. Furthermore, it would be beneficial to recruit more individuals from the global majority to understand the experience of shame and recovery for these individuals. One way of doing this would be the meaningful involvement of 'Community Gatekeepers' from the communities the research is aiming to reach (Bashir., 2023).

Conclusion

The current research used an Abbreviated Grounded Theory methodology to investigate shame and its relationship with recovery for forensic service users. A new model of shame for forensic service users was generated, which found that early trauma, being stigmatised and difficult relationships were sources of shame for participants. The shame experienced was also in the context of significant mental health difficulties and previous offending or anti-social behaviour. Common ways of coping with shame were identified, many of which could reduce shame in the short-term however prolonged shame long-term, for example substance misuse and self-harm. Participants often acknowledged that while these strategies were the only way they felt they were able to cope, they could perpetuate certain difficulties. Difficulty expressing oneself, and detaching from others were also cited as consequences of shame which hindered recovery. However, shame was also suggested to be beneficial in working towards recovery for some service users, as they found it motivated recovery. Strategies such as talking to staff as well as psychology, religion, and engaging in activities were also suggested as being helpful in coping with shame and working towards recovery. Clinical implications for services include the necessity to provide a therapeutic environment for service users in which they have support to work through shame and recover, and access to an environment in which they do not feel stigmatised. Future research should aim to understand more about the factors impacting the way individuals cope with shame in forensic services, due to the significant impact this can have on recovery. It would also be beneficial for future research to understand how different cultures may experience shame while recovering, and the consequences of this.

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Section C: Appendices

Appendix A – Critical Appraisal Tools

Critical Appraising Skills Programme (CASP) criteria for evaluating qualitative research (CASP, 2006)

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Appraisal tool for Cross-Sectional Studies (AXIS tool; Downes et al., 2016)

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Critical Appraisal Skills Programme (CASP) checklist for cohort studies (CASP., 2016)

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Quality appraisal Tool for Before-After (Pre-Post) Studies With No Control Group from National Heart, Lung, and Blood Institute (NIH, 2014)

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Appendix B – Theme Development

Theme	Theme Development	Description	Examples
Relationships	Initially based around the theme of being a mother, which was a prominent theme, and was expanded to include other relationships more generally. This was due to other relationships being seen to impacted, including in a wider cycle in which the role of being a mother was connected with other relationship dynamics.	Investigating how shame impacts on connections with others, including friends, family and romantic relationships	Cooper-Sadlo et al (2019) reported "Shame experienced by participants and the anger and distrust of their children and families impeded participants' return to a mothering role." (p.97)
Recidivism	Recidivism was expanded to include factors known to be related to recidivism	Inclusive not just of recidivism, but also factors which are known to be connected to recidivism	Tangney et al (2011) reported "the findings in Table 3 linking shame proneness to a range of established predictors of violent and nonviolent recidivism" (p.730)
Substance Misuse	This theme was broad to encompass actual changes in substance misuse and its relationship to shame, as well as the exploration of substance misuse in a wider cycle of other factors, in which substance misuse may be a contributor as well as a consequence of shame	How shame impacts on substance misuse, including when part of a wider cycle	Kreis et al (2016) reported "It is very likely that the women in this study also experienced feelings of guilt about their behavior, but shame (i.e., both external shame related to how they were viewed by others and internal shame related to how they viewed themselves) appeared more central to their relational pathways and ongoing substance misuse"

			(p. 43)
Societal Stigma and Community	This theme developed to encompass multiple factors related to the relationship between shame and societal interaction, as well as how women coped with the psychological impact of shame in regards to beliefs about society's perceptions of them	How shame impacts woman's views of society/community, how much of a part of the community individuals feel, and the impact of shame on participants interaction with and behaviour to society as well as how they cope with this shame	Nikartas & Tereškin as (2022) reported "It should be noted that the feeling of shame and fear of stigmatisation limited these women's social ties." (p. 75)
Self-regulation	Initially started with 3 themes (self-control, self-regulation and self-harm), however due to the dearth of research and the relationship between these 3 they were developed into 1 theme	How shame impacted on self-related functions such as self-control, self-harm and self-forgiveness	Milligan & Andrews (2005) "In the first phase of the analysis it was revealed that women reporting self-harming behaviours were significantly more likely to... report higher levels of all facets of anger and shame assessed" (p. 21)

Appendix C – Table of Completed Quality Appraisal Tools for Each Study

Quality appraisal of Qualitative studies using Critical Appraising Skills Programme (CASP) criteria for evaluating qualitative research (CASP, 2006)

Study	Clear statement of aims?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?
Cooper-Sadlo et al (2019)	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Valuable
Kreis et al (2016)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable
Nikartas & Tereškinas (2022)	Yes	Yes	Can't tell	Yes	Yes	No	Yes	Can't tell	Yes	Valuable

Quality appraisal of Cross Sectional studies using Appraisal tool for Cross-Sectional Studies (AXIS tool) (Downes et al., 2016)

Study	Q 1	Q 2	Q 3	Q4	Q 5	Q 6	Q 7	Q 8	Q 9	Q 10	Q 11	Q 12	Q 13	Q 14	Q 15	Q 16	Q 17	Q 18	Q 19	Q 20
Tangney et al (2011)	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Can't tell	Yes
Osei-Tutu et al (2021)	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Unclear	No	Yes	Yes	Yes	Yes	No	Yes
Milligan & Andrews (2005)	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Unclear	yes

Notes:

Question 1: Were the aims/objectives of the study clear?

Question 2: Was the study design appropriate for the stated aim(s)?

Question 3: Was the sample size justified?

Question 4: Was the target/reference population clearly defined? (Is it clear who the research was about?)

Question 5: Was the sample frame taken from an appropriate population base so that it closely represented the target/reference population under investigation?

Question 6: Was the selection process likely to select subjects/participants that were representative of the target/reference population under investigation?

Question 7: Were measures undertaken to address and categorise non-responders?

Question 8: Were the risk factor and outcome variables measured appropriate to the aims of the study?

Question 9: Were the risk factor and outcome variables measured correctly using instruments/measurements that had been trialed, piloted or published previously?

Question 10: Is it clear what was used to determined statistical significance and/or precision estimates? (e.g. p-values, confidence intervals)

Question 11: Were the methods (including statistical methods) sufficiently described to enable them to be repeated?

Question 12: Were the basic data adequately described?

Question 13: Does the response rate raise concerns about non-response bias?

Question 14: If appropriate, was information about non-responders described?

Question 15: Were the results internally consistent?

Question 16: Were the results presented for all the analyses described in the methods?

Question 17: Were the authors' discussions and conclusions justified by the results?

Question 18: Were the limitations of the study discussed?

Question 19: Were there any funding sources or conflicts of interest that may affect the authors' interpretation of the results?

Question 20: Was ethical approval or consent of participants attained?

Quality appraisal of longitudinal studies using Critical Appraisal Skills Programme (CASP) checklist for cohort studies (CASP., 2016)

Study	Did the study address a clearly focused issue?	Was the cohort recruited in an acceptable way?	Was the exposure accurately measured to minimise bias?	Was the outcome accurately measured to minimise bias?	Have the authors identified all important confounding factors?	Have they taken account of the confounding factors in the design and/or analysis?	Was the follow up of subjects complete enough?	Was the follow up of subjects long enough?	What are the results of this study?	How precise are the results?	Do you believe the results?	Can the results be applied to the local population?	Do the results of this study fit with other available evidence?	What are the implications of this study for practice?
Tangney et al (2016)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Clear	Precise	Yes	Yes	No	Clear

Quality appraisal Tool for Before-After (Pre-Post) Studies With No Control Group from National Heart, Lung, and Blood Institute (NIH, 2014)

Study	Q 1	Q 2	Q 3	Q 4	Q 5	Q 6	Q 7	Q 8	Q9	Q 10	Q 11	Q 12
Jackson et al (2011)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No & Yes	Yes	No	Yes

1. Was the study question or objective clearly stated?

2. Were eligibility/selection criteria for the study population prespecified and clearly described?

3. Were the participants in the study representative of those who would be eligible for the test/service/intervention in the general or clinical population of interest?

4. Were all eligible participants that met the prespecified entry criteria enrolled?

5. Was the sample size sufficiently large to provide confidence in the findings?

6. Was the test/service/intervention clearly described and delivered consistently across the study population?

7. Were the outcome measures prespecified, clearly defined, valid, reliable, and assessed consistently across all study participants?

8. Were the people assessing the outcomes blinded to the participants' exposures/interventions?

9. Was the loss to follow-up after baseline 20% or less? Were those lost to follow-up accounted for in the analysis?

10. Did the statistical methods examine changes in outcome measures from before to after the intervention? Were statistical tests done that provided p values for the pre-to-post changes?

11. Were outcome measures of interest taken multiple times before the intervention and multiple times after the intervention (i.e., did they use an interrupted time-series design)?

12. If the intervention was conducted at a group level (e.g., a whole hospital, a community, etc.) did the statistical analysis take into account the use of individual-level data to determine effects at the group level?

Appendix D - Abridged Bracketing Interview

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Appendix E – Approval from Ethics Committee

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Appendix F – HRA approval

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Appendix G – Consent Form

Salomons Institute for Applied Psychology

One Meadow Road, Tunbridge Wells, Kent TN1 2YG

[redacted]

CONSENT FORM

Title of Project: A grounded theory investigation into the recovery journey of forensic service users, and the significance of shame and mental health in this recovery

Name of Researcher: Ella Neil

Please initial box

1. I confirm that I have read and understand the information sheet dated 15/09/2023. (Accessible information sheet version.2.) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason [without my medical care or legal rights being affected]. I understand that I am also able to withdraw my data for up to 2 weeks after the interview, and I will be given the lead researchers details in order to request this. ☐

3. I understand that data collected during the study may be looked at by the supervisors [Dr Rachel Terry and Dr Caroline Clarke]. I give permission for these individuals to have access to my data. I understand that the researchers will have access to my personal data required for the study (outlined in the information sheet), which will be stored securely. ☐

4. I agree to my healthcare team being informed of my participation in the study. ☐

5. I agree that anonymous quotes from my interview and other anonymous data may be used in published reports of the study findings. ☐

6. I agree to the interview being audio recorded. ☐

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

Name of Participant_____ Date_____

Signature _____

Name of Person taking consent __Ella Neil__ Date_____

Signature _[redacted]

Note. 1 copy of the consent form will be retained by participant, 1 copy will be retained for medical records and 1 will be retained for the site file

Appendix H – Information sheet

Salomons Institute for Applied Psychology
One Meadow Road, Tunbridge Wells, Kent TN1 2YG

[redacted]

Full version

Information about the research

Shame and recovery in forensic services. A grounded theory investigation into the significance of shame and mental health in the recovery journey.

Summary

- I am doing some research to try and understand more about shame and recovery in forensic services. I am really interested in your experiences, as I hope it will help me to improve care for people experiencing shame on their recovery journey
- If you take part, we will do a 1 hour interview which will be audio recorded. All information will be kept private and no-one will be able to identify you.
- The only reason I may need to talk to other people about what you say is if I think that your own or someone else' life might be in danger because of what you have told me
- If you have an email address, then you will receive a £10 electronic shopping voucher for taking part. If you do not have an email address you will receive sweet treats.
- You will be supported throughout the process, and you can stop at any time without needing to give a reason
- I will also ask your care team for some personal details about you if you consent for me to do this. Full details about this can be found below

Hello. My name is Ella Neil and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide whether to take part, it is important that you understand why the research is being done and what it would involve for you. The project is being supervised by Dr Caroline Clarke [redacted] nd Dr Rachel Terry [redacted]

Do feel free to also speak to others about the research before deciding whether you would like to take part.

Please note that this research is sponsored by Canterbury Christ Church University, rather than [redacted] herefore, any reference to 'we' refers to the sponsor rather than your local NHS site.

(Part 1 tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study).

Part 1

What is the purpose of the study?
The aim of this study is to investigate forensic service users' experiences of shame, and how it impacts on their recovery. By investigating individual's experience of shame and recovery in inpatient and community forensic services, this study is aiming to help make sense of how shame is experienced in the recovery journey. Shame is an emotion that we all experience at times, and I am hopeful that this research will aid services in better supporting service users who are experiencing shame, and help individuals with this aspect of their recovery. It is likely that shame impacts on the recovery journey in many ways, but we do not yet understand much about how. It may motivate some aspects of recovery, but make others more difficult. Therefore, we are hoping to find out more about what effect shame has for individuals during their recovery, and the factors involved in this.

Why have I been invited?
As a service user under the care of a forensic team, you have been invited to participate in this study. We are interested in your experiences in forensic services. We would like to know more about how shame may be experienced as you are recovering, in order to better support individuals during the recovery process. We are aiming to recruit approximately 15 participants.

Do I have to take part?
Taking part in the research is voluntary. It is up to you to decide whether to join the study. It may be that this research is not relevant to your experience - it is up to you to decide if it is, and if you would like to participate. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw without giving a reason. More information about this can be found in part 2 of this information sheet. Withdrawing would not affect the standard of care you receive.

What will happen to me if I take part?

- If you would like to take part in the study, you will be given a consent form to sign before proceeding. Agreement that you are suitable to participate will also need to be given by your healthcare team before starting.

- You will be asked to participate in an interview, and we will ask various questions about your experience of the connection between shame and recovery in forensic services.
- The interview will last approximately 1 hour, and it will be audio recorded. The audio recording of the interview will be transcribed and anonymised, and then the audio recording will be deleted.
- Before the interview, there will be a briefing about what the interview will contain, and the questions that will be asked. During this briefing, we will also discuss any questions or concerns you may have about the interview, as well as planning breaks during the interview if needed. After the briefing, you can decide if you would like to go ahead with the remainder of the interview. If you would like to, then we will proceed with the interview questions. You will also have the option of doing the remainder of the interview on another day, to suit you. The interview may last up to an hour and will be audio recorded.
- After the interview has been completed, we will set aside some time to have a debrief. The purpose of the debrief is to support your wellbeing, and explore how it felt to complete the interview.
- Afterwards, if there is anything you have said that leads me to believe that you may be a danger to yourself or others, then this may be discussed with a member of your healthcare team. You are also able to speak to your healthcare team about the experience of doing the interview, and they can further support you if needed.

Expenses and payments
As a reimbursement for your time and a thank you, we can offer you a £10 electronic shopping voucher for your participation. Please note that your email address will need to be passed to Canterbury Christ Church University's finance team if you wish to receive a voucher. The voucher will be either an Amazon voucher or a VEX multipay voucher (which can be spent at multiple shopping outlets).

However, we can only offer you this voucher if you have your own email address. Alternatively, if you do not have your own email address, then some sweet treats or a healthy option can be provided on the day of the interview as a thank you for participating.

What are the possible disadvantages and risks of taking part?
It is possible that it may be distressing to talk about your experiences of shame. However, we will not ask you to talk about anything that you are uncomfortable with. The interview will also be paced well, and breaks will be offered throughout if needed. You will be told about the nature of the questions and the interview before you participate, so you can decide if this is something you would like to do. There will also be some time allocated after the interview in which we can discuss anything about the interview that might have been difficult, in order to reduce any discomfort. If you experience any distress after the interview and debrief have finished, you are able to talk to your allocated worker, and they will support you.

What are the possible benefits of taking part?
We cannot promise the study will help you, but the information we get from this study will help improve the treatment of people experiencing shame during their recovery in forensic services. We would, of course, be very grateful if you decided to take part.

What if there is a problem?
Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will information from or about me from taking part in the study be kept confidential?
Yes. We will follow ethical and legal practice and all information about you will be handled in

confidence. There are some rare situations in which information would have to be shared with others. The details are included in Part 2. In this research study we will use information provided to us from your care team. We will only use information that we need for the research study. We will let very few people know your name or contact details, and only if they really need it for this study. Everyone involved in this study will keep your data safe and secure. We will also follow all privacy rules. At the end of the study we will save some of the data in case we need to check it. We will make sure no-one can work out who you are from the reports we write. The information pack tells you more about this.

This completes part 1.
If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2 of the information sheet

What will happen if I don't want to carry on with the study?

You may withdraw from the study at any time, without giving a reason. If you would like to withdraw your data from the study after the interview, please contact me within 2 weeks of completing the study. After this point, it would not be possible to withdraw data, as data analysis may have been started.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to address your concerns. You can contact me by leaving a message on the 24-hour voicemail phone numbe[redacted]. Please leave a contact number and say that the message is for me [Ella Neil] and I will get back to you as soon as possible. If you remain dissatisfied and wish to complain formally, you can do this by contacting Dr Fergal Jones, Clinical Psychology Programme Research Director, Salomon's Institute for Applied Psychology[redacted]

Will information from or about me from taking part in the study be kept confidential?

All information which is collected from or about you during the course of the research will be kept strictly confidential. We will need to use information from your care team about you for this research project. This information will be collected in person and stored securely in a lockbox, or if this is not possible then it will be collected on the phone and stored securely in a database that uses participant numbers rather than names. This information will include your: age, gender, ethnicity, how long you have been in your current service, as well as forensic services generally, section of the Mental Health Act, mental health diagnosis, index offence type whether you completed your interview in an Medium Secure Unit, Low Secure Unit or Community setting. This information will be stored securely and kept confidential. 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.
The only time when I would be obliged to pass on information from you to a third party would be if, as a result of something you told me, I were to become concerned about your safety or the safety of someone else. In this case, I will be required to contact relevant professionals, including your healthcare team. If this is the case, I will try and discuss this with you before talking to other professionals. All information, including quotes, that may be used in the write up of this project will be anonymised.

Your anonymous data would be kept securely at the Salomon's Institute for Applied Psychology for 10 years, after which time it will be destroyed.

What are your choices about how your information is used?
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. 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.

Where can you find out more about how your information is used?
You can find out more about how we use your information
at www.hra.nhs.uk/information-about-patients
Or by asking one of the research team

What will happen to the results of the research study?
Results from this research will be reported anonymously in my university research project and may be submitted for publication in a journal. Anonymised quotes from the interviews will be used in published reports.

Who is sponsoring and funding the research?
This research has been organised by the lead researcher (Ella Neil) with support and input from a lead supervisor (Dr Rachel Terry) and external supervisor (Dr Caroline Clarke). This research project is part of the lead researcher's Clinical Psychology doctoral training requirements at Canterbury Christ Church University, who have funded the study.

Who has reviewed the study?
All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by The Salomon's Ethics Panel, Salomons Institute for Applied Psychology, Canterbury Christ Church University. All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. The Preston NHS Ethics Committee has reviewed the research and given a favourable opinion.

Further information and contact details
If you would like to speak to me and find out more about the study of have questions about it answered, you can leave a message for me on a 24-hour voicemail phone line at [redacted]. Please say that the message is for me [Ella Neil] and leave a contact number so that I can get back to you. You can also contact me if you would like to find out about the results of the study. If you require advice about whether you should participate, you may also consult a health care professional in your team.

Information Sheet – Accessible Version

Salomons Institute for Applied Psychology

One Meadow Road, Tunbridge Wells, Kent TN1 2YG

[redacted]

Information about the research

Shame and recovery in forensic services.

Hello. My name is Ella Neil and I am a trainee clinical psychologist at Canterbury Christ Church University.
I would like to invite you to take part in a research study.

Before you decide whether to take part, it is important that you understand what it would involve for you.

Feel free to speak to others about the research before deciding whether you would like to take part.

Please note that this research is sponsored by Canterbury Christ Church University, rather than [redacted]
Therefore, any reference to 'we' refers to the sponsor rather than your local NHS site.

(Photo of me was included which has been removed for the appendices)

Summary

- I am doing some research to try and understand more about shame and recovery in forensic services. I am really interested in your experiences, as I hope it will help me to improve care for people experiencing shame on their recovery journey
- If you take part, we will do a 1 hour interview which will be audio recorded. All information will be kept private and no-one will be able to identify you.

- The only reason I may need to talk to other people about what you say is if I think that your own or someone else' life might be in danger because of what you have told me
- If you have an email address, then you will receive a £10 electronic shopping voucher for taking part. If you do not have an email address you will receive sweet treats.
- You will be supported throughout the process, and you can stop at any time without needing to give a reason
- I will also ask your care team for some personal details about you if you consent for me to do this. Full details about this can be found below

What is the study about?

- To understand forensic service users' experiences of shame, and how it impacts on their recovery.
- Shame is an emotion that we all experience at times, and I am hopeful that this research will help services to support service users better.
- We think that shame impacts on the recovery journey in many ways, but we do not yet understand much about how. It may make some parts of recovery easier, but make other parts more difficult. We are trying to find out more about this.

Why have I been invited?

- You are under the care of a forensic team.
- We would like to know more about how shame may be experienced as you are recovering, in order to better support people.
- We are aiming to interview 15 people.

Do I have to take part?

- You do not have to take part in the study, it is up to you to decide whether to take part.
- If you would like to take part, I will ask you to sign a consent form
- You are free to leave the study without giving a reason. It will not affect your care.
- If you change your mind about what you said in your interview being used in the study, you will need to contact me within 2 weeks of finishing your interview. If you contact me using the details below within 2 weeks, I can remove your data from the study. More detail about this can be found below.

What will happen to me if I take part?

- You will be given a consent form to sign before starting. Your care team will also need to agree that it is ok for you to take part.
- You will be asked to participate in an interview, and I will ask questions about your experience of shame and recovery in forensic services.

- The interview will last about 1 hour, and it will be audio recorded. I will listen to the recording later and write down what you say, and then I will delete the recording. I will change any information that would let people know who you are.
- Before we start the interview, I will give you all of the information about what will happen including what questions I will ask. I will make sure you understand what will happen and you can ask any questions that you want. You can take breaks during the interview if it's helpful.
- If you would like to split the interview across 2 different meetings, that is ok.
- After the interview, we will have some time together to make sure you are ok and to talk about how you found the interview.
- Afterwards, if there is anything you have said that makes me think that you may be a danger to yourself or others, then I may speak to a member of your healthcare team. I will try and talk to you about this first.
- You can talk to your healthcare team about the interview if you want, and they can support you if needed.

Payments

- As a thank you, we can offer you a £10 electronic shopping voucher.
- Your email address will need to be passed to Canterbury Christ Church University's finance team if you wish to receive a voucher. The voucher will be either an Amazon voucher or a VEX multipay voucher (which can be spent at multiple shopping outlets).

- However, we can only offer you this voucher if you have your own email address. If you do not have your own email address, then some sweet treats or a healthy option can be provided on the day of the interview as a thank you.

What are the possible risks of taking part?

- It may be hard to talk about your experiences of shame. However, we will not ask you to talk about anything that you do not want to talk about. You will also be offered breaks and support during the interview.
- We will give you all of the information you need to decide if you would like to take part. We can also talk after the interview if you need more support.
- If you need to talk after the interview has finished, you can talk to your care team

What are the possible benefits of taking part?

We hope the information we get from this study will help improve the treatment of people experiencing shame during their recovery in forensic services.

What if there is a problem?

- If you are unhappy with any part of this study, I will do my best to help.
- You can contact me via phone on [redacted] and leave a voicemail and I will get back to you as soon as I can.
- If you are still unhappy after this and wish to complain formally, you can do this by contacting Dr Fergal Jones, Clinical Psychology Programme Research Director, Salomon's Institute for Applied Psychology [redacted]

Will the information about me be kept confidential?

- All information which is collected from or about you during the course of the research will be kept strictly private and confidential.
- We will need to use information from your care team about you for this research project. This information will be collected in person and stored securely in a lockbox, or if this is not possible then it will be collected on the phone and stored securely in a database that uses participant numbers rather than names. This information will include your:

  - age,
  - gender,
  - ethnicity,
  - how long you have been in your current service,
  - how long you have been in forensic services generally,
  - section of the Mental Health Act,
  - mental health diagnosis,
  - index offence type
  - Whether you completed your interview in a Medium Secure Unit, Low Secure Unit or Community setting.

- This information will be stored securely and kept confidential. 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.
- The only time when I would need to talk to someone about what you say is if you tell me something that leads me to believe your own or someone else may be in danger. In this case, I would need to contact relevant professionals, including your healthcare team. If this is the case, I will try and discuss this with you before talking to other professionals.
- All information, including quotes, that may be used in the write up of this project will be anonymised.
- Your anonymous data (information which no-one will be able to connect you with) will be would be kept safely at the Salomon's Institute for Applied Psychology for 10 years. After this it will be destroyed.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason. However if you do not contact me within 2 weeks of your interview to let me know that you would like to withdraw then we will keep information about you that we already have.
- 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.

Where can you find out more about how your information is used?
You can find out more about how we use your information
at www.hra.nhs.uk/information-about-patients
Or by asking one of the research team

What will happen to the results of the research study?

- Results from this research will be written in my university research project. We may use quotes from your interview, but will make sure no-one can identify you from the information or quotes we use in the report.
- The project may also be published in a journal.

Who is sponsoring and funding the research?

- This research has been organised by the lead researcher (Ella Neil) with support from a lead supervisor (Dr Rachel Terry) and external supervisor (Dr Caroline Clarke).
- This research project is part of the lead researcher's Clinical Psychology doctoral training requirements at Canterbury Christ Church University, who have funded the study.

Who has reviewed the study?

- All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests.
- The Preston NHS Ethics Committee has reviewed the research and given a favourable opinion.
- This study has been reviewed and given favourable opinion by The Salomon's Ethics Panel, Salomons Institute for Applied Psychology, Canterbury Christ Church University.

Further information and contact details

- If you would like to speak to me and find out more about the study of have questions about it answered you can phone me on [redacted]ve me a voicemail. I will get back to you as soon as possible.
- You can also contact me if you would like to find out about the results of the study.
- If you want advice about whether you should take part, you can also talk to your healthcare team.

Appendix I – Interview Schedule

Salomons Institute for Applied Psychology
One Meadow Road, Tunbridge Wells, Kent TN1 2YG

[redacted]

Interview schedule

The interview schedule will be developed and refined in partnership with an Expert By Experience in [redacted] below is a rough guide to the topic areas. The language used will be simple, and will involve prompts to assist individuals in answering the questions. Additionally, in line with guidelines for grounded theory research, the questions may be changed and developed upon as the interviews progress and a theory starts to be built (Charmaz, 2006).

Please see below for a draft interview schedule, which will be further developed in partnership with Experts By Experience from [redacted]

Information sheet and consent form

Talk through the information sheet and consent form, and offer the opportunity to ask any questions. Ensure that they understand what is being asked of them.

Interview

- Thank them for their participation and for taking the time to meet with me.
- Highlight that the purpose of the study is to explore their experience of shame and recovery in forensic services, and the connection between shame and recovery. It is about their feelings and perspectives, so there are no wrong answers.
- Explain that it may be a difficult topic to talk about at times, but that they do not have to tell me anything they do not want to, including anything about their offence, experience of mental health or things that have happened to them. They will be offered breaks if needed, and an opportunity to talk about something else if things are getting too much. Relaxation exercises can be used if desired, and they will have the opportunity to finish the interview on another day if this is helpful.
- They are welcome to ask any questions or request a break at any time
- Reminder that as a thank you for engaging fully in the interview for at least 30 minutes, they will be offered £10 cash for their time.

Warm up questions

- How are you today?
- Have you got any plans for today?
- What have you got on this week that you're looking forward to?

Recovery and shame definitions

- Will provide definitions of shame and recovery, and provide emotion cards to assist if they are struggling:

Definitions of recovery:

'Learning new ways to live the life you want to, and gaining control over areas of your life that might have felt out of control before. It involves learning more about yourself and developing ways to cope. '(Mind, n.d.)

'When it comes to mental illness, recovery can mean different things. For some people, it will mean no longer having symptoms of their mental health condition. For others, it will mean managing their symptoms, regaining control of their life and learning new ways to live the life they want… Some factors for recovery include good relationships, satisfying work, personal growth, the right living environment (Mental Health Foundation, 2021)

Definitions of Shame:
'Shame is an unpleasant self-conscious emotion often associated with negative self-evaluation; motivation to quit; and feelings of pain, exposure, distrust, powerlessness, and worthlessness' (Tracy & Robins, 2007)

'Shame is a feeling of humiliation or distress caused by the consciousness of wrong or foolish behaviour' (Oxford English Dictionary, 2005)

- May provide prompt of difference between shame and guilt:
  Provide the participant with some images/prompts about shame to help explain the difference between shame and guilt
  Say: 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?

- Ask them to define what shame and recovery means to them (i.e. we have explored what other people understand by the term recovery, but please explain what the term recovery means to you)

<u>Experience of recovery, and shame</u>

- Ask them to describe their experience of recovery while in forensic services
- Ask them to describe how they might have experienced the emotion of shame while in forensic services
- How shame has impacted them in hospital and what has made this better/worse

<u>Connection between shame and recovery</u>

- Ask about their understanding of the connection between shame and recovery (prompt if needed: some people can find that shame can motivate them on their recovery journey, whereas others find that it can make it more difficult to engage in the recovery process)
- How that connection may be relevant to them personally, and what sense they make of this

- How has that experience of shame impacted on their recovery, and whether this has changed over time
- If it has changed over time, what influenced this?

Areas that shame might impact upon during recovery

- Ask about relationships with others (including staff), and how relationships with others might be connected to recovery, and shame
- Ask about how gender might relate to experience of shame and recovery in forensic services
- Any other key areas that shame and recovery has impacted
- How they see their relationship with shame moving forward through the recovery journey
- Anything else relevant they would like to tell me about the experience of shame and recovery

Debrief

- Check in with how this experience was for them, and whether there is anything they need following it, or any questions for me
- Thank them for their participation
- Recap the information from the information sheet and remind them what will happen to their results, as well as who to contact if they would like further information
- Provide contact details for if they would like to withdraw their data in the next 2 weeks
- Ensure they know who they can talk to for support (key worker/nurse in charge)
- Give them the £10 cash as a thank you

Appendix J – Coded Transcript

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Appendix K – Development of Themes/models

Theme and model development

Part way through sorting codes into themes and arranging visually the connections between themes:

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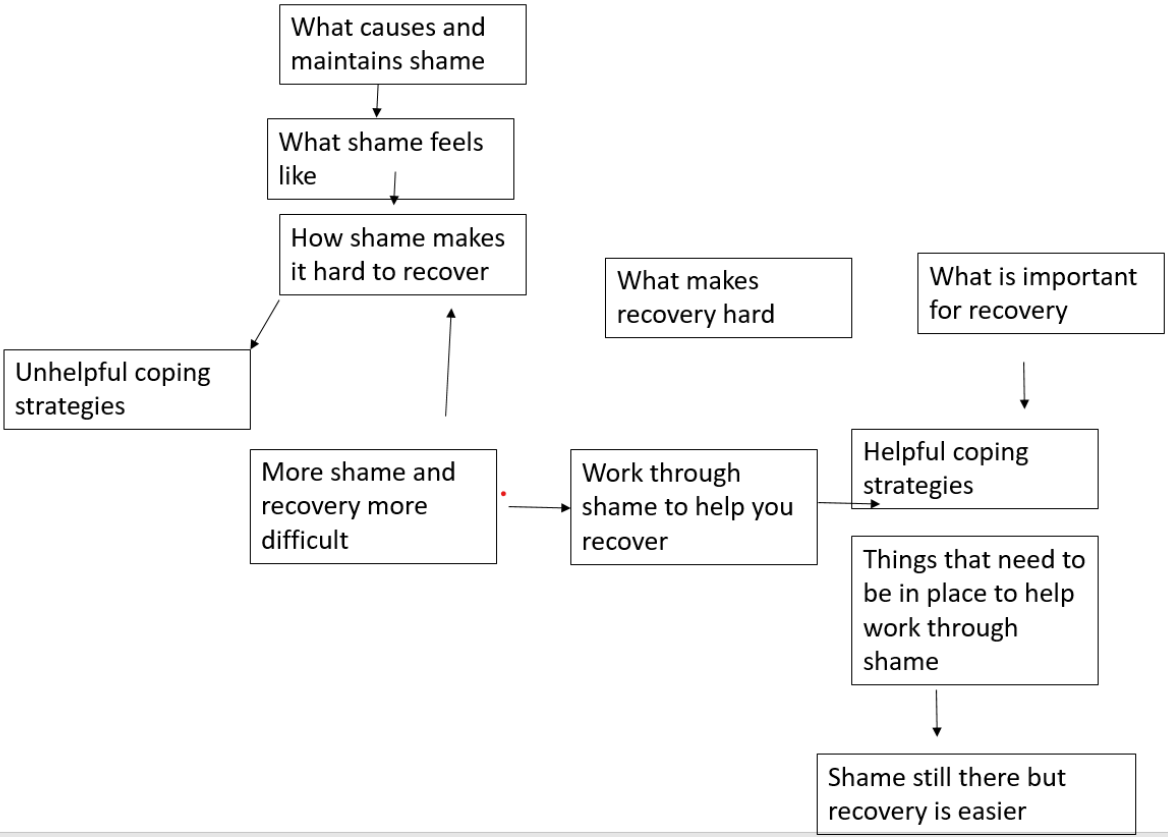
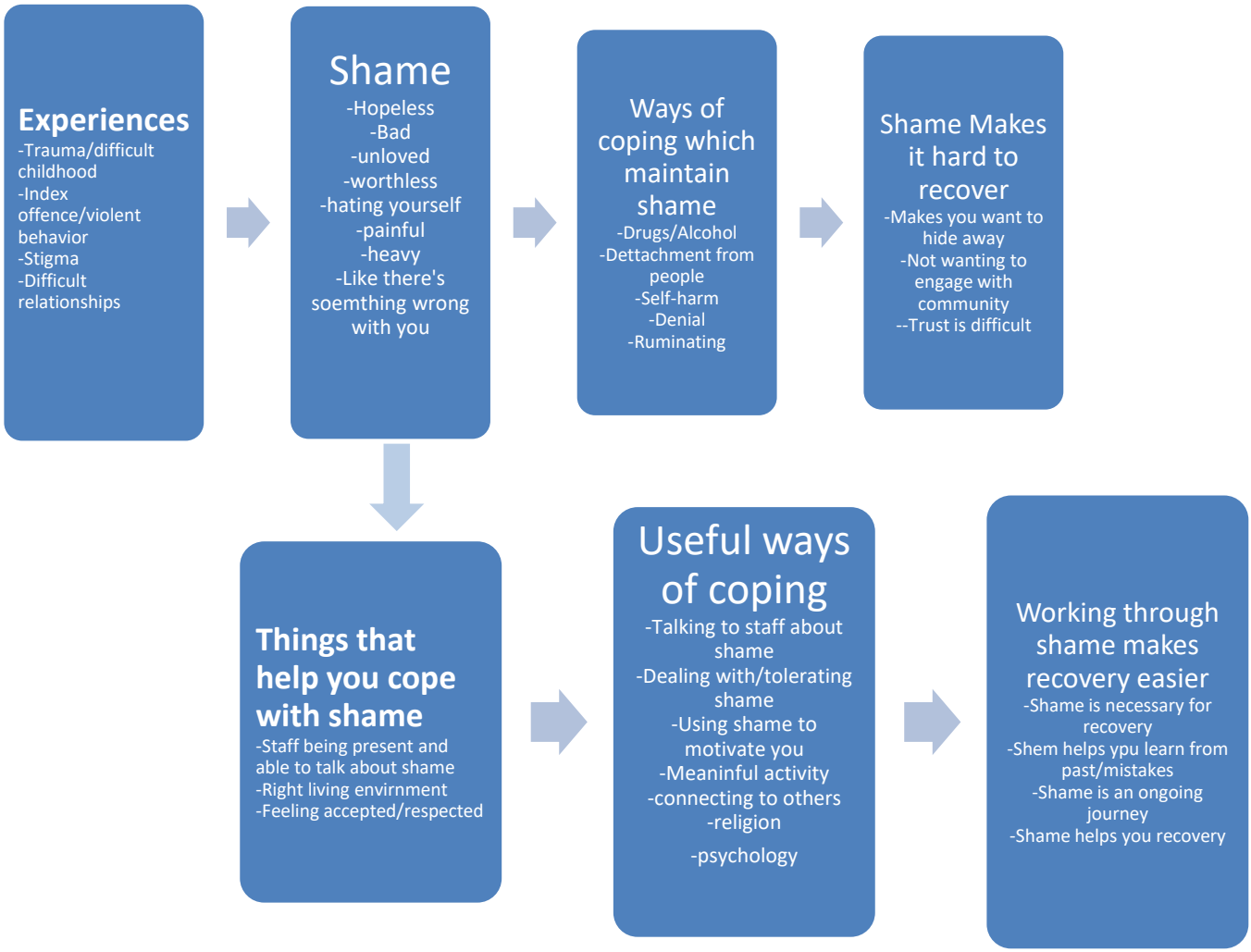
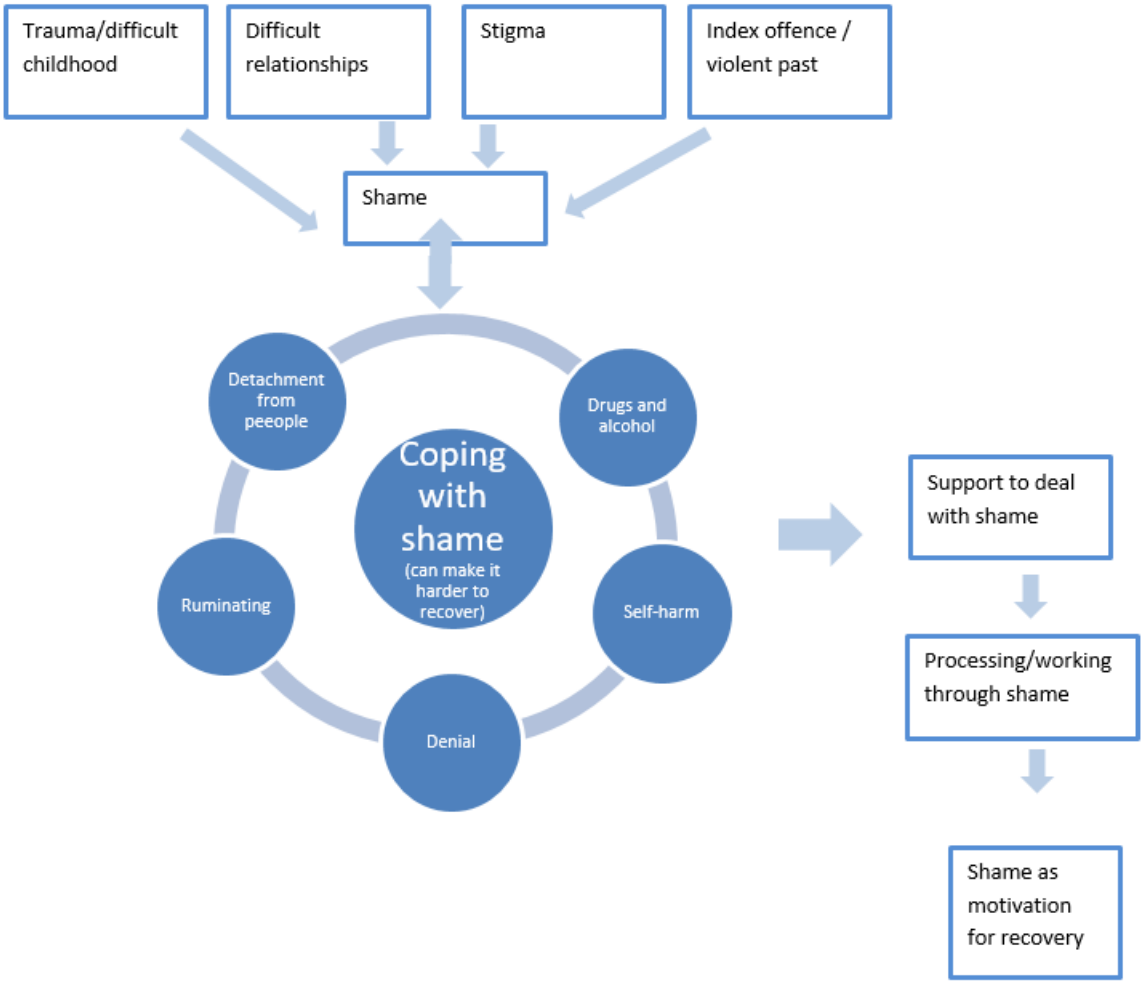


Initial preliminary model



Model which helped to understand important factors and relationships, however was not dynamic enough



Model which did not go into enough detail about helpful coping strategies and how shame can help recovery

Appendix L – Further Examples of Quotes in Themes

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Appendix M – Participant Validation Summary

After developing a working theory based on the interviews, the lead researcher met with one of the original participants to discuss the theory. The participant was encouraged to collaborate with the researcher in the development and share their thoughts and any questions regarding the theory. The participant generally agreed that they thought the model was appropriate and useful. The participant provided helpful suggestions, clarifications and questions which helped to refine the theory. For example, they expanded on the idea that staff are pivotal in helping service users cope with shame. They agreed that often the ways that people cope do not bring people closer to recover. They self-harm, and reported that often they feel just as much shame afterwards as they did before. They also knew people who drank alcohol to cope and this made their shame worse. They explained that the most important thing about staff is compatibility. Two members of staff could offer similar support but they explained how you need to trust/click with the staff member for it to be helpful. She explained how sometimes staff can be helpful and sometimes they are not. This is mediated by the trust of the relationship and also how receptive the participant is on that day. They reported that they agreed that psychology was very good.

The participant made a very helpful clarification in terms of the theme ‘shame is necessary’ and shame helps you learn from your mistakes. They explained how this was only the case if your shame is caused by your own actions. They explained that if the shame is caused by external factors or others actions, this does not apply, as you cannot take the same learning from this shame.

Appendix N – Feedback to Ethics Panel

Project Title: A Grounded Theory Investigation into Shame and Recovery in Forensic Services

Thank you for your consideration and approval of my research project for submission in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology. This project, which you approved in May 2023, has now been completed. A summary of the study can be found below:

Introduction

An abbreviated Grounded Theory investigation was conducted to understand the relationship between shame and recovery for individuals in forensic services. It was conducted in order to better support individuals on their recovery journey. The study aimed to investigate how service users experienced shame in forensic services as well as how they coped with shame and how this changed across the recovery journey. It also aimed to investigate any connection between shame and recovery, and if there was a connection, what sense service users make of this connection.

Method

A qualitative abbreviated Grounded Theory methodology was used. Semi-structured interviews were conducted with eleven service users across three forensic settings; a community mental health setting, a low secure hospital and a medium secure hospital.

Findings

A tentative model was constructed which described how shame developed and how it felt. Shame commonly developed from service user's childhood, index offence or due to how they believe the community perceives them. Shame was described as feeling bad, hopeless and painful. The model also described how shame could at times help recovery, and at other times hinder recovery. Coping with shame through substance misuse and self-harm helped participants with shame in the short term, however could hinder recovery long-term. Talking to staff was identified as a factor which could help individuals cope with shame and recover longer term. Some participants reported how shame was beneficial in working towards recovery.

Discussion

Implications were considered, including the role of clinical psychologists in facilitating conversations regarding shame with both service users and staff, in order to better support services users with shame so that they are able to work towards recovery.

Best wishes,

Ella Neil

Trainee Clinical Psychologist

Appendix O – Feedback to Participants

Dear Participants

Project Title: A Grounded Theory Investigation into Shame and Recovery in Forensic Services

I am writing to thank you for taking part in my study, and to let you know what I have found. I am extremely grateful for your input in my study and your openness in our interview. This research would not have been possible without you, and I am hopeful that the information from the study will help services to better support people in forensic services with shame and recovery.

From the interviews, I have created a model based on common themes that came up from what people said.

Things That Cause Shame

There were a few things that caused participants to feel shame. This included shame coming from difficult childhood experiences. Some participants also described feeling shame about their index offence, or about anti-social behaviour in the past. Some people felt shame because of how they think the community views them.

What Shame Feels Like

Shame was described as feeling bad, unloved, worthless, painful, heavy, like there's something wrong with you, and hating yourself.

Ways of Coping with Shame

Participants said that shame was understandably a very difficult emotion to cope with. Participants reported coping with it in the best ways that they could. There were many ways participants reported coping with shame. There were some ways which helped them cope in the short term, however might not help them to recover, and could sometimes make shame worse. This included

- Using drugs and alcohol
- Self-harming
- Denying/avoiding the shame
- Ruminating on the shame

There were also others ways that some participants coped with shame, and some things that needed to be in place to help them cope. It was helpful if

- Staff were there and able to talk about shame
- Participants had the right living environment
- Participants felt accepted and respected

Helpful ways of coping included

- Psychology
- Religion
- Meaningful activity
- Processing/working through shame to help recovery

How Shame Impacts on Recovery

- Some participants found that shame made it harder to recover, as it made them feel like they wanted to hide away, and meant they found it difficult to express themselves. Some of the ways they coped, for example through using alcohol or self-harming, also sometimes made recovery more difficult
- Some participants found that actually shame was helpful in recovering and could motivate recovery. They found that shame was necessary and could help them to recover if they worked through it

- Often participants who now thought shame was helpful, had found shame difficult to cope with to start with. This suggests that even if participants are struggling to cope with shame now, there is hope that this can change in future and recovery can be easier.

Summary

Shame is a very difficult emotion that people cope with as best they can. Participants cope with it in a variety of ways, and it is easier to cope with at some times than others. This study shows that with the right support, living environment and coping strategies, shame can be easier to cope with, and may actually be helpful in working towards recovery.

Thank you again for taking part in my study. I wish you all the best.

Yours Sincerely

Ella Neil

Trainee Clinical Psychologist

Appendix P – Feedback for Staff/Collaborations

Dear Staff,

Project Title: A Grounded Theory Investigation into Shame and Recovery in Forensic Services

Thank you for your support in allowing me to conduct research within your service, and helping to facilitate recruitment. I am extremely grateful for your support, as this project would not have been possible without it. My research is now complete, and I am writing to you to summarise my findings and subsequent recommendations for services. I conducted interviews with eleven participants across 3 forensic services, and created a model based on the quotes and themes from the data.

Shame

Participants felt shame for a number of reasons: from difficult childhoods, index offence/anti-social history, and from how they believe the community views them. Shame was described as feeling bad, unloved, worthless, painful, heavy, like there's something wrong with you, and hating yourself.

Ways of coping with shame

Participants said that shame was an understandably difficult emotion to cope with, and they were coping with it in the best ways that they could. There were many ways participants reported coping with shame. There were some ways which helped them cope in the short term, however would not necessarily help them to recover, and could sometimes make shame worse. This included:

- Using drugs and alcohol
- Self-harming
- Denying/avoiding the shame
- Ruminating on the shame

- Distancing themselves from people

There were others ways that some participants coped with shame, and some things that needed to be in place to help them cope. It was helpful if

- Staff were there and able to talk about shame
- Participants had the right living environment
- They felt accepted and respected

Helpful ways of coping included

- Psychology
- Religion
- Meaningful activity
- Processing/working through shame to help recovery

How shame impacts on recovery

- Some participants found that shame made it harder to recover, as it made them feel like they wanted to hide away, and made it difficult to express themselves. Some of the ways they coped, for example through using alcohol or self-harming, could also make recovery more difficult
- Some participants found that actually shame was helpful in recovering, and helped motivate them to recover. They found that shame was necessary and could help them to recover if they worked through it
- Often participants who now thought shame was helpful, had initially found shame difficult to cope with. This suggests that even if participants are struggling to cope with shame now, there is hope that this can change in future and recovery can be easier

Summary

Shame is a very difficult emotion that participants cope with as best they can. Participants cope with it in a variety of ways, and it is easier to cope with at some times than others. This study shows that with the right support, living environment and coping strategies, shame can be easier to cope with, and may actually be helpful in working towards recovery.

Recommendations from the Interviews

Recommendations have been gathered directly from what participants said, as well as from the model as a whole

- It is beneficial if staff feel able to talk about shame and know which manager they are able to seek support about this from if necessary, as staff availability and ability to talk about shame is suggested to be key in the present model for supporting service user recovery.
- It would be helpful to have psychological input to support training of staff so that they feel able to manage emotionally laden conversations, particularly shame, in a way which allows participants to process the emotion in a safe way.
- Psychological professionals could facilitate staff training sessions to give more information to staff about shame in forensic services and the impact of shame in this context, as well as a facilitate a reflective space in which staff are able to bring related issues they have had.
- Therapists could also structure psychological treatment in such a way that service users are able to directly discuss shame. One approach which would lend itself to discussing shame in a validating way is Compassion Focused Therapy (CFT) (Gilbert., 2010).

- Forensic service leads could ensure that they structure services and staffing in such a way that staff are both accessible to service users and have the correct training to be able to support service users in coping with their emotions, including shame.
- Services should continue to structure care in a way which appropriately discusses and mitigates risk, which will involve discussing aspects of their past which service users might be shameful about. However, importantly, services should take caution to do this in a therapeutic way in which service users feel supported to process the emotion and change their behaviour.

Thank you again for your support with my study. Please feel free to contact me using my email (Xxxx) if you have any questions, and please feel free to contact me if you would like me to present these findings at a team meeting, as I would be more than happy to do this.

Yours sincerely

Ella Neil

Trainee Clinical Psychologist

Appendix Q – Abridged Research Diary

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Appendix R - Guidelines for Journal for Submission

The Journal of Forensic Psychiatry & Psychology

Instructions for authors

Should be written with the following elements in the following order: title page (including Acknowledgements as well as Funding and grant-awarding bodies); abstract; keywords; main text; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figure caption(s) (as a list).

Should contain an unstructured abstract of 200 words.

This title utilises format-free submission. Authors may submit their paper in any scholarly format or layout. References can be in any style or format, so long as a consistent scholarly citation format is applied. For more detail see the format-free submission section below.

Preparing Your Paper

original manuscripts

- Should be written with the following elements in the following order: title page (including Acknowledgements as well as Funding and grant-awarding bodies); abstract; keywords; main text; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figure caption(s) (as a list).
- Should be between 3,000 and 4,000 words, excluding abstract, tables, figure captions, footnotes, endnotes.
- Should contain an unstructured abstract of 200 words.
- Should contain between 3 and 6 **keywords**. Read making your article more discoverable, including information on choosing a title and search engine optimization.
- Please include a word count.