“This is Me, Shameful Me”: How Shame and Guilt Present for Individuals Convicted of an Offence

By

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Abstract

This thesis aims to develop the understanding of shame and guilt and how these emotions are experienced by individuals convicted of an offence. Both feelings have been shown to be of particular importance for this population yet appear to be given limited consideration in practice. This thesis demonstrates the negative influence shame and guilt can have for an individual as supported by earlier research, and why this area is important to consider. Chapter two presents a systematic literature review which explores the sociological and psychological factors associated with offence-related shame and guilt. The review highlights the presence of these feelings among individuals in forensic settings. This systematic review includes findings from eight quantitative design studies, which were screened against inclusion and exclusion criteria and quality assessed. The main findings of associated factors for feeling guilt or shame are discussed, considering the implications for professionals.

Chapter three describes an empirical study looking at the experience of feeling shame and how these feelings relate to five individuals sentenced to a mental health treatment requirement (MHTR). Using Interpretative Phenomenological Analysis (IPA), three group experiential themes were identified: *Trapped in Feelings of Shame; Experiences of Opening Up* and *Moving Through Shame.* These themes illustrate the transformative journey of MHTR clients, from feeling trapped in shame, to the process of opening up to and moving through this feeling. The findings hold significant practical implications for the work of professionals within such services but also, instils hope for those struggling with shame.

The aforementioned chapters highlighted the relevance of shame and guilt to forensic work that supports both mental health and rehabilitation. Chapter four therefore presents a critique of the Offence-Related Shame and Guilt Scale (Wright & Gudjonsson, 2007). As one of the only psychometric scales in this area, it is considered a valuable scale to explore these

feelings for this specific group. Whilst there remain some limitations in the reliability and validity of the tool, this thesis concludes it remains a useful scale that would benefit from further research. In the meantime, it can be used to aid some helpful discussions about feelings of shame and guilt when working with someone who has committed an offence.

Dedication

This thesis is dedicated to my dad, whose courage in the face of his mental health struggles rooted in the aftermath of a traumatic car accident, taught me the true meaning of resilience. Though his journey was one of great difficulty and a tragic ending, it has shaped my own path as a psychologist, where I am determined to ensure that others receive the help and support that he, and so many like him, deserve.

His unwavering support, love, and guidance have shaped me in ways words cannot express. Though he passed during the final stages of my doctorate, his presence has remained with me every step of the way. His own strength and determination, and constant belief in me were continuous sources of inspiration, and it is through his example that I have persevered, even in the most difficult moments.

To my mum, who has shown immeasurable resilience and love in the face of so many challenges; to my siblings, whose support and care have been a constant source of comfort; and to my husband, whose unwavering partnership, patience, and understanding have helped me navigate the hardest moments.

In the past few months, we have all faced tremendous loss and heartache, but it is through each other that we have found strength, and it is to all of you that I owe my deepest gratitude.

It is with his memory in mind that I am driven to continue my work as a psychologist, determined to help others and provide the support and care that is so often needed but not always available.

This work is dedicated to the memory of my dad and to the incredible family that has stood by me through it all.

I wish he could have seen this day, but I know he would be beaming with pride.

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I would also like to express my sincere gratitude to those who assisted in the recruitment of participants for this research. Their support was instrumental in connecting with individuals who contributed to the study. I truly appreciate their dedication and the trust they placed in this research process.

The first version of this thesis was proofread for conventions of language, spelling and grammar by Dr Nichola Schaum, Registered Forensic Practitioner Psychologist. The second version has not been proofread. Editorial help was provided by a generative AI tool, Grammarly; the editorial remit was spelling and punctuation only. I confirm that the editorial contribution made by the tool did not exceed this remit.

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CHAPTER ONE

Introduction to Thesis

Overview of Chapters and Aim(s) of the Thesis

Moral Emotions and Offending Behaviour

Literature has long considered the role of moral emotions in behaviour and how various emotional responses may increase the possibility of antisocial behaviour (Clark, 2005). Shame and guilt, along with several other emotions such as pride, are considered "self-conscious emotions" (Tangney et al., 2007, p. 2). Gilbert (2004) explains self-conscious emotions emerge from, or with, primary emotions such as anger. They merge with higher human cognitive abilities, including theory of mind, our ability to understand the thoughts and feelings of others (Leslie, Friedman & German, 2004).

Self-conscious emotions are associated with evolved motivational and emotional systems connected to perceived threats, such as social rejection and the need for acceptance (Gilbert, 2004). Such emotions and motivations are shaped by social mentalities, an internal system for navigating the social world and eliciting role-appropriate responses, i.e., submission (Brasini et al., 2020). This relates to social rank, the perception of social status, which can lead to feelings of inferiority and subsequent submissiveness (Gilbert, 2000), prompting shame. Self-conscious emotions and their relation to rank, rejection and role appropriateness underscore the importance of moral emotions in the field of offending.

Social rank, therefore, may explain offending and an individual's capacity for harm, with research offering a link between social rank, dominant behaviour, and automatic responses to threat (Liotti & Gilbert, 2011). This was further explained by Morrison & Gilbert (2001), who found social rank and self-esteem predicted anger responses. They found individuals with higher social rank perception had lower shame and anger towards others. Thus, perceived lower social ranking may contribute to offending. Similarly, the competitive state associated with social rank and the avoidance of inferiority has been described as having a "dark side" by

increasing vulnerability to depression and anxiety (Gilbert et al. 2009). As will be explored, offending has a direct link with mental health problems (Silver, Felson & Vaneseltine, 2008).

Interestingly, moral emotions have been depicted as the motivational force that drives individuals to do good and avoid doing bad (Kroll & Egan, 2004). This provides a fundamental reason for the importance of understanding such emotions in interventions with those who have committed an offence. Moral emotions should play an integral part in working with individuals who have committed offences, understanding both what happened at the time of the offence and thereafter. Practitioners should consider where the opportunity for self-reflection and evaluation evokes such emotions (Tangney et al., 2007), as they may promote change. This observation highlights an important consideration for therapeutic interventions designed to increase moral emotions and support rehabilitation. However, research has also shown individuals can become trapped in certain moral emotions, such as shame (Roth et al., 2021); thus, these emotions can have detrimental effects and are viewed as a transdiagnostic problem (Clark, 2012). This thesis explores such problematic emotions with the hopes of facilitating therapeutic progress.

A Note on Language

This thesis explores feelings of shame and guilt among individuals who have committed offences. Research has examined the impact of language, specifically labels and their associated effects on feeling shame in this population. For instance, Wheatley and Underwood (2023) report high levels of shame associated with being labelled as a “stalker”. The same for the label “offender” (Karp, 2000). Therefore, this thesis intentionally avoids labels, acknowledging the shaming effects they have.

Moral Development and Judgements

Moral emotions are thematically situated within the broader literature on moral development and judgments. Erikson (1950, as cited in Clark, 2012) was one of the first psychoanalytic writers to consider shame and its development from a scientific and therapeutic standpoint. He posited that this emotion develops in the second stage of human development when a child develops a sense of self-consciousness. Similarly, Piaget (1965, as cited in Pantanella, 2011) and Kohlberg and Hersh (1977) proposed staged models of moral development. Piaget outlined the second stage of moral development where the child moves into "moral realism" and submission, referred to as "moral constraints", with a focus on consequences and rule following. The third stage enables a more critical evaluation of rules and greater flexibility (Pantanella, 2011). As Kohlberg and Hersh's (1977) theory states, moral development is closely related to cognitive development influenced by society and education; with the highest stage concerned with justice and law (Zhang & Zao, 2017). Although, some of these theorists have been criticised for not portraying an accurate or entire picture of moral development (Carpendale, 2000; Greene & Haidt, 2002).

As research suggests, a level of awareness is necessary for the development of moral judgements and subsequent behaviour. Traditional theories have typically emphasised the role of cognitions. Aside from Erikson, there appears to be less consideration given to the emotional development of moral decisions. As Teper et al. (2015) indicated, emotions are instrumental in moral actions. Similarly, Greene and Hadit (2002) highlighted the importance of affect by demonstrating moral judgements are a matter of emotion and affective intuition rather than deliberate reasoning. This notion is long debated but has received support through more recent developments of the 'dual decision-making model' (Crivelli et al., 2024). Nevertheless, the fundamental issue with exploring moral judgements is the reliance upon self-report, and often, scenarios used in research do not represent real-life moral decision-making (Teper et al., 2015).

Therefore, research surrounding moral emotions and judgements can be complex, and as will be explored in the following chapters, there are limitations to the usefulness of these concepts. Despite this, continuous research in these areas is essential to improve psychological interventions and should not be avoided due to such disputes.

Working with Moral Emotions

An overarching theme of this thesis is to consider how practitioners and professionals in the criminal justice system work with moral emotions. Chapter Two explores the factors that may be associated with guilt or shame and potential implications for practitioners. In turn, chapter three considers how a particular service and the therapeutic intervention offered therein are impacted, or not, by feelings of shame. As will be outlined, research has shown this consideration crucial; however, the amount of thought given to moral emotions in practice remains unclear.

As outlined, shame and guilt are classed as self-conscious emotions evoked by self-reflection and self-evaluation (Tangney et al., 2007). Thus, the work of practitioners is partially to identify such emotions in their clients and to support them in developing awareness of them and their impact. This is important because shame can make clients feel exposed, have a significant impact on psychological well-being, and influence the resolution or exacerbation of mental illness (Kroll & Egan, 2004; Tangney et al., 2007). Shame, therefore, can be problematic to engagement in treatment and could harm treatment outcomes, especially for those in forensic settings. Conversely, guilt can be considered a protective factor for recidivism and essential to resocialisation, although only when in its adaptive form, where there is a focus on behaviour as external to the self and linked to making amends (Tangney et al., 2011). However, excessive guilt can be problematic, with links to depression, although, what constitutes excessive is not well documented (Harder, Cutler & Rockart, 1992; Tilghman-Osborn et al.,2014). The

functionalist perspective argues that guilt can be both adaptive and maladaptive depending on situational factors, although this view has been challenged by the social- adaptive perspective (Dempsey, 2017). This perspective instead, argues guilt is always inherently adaptive and shame inherently bad. Dempsey (2017) however, states the functionalist perspective does not yet have the data to support this stance. This consideration for guilt will be explored.

Consideration of moral emotions can be instrumental in forensic interventions. As Teper et al. (2015) proposed, using behavioural measures is an important step to fully understanding how moral emotions shape moral behaviours, a key area for forensic settings. Chapter four critiques one measure that explores shame and guilt related to offences committed. However, as suggested, this is one of the few measures that examines shame and guilt in the context of a forensic population. Thus, this thesis proposes not enough consideration is given to moral emotions in forensic populations, as evidenced by the limited availability of measures that help practitioners identify guilt and shame in their clients. Of course, a wider issue is the accuracy of such measures and the issue of reliance on self-reports. Chapter four addresses some of these concerns.

There have been some suggestions for working with moral emotions in practice. Tangney et al. (2011) proposed the need for approaches that enhance a person's capacity for adaptive guilt. Whilst this appears supported in the literature (e.g., Mottershead et al., 2024), intervention-specific information has not been offered. However, working with shame appears to be better considered. Tantum (1990, as cited in Smith, 2008) suggested an open discussion of shame within group therapy can help modify it. This can be achieved by creating a non-judgmental and shame-free environment that helps challenge self-perceptions. It would appear, therefore, it is important to consider how practitioners respond to a person, demonstrating they are non-judgmental. Part of this is the therapeutic relationship established between a professional and client. Clark (2012) noted the therapeutic relationship of prime importance

and recognised how individuals do not readily share such feelings and may not have the words for them. Clark (2012) felt creating a sense of shared humanity was crucial for addressing shame. It is proposed the fundamental training all therapy practitioners receive, is beneficial; however, consideration should be given to the practical integration of teaching about moral emotions, encompassing both guilt and shame.

The above considerations by Clark (2012) align with the work of Rogers (2020) and the role of the therapeutic relationship, with emphasis on transparency, acceptance and empathetic understanding. Furthermore, Clark (2012) proposed two key therapeutic concepts, acceptance and forgiveness, when working with shame and guilt. Indeed, therapeutic models such as Acceptance and Commitment Therapy (Hayes et al., 2011) and Compassion Focused Therapy (Gilbert, 2009) help target these emotions. CFT was introduced specifically for those with high levels of shame and self-criticism (Gilbert, 2009). Gilbert (2005) considers shame and self-criticism as connected to humans' need for attachment and to feel they belong. Hence, connection either through group therapy, as per Tantum (1990) or the therapeutic relationship itself appears integral to working with shame, in particular.

Furthermore, Smith (2008) emphasised the importance of open dialogue with individuals who are likely to feel shame. Smith (2008) recognised how shame can derail the dialogue in therapy and how individuals can experience a sense of being on their own with the intense inner conflict they feel. Integral to working with either shame or guilt is creating a safe, therapeutic space marked by openness and the absence of judgment.

Guilt appears to be much less considered in published literature regarding therapeutic approaches, and this may be because of shame’s negative consequences, as already suggested. However, Taylor and Hocken (2021) introduced Forensic Compassion-Focused Therapy, which focuses on the inclusion of guilt. They acknowledge the adaptive form of guilt, like Tangney et al. (2011), and its role in improved outcomes. Their approach outlines the addition

of understanding criminogenic needs and facilitating guilt within CFT, recognising its association with the development of pro-social behaviour. As a target, the motivation to behave compassionately is explored, including the role of shame and the development of guilt. Taylor and Hocken (2021) emphasised the need for a well-considered approach to encouraging intense feelings of guilt, in terms of practising awareness and tolerance of this.

This poses an interesting point. Guilt, as suggested, is not consistently negative and can have prosocial functions. The aversive and uncomfortable feeling motivates individuals to make amends and adhere to social norms (Vaish et al. 2016). However, guilt may not always be helpful and instead could be avoided altogether. Anticipating its painful nature, individuals may use self-serving justifications, such as making excuses for their behaviour, to sidestep guilt, thereby increasing the likelihood of offending behaviour (Buck & Pauwels, 2022). Similarly, research has investigated the avoidance of the uncomfortable feeling of guilt by repressing (Luck & Luck-Sikorski, 2022), which may be associated with denial, recognised as a barrier to treatment (Blagden et al., 2011). This supports why working with guilt is important, where avoidance may prevent more meaningful and adaptive forms.

Whilst the literature offers a promising start to developing the evidence base, publications in this area of research are limited. This thesis highlights the need to consider working with both shame and guilt. Research supports the need for strategies to reduce shame, as doing so has been shown to decrease the likelihood of harm (Garbutt et al., 2023a). In their study, they found shame and self-compassion mediate the relationship with harm, with self-compassion a moderator of shame. Thus, in reducing shame through interventions, recidivism can be decreased.

The disparity in research focus to date may be due to the shared acknowledgement that shame may pose more challenges than guilt (Roth et al., 2021). Although, as Tangney et al. (2011) have suggested, guilt can lead to rumination and is still an unpleasant emotion.

Understanding and addressing the complex interplay between shame and guilt is essential for developing effective therapeutic interventions.

Aims of the Thesis

Moral emotions are essential and should be considered when working with individuals who have committed offences. This thesis focuses on shame and guilt, an evolving area for practitioners, as demonstrated by third-wave therapies such as Compassion-Focused Therapy (Gilbert, 2014). Third- wave therapies refer to a shift in focus from the content of thoughts and emotions to the relationship a person has with them (Hayes & Hofmann, 2017). Both these emotions have been shown to have profound impacts, so understanding them is essential. This thesis aims to contribute to the growing body of knowledge on shame and guilt within forensic populations. More specifically, it aims to improve the understanding of the mechanisms driving shame and guilt and how practitioners may measure these feelings in practice. Additionally, chapter three explores the significance of shame in psychological treatment. It is hoped this will provoke thought for professionals working with offending populations about how regularly shame is being recognised and factored into therapeutic approaches and rehabilitation.

Overview of Chapters

Chapter two is a systematic literature review (SLR) exploring the factors associated with offence-related shame and guilt. Eight quantitative studies were screened against inclusion and exclusion criteria before being assessed for methodological rigour. The implications of these findings are considered, including how professionals can support individuals accessing psychological support within the criminal justice system.

Chapter three is an empirical study examining the experience of feeling shame and its relationship to individuals sentenced to an MHTR. Several MHTR services across the UK were

contacted, and participants engaged in semi-structured interviews, which was subsequently analysed using IPA. The aim was to explore the lived experiences of shame among clients and to understand how shame manifests in participants' lives and how shame influences their MHTR.

Chapter four presents a critique of the Offence-Related Shame and Guilt Scale (Wright & Gudjonsson, 2007). This psychometric was deemed important to critique as it is one of the only scales considering shame and guilt within forensic settings. Reliability and validity are discussed, along with their application in forensic settings.

Chapter five summarises the chapters and discusses overall implications for practice with consideration for future research.

CHAPTER TWO

Associated Factors with Offence-Related Shame and Guilt: A Systematic Literature Review

Abstract

This review examines the factors associated with offence-related shame and guilt, with a focus on their impact on well-being, relevance in forensic settings, and association with reoffending. Given the problematic outcomes associated with these emotions, understanding the factors linked to them is critical for informing effective interventions.

The studies included in this systematic review were meticulously identified through a comprehensive search of electronic databases, including OVID PsycINFO, Scopus, Web of Science, and ProQuest. Reference lists were examined to extract relevant research. The SPIDER search strategy tool (Cooke, 2012) was employed to develop criteria for identifying relevant papers; a process deliberately kept broad due to the limited number of papers found.

Ten quantitative studies were subjected to quality assessment, two were removed with the remaining eight papers considered of reasonable quality, meeting six or more criteria. The quality assessment was conducted using the JBI Critical Appraisal Checklist, a robust tool for evaluating the methodological soundness of research by evaluating credibility, relevance and outcomes for each paper. To ensure accuracy, dual coding was performed with the assistance of doctoral supervisors.

The findings of this review indicate several factors may be associated with offence-related guilt: mental health, offence circumstances, and personality styles, although the association with personality styles was not definitive and requires further exploration. For offence-related shame, mental health emerged as the most consistently associated factor. Overall, the findings suggest mental health plays an important role in both offence-related shame and guilt, and offence circumstances may also influence levels of offence-related guilt.

This review has implications for working within forensic populations. The findings suggest the importance of awareness and working with feelings of shame or guilt.

Introduction

There are several definitions for shame and guilt. The following definition by Niedenthal et al. (1994) helps understand why such an SLR is important, particularly for those working with forensic populations. Niedenthal et al. (1994) defined shame as an evaluation of the self which leads to a sense of being a "bad" person or worthless in the eyes of oneself and others. The consequence of feeling ashamed is to have a desire to hide or escape. In contrast, they defined guilt as a feeling of having done something wrong, often accompanied by tension, remorse, and regret. The difference between the emotions is guilt is about the situation, not the person. It has been recognised within therapy such feelings can significantly impact both patient and therapist, with shame posing complex problems (Gilbert, 1997). However, beyond the awareness of such feelings, how well practitioners understand shame and guilt is unknown.

Practitioners should understand the factors associated with shame and guilt, to facilitate the recognition and minimisation of unwanted outcomes, including offending and poor well-being. This review aims to generate knowledge that supports this need. Related research has examined factors influencing treatment outcomes (Gale et al., 2018). In their study, four psychologists were interviewed about factors related to difficult or slower responses to psychological treatment. Their research directly informed the psychologists practice in terms of understanding what factors influence the perception of progress. It is hoped this review can be helpful in similar ways by informing knowledge and practice.

An Exploration of the Concepts of Shame and Guilt

As suggested above, shame and guilt may influence mental health. A proneness to shame has been related to maladaptive responses such as anger, self-directed hostility, and negative long-term consequences (Tangney et al., 1996). Conversely, guilt has been associated with constructive means of handling anger, corrective action, and favourable long-term

consequences (Tangney et al., 1996). Therefore, shame and guilt may be associated with different outcomes for mental health. Such a difference highlights the complexity of both feelings and the importance of a more developed understanding. In their literature review, Proeve and Howells (2002) suggested a greater emphasis is needed on other aspects of shame, i.e., concern for scrutiny by others, rather than just self-evaluation. Therefore, whilst shame is concerned with viewing oneself as bad, there is also the concern of others sharing this view. Goss et al. (1994) similarly showed judgements from self and others are highly correlated. This gives a sense of the importance of shame, particularly concerning an often highly stigmatised population such as those who have committed a crime. Such people often experience judgments from others and feeling shame may exacerbate this.

Interestingly, Xu et al. (2011) distinguished between guilt and guiltlessness. According to the authors, guilt is the acceptance of a mildly defective self, and guiltlessness is the rejection of the unbearable distress of anticipatory guilt. This acknowledgement of the distress caused even if anticipated, suggests the need to explore these feelings and their impact. Moreover, the distinction proposed here offers an interesting perspective: feelings of guilt are not straightforward, and some may reject this feeling altogether. Again, this supports the need to further explore the concept of guilt. Many years ago, Alexander (1938) highlighted guilt plays a permanent and central role in explaining psychopathological phenomena. This suggests guilt, if left unaddressed, can have long-lasting impacts and links to the previously mentioned need for adaptive forms of guilt (Tangney et al., 2011).

The nature of shame and guilt is complex, and this is exemplified in gender differences. Seidler et al. (2022) found men's shame can be expressed via anger when experiencing psychological distress. Hence, feelings of shame can be less obvious, instead expressed as other emotions. This poses potential difficulties in recognising shame and guilt, whereby the expression of both may differ across genders. However, there is agreement expressions of

emotions differ from person to person, regardless of their assigned gender. Ferguson and Crowley (1997), whilst dated, suggested how we perceive and experience information about ourselves is congruent with gender-linked differences in socialisation. They indicated a woman's model for themselves is a proneness to feel shame, and a man's is guilt. Thus, these feelings are complex, and how shame and guilt are conceptualised differ across several factors, including gender.

Factors in the General Population

This review aims to understand offence-specific factors. To establish a foundational understanding, it is helpful to review literature within the general population. Studies have demonstrated a strong association between external shame and symptoms of social anxiety. Further associations were found with Obsessive Compulsive Disorder (OCD) and Post Traumatic Stress Disorder (PTSD; Candea & Szentagotai-Tatar, 2018). Therefore, in the general population, feelings of shame are associated with difficulties in mental health. Similarly, guilt was significantly associated with depression but unrelated to socio-demographic factors such as age, sex and education in an extensive German study (N=1003, Luck & Luck-Sikorski, 2021). This suggests mental health, rather than demographic factors, may be integral to both shame and guilt.

Experiences of Shame and Guilt in Forensic Populations

The focus of this review is on those who have committed offences. It is, therefore, essential to look at the role of shame and guilt more closely in this context. Such feelings are regularly considered in forensic and popular literature about victims of crime. However, there appear fewer that consider shame and guilt experienced by those who have committed a crime. Of the research, a large amount has explored the effects of shame or guilt on reoffending, for example, Hosser et al. (2008) interviewed a large sample of young people who had committed

offences. The researchers observed feelings of guilt at the beginning of prison correlated with lower rates of recidivism, whilst shame correlated with higher rates. This finding proposes guilt may be functional in reducing the risk of reoffending, whilst the same cannot be said about shame. This idea of shame as an unhelpful emotion has been considered. Roth et al. (2021) raised the challenge of being "trapped in shame" regarding forensic patients. The authors suggested people experiencing high levels of shame struggle to move beyond such feelings and feel "stuck". This is viewed as problematic for the outcome of any rehabilitative work. With this challenge, Hosser et al. (2008) considered how loss of self-respect, social withdrawal and aggression were associated with feelings of shame. Therefore, it appears shame is viewed unhelpful, causing complex psychological and behavioural outcomes.

In contrast, guilt is viewed as having the potential for longer-term positive outcomes, serving as a negative predictor of recidivism (Tangney et al., 2014). As above, unaddressed guilt can be unhelpful, and it appears conditions must be met to achieve the desired effects. Optimal levels of empathy and the motivation to understand another person's feelings may be crucial (Taylor & Hocken, 2021). Most crucially, negative experiences of guilt seem determined by the absence of opportunities for reparation or a lack of commitment to avoid future transgressions (Tagney & Dearing, 2002, as cited in Fisher & Excline, 2010). Undergraduates were asked about negative and positive experiences of guilt. Positive experiences were a result of having decided to change or repair. Thus, motivation and commitment appear to be crucial factors.

Further, the work by Proeve and Howells (2002) helped expand knowledge of the impact of shame on treatment, victim empathy and relapse. Their research considered this in relation to individuals with a prior sexual offence and suggested progression is evidenced by moving from shame towards guilt. This important finding is magnified by the understanding that shame is salient in the presentation of many individuals with a sexual offence and poses a

barrier to successful treatment. Wright et al. (2008) found the relationship between shame and anger is particularly relevant where the experience of committing a criminal offence has the potential to be highly shame-evoking and associated with elevated levels of anger. Therefore, shame can be present in forensic populations. As Proeve and Howells (2002) suggest, this can be found in certain offence groups, such as those with convictions for sexual offences and has been shown to have profound effects. Guilt, however, has been associated with treatment progress. Interestingly, there is an emphasis on the consequences of shame and guilt for this population.

The experience of guilt by the perpetrator of an offence appears to be regarded as less critical within literature unless considered within the realms of sentencing. Feelings of guilt appear less studied than shame, as suggested by the scoping search of this review. However, feeling guilt is regarded as an essential component of remorse (Tangney et al., 2011). For that reason, guilt may be essential to the process of resocialisation and, therefore, important to this review. Fisher and Exline (2010) considered how, sometimes, those who have committed an offence may avoid feelings of guilt, taking shortcuts, i.e., excuse-making, or blaming someone else, to repair their moods and views of themselves without the reparative behaviour (i.e., making amends) that typically follows guilt. The researchers explored the consequences that may follow. Instead of guilt, individuals convicted of an offence may be overwhelmed with shame or self-condemnation, which, as previously mentioned, may lead to aggression and self-hatred (Hosser et al., 2008). When left unaddressed, these psychological mechanisms can crystallise, leading to further difficulties. It is hoped the current review can help professionals better recognise these psychological mechanisms as a possible result of unresolved feelings of shame or guilt, to work directly with them to maximise mental health and rehabilitation outcomes.

The consideration of the role of shame and guilt in early life has also proven informative for the field of forensic psychology. In a longitudinal study, Stuewig et al. (2015) measured proneness to shame and guilt in 380 10- to 12-year-olds. They interviewed 68% of the participants once they had reached the age of 18 years. They found guilt proneness predicted less involvement in the criminal justice system, alongside other factors such as the use of drugs and alcohol. On the contrary, shame proneness was a risk factor for later deviant behaviour. While there is a question of the appropriateness of considering the moral development in young people, extending also to older children (Bajovic & Rizzo, 2021), this study offered thought-provoking findings. Bajovic and Rizzo (2021) suggested the influence of guilt and shame, focusing more specifically on a person's proneness to one feeling over another and how this affects criminal behaviour. The implications of this, even from a young age, appear profound.

The Role of Shame and Guilt in Compassion-Focussed Therapy

There is a growing understanding of shame and guilt, particularly in CFT (Gilbert, 2014). CFT is a psychological intervention grounded in evolutionary, motivational and functional emotional systems (Gilbert, 2014). The model proposes three motivational systems, previously known as emotional systems, but best understood for their motivational purposes which include: to alert to potential threats which activates defensive strategies; provide information on access to resources and rewards; and to provide information on safeness, to allow for rest and digestion, which can be activated by connection with others (Gilbert, 2017). These systems, named the Threat, Drive, and Soothe, help to regulate each other. Gilbert (2009) suggested feelings of safety and overall well-being associated with the activation of the soothing system are poorly accessed by those with high shame and self-criticism. Instead, shame and self-criticism activate the threat system, which, when overactive, leaves a person alert and feeling unsafe. Again, this highlights shame can unhelpfully impact a person's overall emotional well-being, including self-esteem (Budiarto & Helmi, 2021), and loss of ability to

function and attend to self-care as found in medical students experiencing shame (Bynum et al., 2021). In the context of forensic settings, an overactive threat system, whereby a person is alert to threats such as perceived rejection, may explain offending. For instance, feeling ostracised has been identified as a trigger to aggression due to its connection with sadness and impact on the basic psychological need of belonging (Ren et al., 2017). This offers another reason as to why practitioners' awareness of shame is fundamental, as social exclusion increases shame (Catton et al., 2025).

This model has been utilised within the context of forensic populations. Anti-social behaviour patterns and psychopathic traits are conceptualised in the CFT model as evolutionary strategies which deal with traumatic experiences, e.g., threat, abuse, and the absence of safety (Da Silva & Rijo, 2022). Gilbert and colleagues explained individuals with such experiences have overdeveloped and hypervigilant threat systems, as above, and overall emotional dysfunctions. Da Silva and Rijo (2022) suggested these emotional dysfunctions comprise high levels of shame and a tendency to block or attack in situations where shame may be evoked. As such, shame has been said to contribute to offending behaviour as well as creating hopelessness leading to resistance to treatment and emotional denial (Taylor, 2017). Roth et al. (2021) echoed feelings of guilt and shame can be a strong driver of behaviour and suggested they need to be understood with criminality, risk, and recovery. Collectively, these studies emphasise the importance of recognising and understanding moral feelings (i.e., shame and guilt) in people who have committed offences. Moreover, Gilbert and his successors' work instigated a move towards a more trauma-sensitive approach, acknowledging those who harm have often been harmed themselves (Taylor & Hocken, 2021). As discussed earlier, more compassionate and trauma-informed approaches will support improved treatment outcomes.

Supporting the model, Tangney et al. (2011) depicted shame and guilt as critical steppingstones to rehabilitation and interventions for those who have committed an offence,

due to their potential role in promoting more positive behaviour and inhibiting antisocial behaviours. As such, CFT has become an increasingly used intervention in forensic settings, and its application has been found to reduce shame and increase experiences of guilt (Taylor & Hocken, 2021). This promising result underscores the potential of CFT in transforming shame into guilt, a more constructive emotion. In doing so, individuals are supported to build on their compassionate motives and turn towards distress in a way that facilitates more positive outcomes. This is well supported, with the essence being to move from destructive feelings of shame about self into adaptive feelings of guilt about the behaviour (Mottershead et al., 2024); where feelings of guilt support a more positive and increased attention to reparation (Graton & Ric, 2017).

Crucially, Taylor and Hocken (2021) emphasised the important safety aspects of work surrounding inducing feelings of guilt, once more acknowledging the potential for harm from evoking these strong feelings, particularly recognising guilt can be difficult to tolerate for someone who has committed an offence. Research has shown individuals may find ways to reduce guilt through self-punishment (Fisher & Exline, 2010), highlighting the potential for further harm. However, under the correct conditions, guilt plays a constructive role in rehabilitation.

Interestingly, shame has been linked with increased possibility of recidivism (Hosser et al., 2008; Tangney et al., 2014), with the reduction of shame shown to reduce the potential for harm (Garbutt et al., 2023). This suggests addressing shame has significant offending implications. Consistent with this, shame has been depicted as having “two faces”: a destructive and constructive form. Interventions can focus on reducing defensive responses and encouraging individuals to use the pain of shame constructively (Tangney et al., 2014). These are important observations to consider in research exploring offence-related emotions.

Overall, shame and guilt are emphasised as crucial for someone with a criminal offence to their mental health and resocialisation. Forensic clinicians must have a good understanding of these core emotions, how they arise, and which other feelings can be associated with them. Thus, the impact of this review is to add or enhance an understanding of shame and guilt in the context of offending and how these emotions can contribute to reducing reoffending. Understanding the associated factors of shame and guilt goes one step further in considering the important interplay between these two emotions.

The Role of Shame and Guilt in Therapeutic Interventions

There are limited studies regarding psychological interventions or programmes that focus on shame and guilt, with CFT having been the main therapeutic model used to address this. Despite the well-recognised impacts of shame and guilt, there appears to be very little consideration for working with and addressing such feelings within forensic research. However, general psychotherapy has given attention to this. Within psychodynamic psychotherapy, there is an acknowledgement shame avoidance can produce transference and countertransference (psychological defensive strategies) enactments within therapy, leading to adverse outcomes. Hence, addressing shame related issues for both therapist and patient is critical (Goldblatt et al., 2013).

Considering the interpersonal difficulties that can arise due to defensive strategies, addressing shame is necessary due to the potential impact on treatment (Prasko et al., 2010). Gilbert et al. (2011) considered the role of such strategies, including avoidance and the difficulties that arise in therapy as a result. They noted client's tendency to keep shameful parts concealed due to concerns for the therapist's perception. Such tendencies are likely in the face of increased shame vulnerability, which is often the case with therapy being shame-evoking (Goldblatt et al., 2013). Thus, when working with shame, it is particularly crucial to be mindful of these underlying processes.

Interestingly, it has been suggested much established evidence-based psychosocial interventions effectively reduce shame (Goffnet et al., 2020). Of the 37 studies reviewed, 33 reported reductions in shame; two of these studies included a forensic population from within a prison. Goffnet et al. (2020) suggested shame is responsive to many interventions, including Cognitive Behavioural Therapy. They did, however, state few interventions have been designed specifically to reduce shame. This suggests shame reduction may be an unintended side effect of these approaches. Stynes et al. (2022) explored how effective mindfulness- based and third-wave interventions are in addressing shame and self-stigma. They found acceptance and commitment therapy interventions or those focused on increasing compassion for self (Hayes et al., 2006), were most likely to affect self-stigma and shame. This is a positive finding as it directs practitioners to what may be most helpful in working with shame and suggests the available interventions are helpful. Similarly, Dialectical Behavioural Therapy and emotional dysregulation work has been effective in reducing shame (Neacsiu et al., 2018). Therefore, the findings of the current review may be applied broadly, including to non-CFT interventions.

Interventions however, that consider how to work with guilt appear more limited. Norman (2022) completed a review of Trauma-Informed Guilt Reduction Therapy (TriGR), a model for reducing the guilt and shame components of moral injury. It was found effective for reducing trauma-related guilt specifically. Alternatively, Clark (2012) highlighted the importance of the therapeutic relationship for shame, guilt, and the sense of shared humanity. This suggests the specific intervention may not be as essential as how the practitioner responds to and makes the individual feel. Again, this links with earlier considerations for compassionate responses from others as helpful. Clark (2012) makes an important point whereby he stated traditional models of psychological therapy are being modified to consider shame; however, he did not suggest the same applies to feelings of guilt. Hence, the current review may inform

links between moral emotions and consideration for how psychological interventions can be conducted.

From the limited research available within forensic settings, it seems the goal of therapeutic interventions addressing shame and guilt is to help a person move from feeling shame into feeling guilt, in line with recommendations made by Taylor and Hocken (2021). This allows practitioners to complete the necessary work to repair and resolve guilt. This process has been coined as "shame-reducing, guilt-inducing" (Malouf et al., 2013).

Despite this, it could be argued interventions have not been designed to target shame and guilt directly, and this may be because it is challenging to do so without a good understanding of these feelings. Although the introduction and increasing use of CFT could be considered a breakthrough, there appears to be limited development beyond this type of intervention. Notably, interventions for individuals who have committed sexual offences often emphasise the development of victim empathy, as set out by Salter (1988, as cited in Mann & Barnett, 2013). These approaches include writing exercises about the offence from the victim's perspective. This raises a question whether doing so induces levels of shame, which the authors confirm. The negative outcomes of feeling shame are then worsened, creating more problems for the individual and larger implications for reoffending (Garbutt et al., 2023).

Similarly, Restorative Justice focuses on the idea that those who commit an offence should participate in its resolution; thus, the person who committed the offence and the person harmed have an opportunity to participate in a restorative process (Andruczyk, 2015). A non-judgmental stance is emphasised (Bouffard et al., 2017), and communication of respect for the perpetrator of the offence as a person (Tyler et al., 2007). This is promising considering the thoughts on therapeutic interventions, particularly Clark's (2012) emphasis on shared humanity. Whilst shame and guilt can be conducive to the aims of restorative justice, they can

be problematic (Rodogno, 2008). This appears consistent with literature reviewed, which suggests shame and guilt can have both adaptive and maladaptive parts in outcomes, whether it be offending, mental health or both.

Aims of the Current Review

This introduction shows the crucial role of shame and guilt in the rehabilitation of individuals. It is noteworthy that conceptualising both proves difficult, and a general complexity is seen. On one hand, shame can have detrimental influences on a person's mental health as well as larger implications for reoffending. On the other hand, guilt can be seen as a positive step towards treatment outcomes, but still requires intervention, of which available approaches appear to be somewhat limited. This SLR aims to answer the following research question: *What factors are associated with offence-related feelings of shame or guilt in individuals who have committed an offence*? In seeking to answer this, it is hoped an improved understanding will inform the development or use of existing interventions.

In identifying the factors associated this review can provide insight into the key areas to target within therapeutic interventions. Similarly, understanding associated factors would help gain perspective on the broader understanding of shame and guilt, which subsequently informs this review.

No known SLR has been conducted that considers the associated factors of offence-related shame and guilt more broadly and the implications of this in a forensic population. Considering the above and the growing understanding of how shame and guilt are featured, this review aims to further the evidence-base and inform treatment approaches. It is anticipated the findings may also provide useful context for understanding how these emotions manifest in forensic settings, including increased knowledge of the prevalence and potential impact of offence-related guilt and shame, and a move towards supporting professionals to work more effectively with those in the criminal justice system accessing psychological support.

Method

Sources of Literature

A scoping search was completed of Cochrane Library for title, abstracts, and keywords however no results were found searching “Shame, guilt and systematic literature review”. This was run in 2022 and in May 2025. A further search was conducted on Web of Science, and one review was found. This review by Mottershead et al. (2024) was specifically focused on individuals with violent offences, excluding any sexual offences. They acknowledged this narrowed the results and therefore support conducting this review across a broader population.

Inclusion and Exclusion Criteria

A SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research Type) search strategy tool (Cooke, 2012) was used to guide the construction of study inclusion and exclusion criteria, as per Table 1 below. This strategy supported the identification of papers included in the final review.

Table 1
SPIDER Protocol: Inclusion and Exclusion Criteria

SPIDER Category	Inclusion Criteria	Exclusion Criteria	Rationale for Criteria
Sample	Individuals with a criminal conviction aged 18 and above Both males and females Offences leading to imprisonment or detainment in secure settings. Offences requiring probation.	Juveniles/adolescents involved in the criminal justice system Individuals who have not committed a crime or not involved in the criminal justice system. Victims of crime	Age requirement was necessary considering knowledge around the age of development of moral emotions and moral thinking, with adolescence being at a stage of significant change in moral development (Bajovic & Rizzo, 2021). The offence needed to result in a secure setting or probation. Participants not receiving a criminal charge, or for example, points on their license for speeding, did not support what was being sought by this review and so were excluded. Statistics show speeding offences are common, with 176,441 speeding offences in

			2017 (DPP Law, 2020). It was not felt that this type of population or offence met the necessary criteria for this review. For this review, setting specific inclusion criteria for offence type or setting was not possible due to the limit this would have placed on the scope of the review. Limiting papers to specific offences was considered in the earlier stages of planning this review; however, upon initial scoping searches, it was clear that this would significantly reduce the available pool of literature.
Phenomenon of Interest	Offence related Shame or Guilt Offending Factors associated with offence related shame or guilt	Victim experiences Judicial or Juror perceptions Sentencing/ verdicts/ perceptions relating to guilty or not guilty Low-level driving offences, i.e. speeding	Regarding the phenomenon of interest, the strategy was kept purposefully unrestrictive so as not to exclude potentially important papers. The papers included needed to be concerned with shame or guilt, but both didn't

		Shame or guilt not related to offending behaviour.	have to be considered in one paper. The papers did not need to state that they were exploring factors specifically, though the papers needed outcomes relevant to what could be considered associated factors of shame or guilt. Papers were excluded if they discussed "guilty" in terms of sentencing outcomes.
Design	Case study Interview Questionnaires/ surveys Mixed design Experimental		There were no exclusion criteria for design; intentionally allowing for a broader scope in the review.

Evaluation	Factors associated with feeling shame and guilt		
Research Type	Qualitative, Quantitative, and Mixed methods English Language and conducted in the United Kingdom only	Review articles, commentaries, conference papers, book chapters, dissertations	The inclusion of UK only studies was necessary due to known cultural differences between experiences of shame and guilt and how transgressions are viewed (Fessler, 2004; de Groot et al., 2022). Similarly, there are well-known differences across legal systems, for instance, the death penalty in the USA, which does not compare to the UK and may alter experiences of shame or guilt. Commentaries, conference papers, or book chapters were excluded because they did not provide sufficient detail for a systematic literature review. Other reviews were excluded

	due to the secondary reporting of data. Beyond this, if the study discussed factors associated with shame or guilt and included a population aged 18 or over with criminal convictions, then the paper was included in the review.

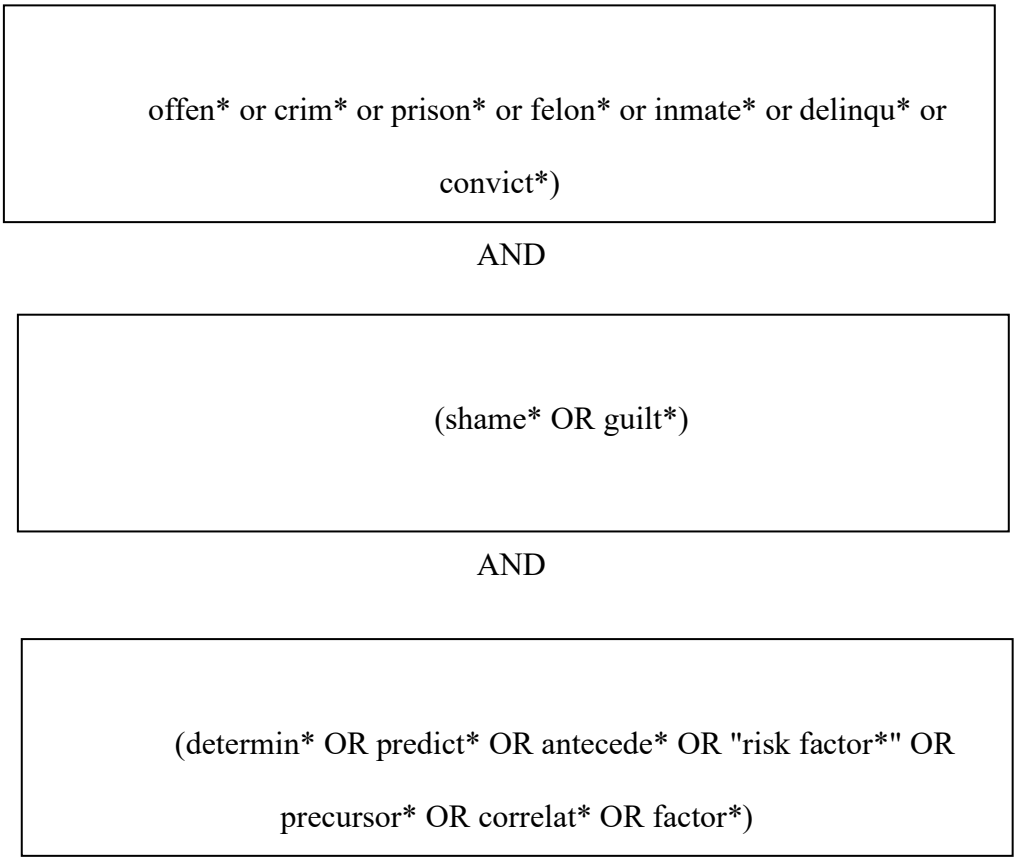
The above inclusion and exclusion criteria were applied to all studies after removing duplicate studies. Full text was obtained for those that met the criteria. Some studies did not specify information relevant to the SPIDER criteria within their title or abstract; in these instances, these were categorised as “maybe;” see PRISMA below. Those listed as “maybe” were obtained for a more detailed review and then included or excluded based on the SPIDER criteria.

Search Strategy

The search terms were developed through meetings with academic supervisor and trainee, as well as with staff from the university library. This ensured the search terms correctly captured the intention of the review.

The input of the search terms differed depending on the database (see Appendix A). The databases used were agreed with library staff and the research team. The four selected were considered the most aligned with the topic. The search terms used are shown in Figure 1.

Figure 1
Search Terms



The first search strategy was conducted using the above terms across four databases on 23rd May 2025. The total number of hits was 9,072, and 3,600 duplicates were removed using Rayyan software and hand searching. 5,472 were screened, with 5,443 excluded for not meeting the inclusion criteria. From this, 29 were selected for complete retrieval; four records could not be obtained due to being unlocatable but did not appear relevant, and 19 were excluded for relevance, incorrect population or country, see Appendix E. This left six papers, which were quality assessed. The PRISMA outlines the process followed.

An auxiliary search was conducted to ensure completeness of the review by focusing specifically on measures to assess feelings of shame or guilt. This was run across the same four databases with the search terms shown.

Figure 2
Search Terms

offen* or crim* or prison* or felon* or inmate* or delinqu* or convict*)

AND

("Offence-Related Shame and Guilt Scale" or ORSGS or "Gudjonsson Blame Attribution Inventory" or GBAI or "Guilt and Shame Proneness Scale" or GASP or "State Shame and Guilt Scale" or SSGS or "Test of Self-Conscious Affect" or TOSCA)

This returned 912 records, of which 186 were duplicates. Of the remaining 726 records, 721 did not meet the inclusion criteria. This left five remaining papers for full screening. Two were excluded for duplication or being conducted outside the UK (see Appendix E). This left three for quality assessment.

Across all final papers, a manual search of reference lists was conducted; one paper was found but excluded due to quality concerns due to poor reporting standards. The limited detail given meant the paper could not be well understood or evaluated. This was included in Appendix E.

Screening and Agreement Process

To assess interrater reliability, two secondary reviewers independently examined all ten papers identified to determine inclusion or exclusion of papers. Both raters agreed 20% of the papers did not meet the criteria for inclusion. Therefore, there was 100% agreement of raters. Given the small number of papers double-reviewed, percentage agreement was calculated as the primary indicator of interrater reliability. While Cohen's kappa is typically recommended

for binary categorical decisions, the limited dataset size meant kappa was not calculated, as small samples can produce unstable estimates that are less informative than raw agreement rates.

Figure 3
PRISMA Flow Diagram of the Process of the SLR – Main Search

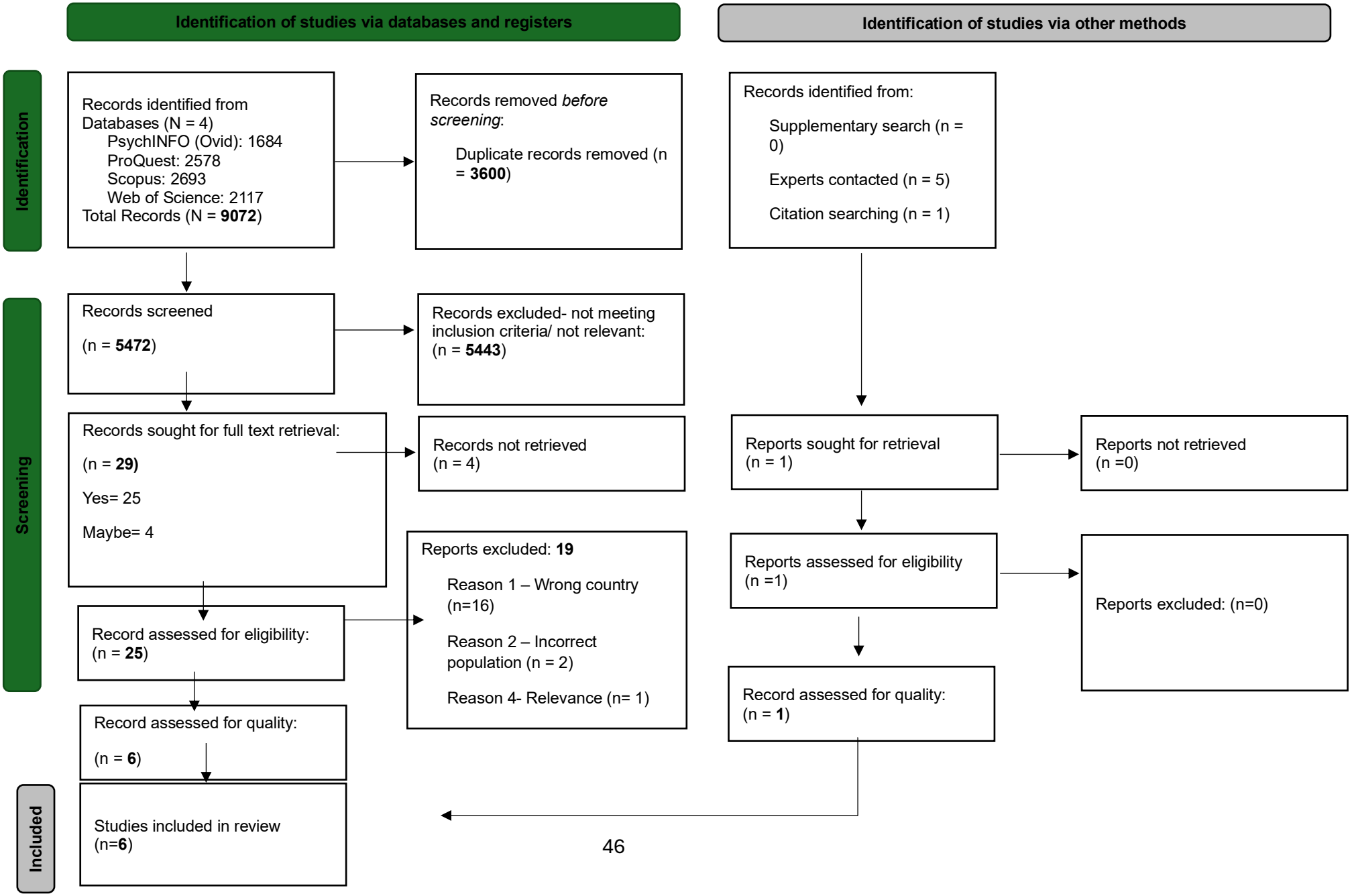
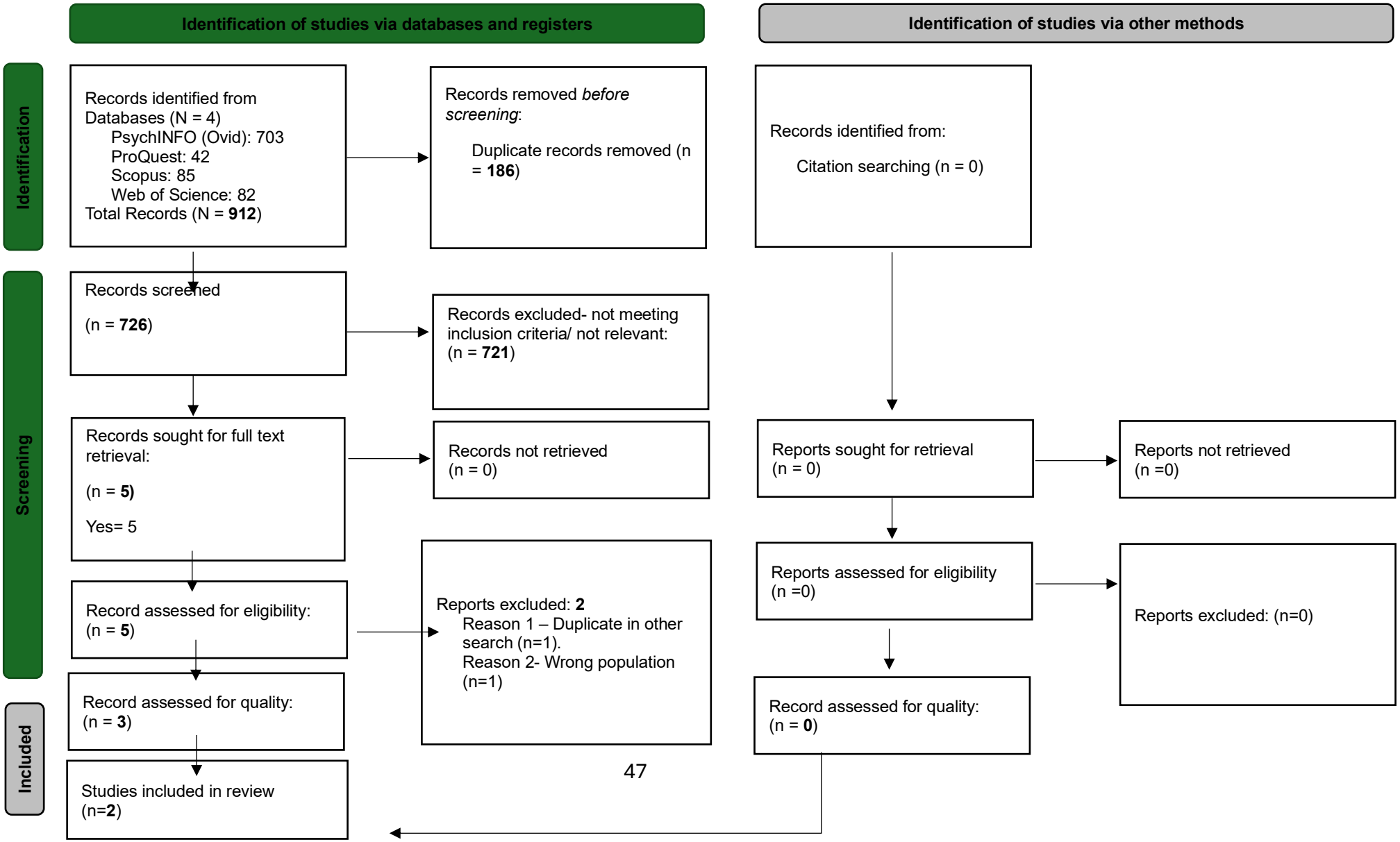

Identification of studies via databases and registers
Identification of studies via other methods
Identification
Screening
Included
Records identified from
Databases (N = 4)
PsychINFO (Ovid): 1684
ProQuest: 2578
Scopus: 2693
Web of Science: 2117
Total Records (N = 9072)
Records removed before screening:
Duplicate records removed (n = 3600)
Records identified from:
Supplementary search (n = 0)
Experts contacted (n = 5)
Citation searching (n = 1)
Records screened
(n = 5472)
Records excluded- not meeting inclusion criteria/ not relevant: (n = 5443)
Records sought for full text retrieval:
(n = 29)
Yes= 25
Maybe= 4
Records not retrieved
(n = 4)
Reports sought for retrieval
(n = 1)
Reports not retrieved
(n =0)
Reports excluded: 19
Reason 1 – Wrong country (n=16)
Reason 2 – Incorrect population (n = 2)
Reason 4- Relevance (n= 1)
Record assessed for eligibility:
(n = 25)
Reports assessed for eligibility
(n =1)
Reports excluded: (n=0)
Record assessed for quality:
(n = 6)
Record assessed for quality:
(n = 1)
Studies included in review
(n=6)

Figure 4
PRISMA Flow Diagram of the Process of SLR- Auxiliary Search



Quality Assessments

The JBI Critical Appraisal Checklist for Analytical Cross-Sectional Studies was used for all but one of the papers, with the JBI Critical Appraisal Checklist for Randomised Controlled Trials used instead. The research design of each paper was identified upon reviewing the method, abstract, and results sections. All papers were quantitative. An overall scoring for each criterion was implemented to distinguish quality between papers. Each item was rated with either 'Yes', 'No', 'Unclear' or 'N/A'. This means the highest possible quality assessment score was 8/8; see Appendix C.

It is not recommended the JBI be used for scoring purposes to then exclude based on quality; instead, the quality assessments were used to inform the weight of which findings could be considered. However, in practice, it is not uncommon for researchers to use such tools to set minimum quality thresholds, particularly in systematic reviews where poor reporting or methodological weaknesses would substantially limit the interpretability of the results. In the current review, completion of quality assessments highlighted some papers did not meet expected areas of quality, for instance, low reporting standards of information, making it challenging to report on the data. Therefore, two papers were excluded (see Appendix E).

To assess consistency, dual coding was conducted with a doctoral supervisor. Four of the eight final papers (50%) were independently reviewed. There was 100% agreement on the RCT study and 75% on the other; a discussion was held, and agreement was then sought, and ratings updated. Dual coding was conducted with two further papers to confirm their exclusion, with agreement achieved. It was not necessary to include a third rater to resolve any differences.

Data Extraction

Data from the papers were extracted using a data extraction form (Appendix D), see Table 2. The researcher designed the form based on the review's needs to extract the essential information. The headings were based on the inclusion criteria to extract the key elements of each paper. Consideration was given to the implications of findings, given the hope this review may have practical implications in the work of professionals. The development of an extraction form was informed by the researcher's understanding of research and doctoral-level teaching, which informed the necessary component.

Table 2
Data Extracted from the Included Studies

Author	Study Type	Participants	Aims	Shame or Guilt related measures	Findings/ Outcomes	Strengths and Limitations/ Biases	Future Implications Relevant to Shame and Guilt
Crisford et al. (2008)	Quantitative	Secure unit in the UK- 45 participants, 2 were female. 53% of those asked agreed to participate. Severity of offences rated by researcher and two clinical psychologists. Mixture of diagnoses including schizophrenia and personality disorder.	• To see if Guilt and offence-related PTSD are associated.	• The GBAI-R • Trauma-Related Guilt Inventory	**Guilt findings only:** • They found where trauma symptomatology was higher there was increased guilt cognitions. • The severity of violence did not affect levels of offence- related guilt. • Instances where the victim was unknown increased guilt.	**Strengths:** • Control of variables • Valid assessment of guilt cognitions • First quantitative study to use self-report to assess guilt. • Allowing participants to choose which offence they discussed, limiting to index offence could have lost information. **Limitations:** • Categorisation of ethnicity limited • Limited method for exploring substance use and psychotic symptoms. • Prompt by researcher to participants to	• Treatments and assessments may induce guilt and possible trauma symptomatology by increasing insight and so professionals must be mindful of this.

						consider upsetting, horrible or distressing offence. • Giving choice to participants about offence may have allowed for avoidance. • Individuals with sexual offences in the sample • Shame was not assessed. **Biases**: No mention.	
Wright et al. (2008)	Quantitative	• 60 men in a forensic psychiatric unit– 18+ years old • 87% had a violent offence • "90% had diagnosis of schizophrenia, or schizoaffective disorder"	To explore if feelings of guilt and shame are predicted by the tendency to become angry or control anger.	• Offence related guilt and shame scale (ORSGS)	**Shame and Guilt findings:** • "Offence- related shame is associated with elevated levels of anger difficulties, whilst offence- related guilt is associated with anger control"	**Limitations:** • The ORSGS remains in developmental stages and requires further validation. • Small number of males – cannot be applied to females and those without psychiatric disorder. • The relationship between psychotic illness, guilt and shame is not well known. The presence of psychosis may have influenced these feelings. **Strengths:**	A focus within psychological work on the factors that increase the likelihood of someone feeling shame, as these may also be associated with other psychological difficulties.

						• Findings support knowledge of shame, guilt and anger. • This paper supports that higher shame can be problematic. • The findings of this study support the understanding of factors which contribute to violence. This helps to create therpaies to support this. **Bias:** Possibility of participants giving socially desirable responses.	
Fuller, et al. (2019)	Quantitative	"66 adult male patients in a secure hospital"	To examine readiness and treatment engagement motivation with guilt and shame.	• TOSCA-SD • ORSGS	**Shame and Guilt findings:** • Positive correlation of "Guilt proneness and offence- related shame with treatment readiness". • Positive correlation of "Offence- related guilt with motivation and readiness".	• **Limitations:** Correlational meaning causality cannot be assumed. • The sample was heterogenous- there were "mixed ages, mental health, and offence behaviours" • Needed a larger sample size- minimum of 97 • Participants were already in treatment which means	To assess guilt attribution in forensic populations for consideration of treatment timing.

						findings cannot be generalised to those who haven't. • The assessments used may limit validity as measuring shame and guilt distinctly is complex. • Scenarios used in the TOSCSA means negative aspects of guilt are poorly represented. The authors did not note any strengths.	
Batson et al. (2010)	Quantitative	"67 males in six medium secure units" 83% primary diagnosis of paranoid schizophrenia	Explore how blame attribution and psychopathy relate.	• Gudjonsson Blame Attribution Inventory (GBAI-R).	**Guilt findings only:** • No positive correlation found between guilt and psychopathy. • "External attribution of blame for offence associated with psychopathy".	**Limitations:** The presence of major mental illness may have affected the results in terms of expressing guilt feelings. This group of participants were explored for psychopathic traits as well as mental illness, not primary psychopathy. No explicit discussion around strengths. Acquiescence bias was reduced by negative and positive scoring.	Cognitive distortions and abnormal social cognitions importance are shown in violent offences and the need to target.

Mandel & Dhami, (2005)	Quantitative	90 individuals in prison	To investigate if counterfactual thinking would increase guilt, but not shame and whether mediated by self- blame.	No relevant shame or guilt scale.	**Guilt and Shame Findings:** • Counterfactual-focused prisoners reported significantly more self-blame and guilt but no significant change in shame. • Guilt positively corelated with blame. It did not with distress. • Shame and distress were positively correlated. Blame was negatively correlated.	No reports of limitations or strengths. No mention of bias.	• Shaming those who have committed offences is ineffective. • Encouraging counterfactual thinking about offences and how it could have been prevented may prove helpful, not just for the individual but society.
Fox et al. (2003)	Quantitative	"65 male inpatients from two medium secure units" Violence offences.	To explore personality, depression and blame attribution of violent offence.	GBAI	**Guilt Finding only:** • Negative correlation between Guilt attributions and psychotism.	**Strengths:** • Focus on one offence only-homogenous group and reasonable sample size. This meant the	Findings suggest treatment aimed at controlling violent urges and increase responsibility for an act of violence involves reconstructing the core role structure for the individual.

					• Higher guilt attributions and increased depression scores.	results were less affected by type of offence. **Limitations:** • Large variation in severity of offences. • Cannot be generalised to offenders without mental health. • EPQ-R scores were high suggesting participants were presenting themselves in a more favourable light.	
Fox & Leicht (2005)	Quantitative	"65 male psychiatric inpatients from two secure units" Nine forensic clinical psychologists selected victim group.	To investigate offender-victim relationship, how severe the violence was and how blame is attributed.	GBAI	**Guilt Finding only:** • Know victims resulted in higher guilt attributions. • More serious offences i.e., murder was most common when the	**Limitations:** • All participants had mental illness. • There were little participants for each severity.	Programmes need to address an individual's history of violence to understand their view of their offence. This could impact on the possibility of change. Programmes need to support an increase in the sense of

					victim was known well. • Higher Guilt-feeling attributions for most serious offence.	No mention of strengths or bias.	responsibility by the individuals.
Xuereb et al. (2009)	Quantitative	339 males within medium secure prison.	"The development and assessment of a measure" intended to measure shame, guilt and denial in individuals who have committed an offence.	No relevant measure.	**Shame and guilt finding:** • No significant difference between offence types and shame or guilt. • Higher self-esteem associated with low guilt**.**	**Strengths:** • Improves scenario-based measures by encouraging reflection on index offence and therefore based on an actual event increasing ecological validity. **Limitations:** • Absence of reliable measure • Impact of factor analysis and the effect of samples characteristics, limiting generalisability.	No practical implications discussed.

		• Self- report data collection increasing likelihood for biased responses.

Note. Quotes are taken from papers listed in the first column.

Method of Analysis

This review aimed to find the factors associated with feelings of guilt and shame for individuals who have committed an offence. Data were extracted from eight papers that met the inclusion criteria and were subsequently quality-assessed. Notably, their aims were not always precisely aligned with this review. However, the findings were, and therefore the papers were rightly included. Consequently, all findings discussed are aligned with the aim of this review.

To support conducting this review, several established guides were accessed. Booth et al. (2016) provides a detailed guide on performing a narrative review and how the findings should be synthesised. A narrative synthesis was necessary due to the heterogeneity of the studies, with varying research questions, populations, settings, and measures used to obtain results. Popay et al. (2006) describe a narrative synthesis as a form of storytelling that brings together data, identifies patterns, and provides evidence for why something needs to be done, stopped, or done differently. In this instance, this review aims to provide evidence for why understanding associated factors is essential to good clinical and rehabilitation outcomes; thus, the aim of this review is well supported by a narrative synthesis. See Appendix F for a brief description of the process used for the narrative synthesis.

Reflective Account

The researcher took a reflective approach when developing the synthesis, see Appendix G.

Results

Population and Settings

The populations studied across the papers varied for offence type. Individuals with mixed offences were included, and some categorised offences as violent only (Batson et al., 2010; Crisford et al., 2008). It is likely, depending on the offence type, the levels of offence-related shame or guilt experienced may vary. As discussed, limiting offence types was not possible. Table 3 presents each study.

Six of the papers recruited individuals from secure hospitals (Batson et al., 2010; Crisford et al., 2008; Fox et al., 2003; Fox & Leicht, 2005; Fuller et al., 2019; Wright et al., 2008). Two papers conducted research within prisons (Mandel & Dhami, 2005; Xuereb et al., 2009). All studies were UK based.

Only one paper included females (Crisford et al., 2008). However, of 45 participants, only two were female. Of 797 participants across all papers, females accounted for only 0.25%.

There were a range of mental health diagnoses. Five papers included individuals with major mental illness, i.e., Schizophrenia or a personality disorder (Crisford et al., 2008; Fox et al., 2003; Fox et al., 2005; Wright et al., 2008). Batson et al. (2010) included only individuals with major mental illness or depressive disorder, whilst Fuller et al. (2019) did not provide any mental health details. One paper did not include individuals with mental health difficulties (Mandel & Dhami, 2005).

Across the papers, demographics varied; however, four papers, did not mention participants' ethnicity (Fox et al., 2003; Fuller et al., 2019; Mandel & Dhami, 2005; Wright et al., 2008). Otherwise, participants were predominantly listed as white across the remaining papers.

Table 3 Study Characteristics

Study	Participant Gender & Age	Ethnicity	Offence Type	Mental Health	Setting
Crisford et al. (2008)	45 Participants- 2 Female. Mean age = 39	"White- 17 and non-white- 28"	• Robbery/ Armed- 4 • ABH/ Assault- 3 • Arson- 3 • GBH- 2 • Attempted Murder- 1 • Sexual- 3 • Weapon- 1 • Criminal Damage- 1 • Manslaughter/ Murder- 1	• 19 Paranoid schizophrenia • 8 schizophrenia • 5 schizoaffective disorders • 5 Personality disorder • 5 paranoid schizophrenia and personality disorder • 1 Bipolar affective disorder and personality disorder • 1 refractory schizophreniform disorder • 1- delusional disorder	Secure hospital
Wright et al. (2008)	60 males Mean age 39.6	No details	87% Violent Offences	• 90% had diagnosis of schizophrenia or schizoaffective disorder. • 4 diagnosis of personality disorder • Two diagnoses of bipolar affective disorder.	Secure hospital

Fuller et al. (2019)	66 Males Mean age 39.05	No details	• Murder 21 • Violent 18 • Sexual 4 • Mixed violent & sexual- 3 • Arson- 9 • Theft- 3 • Other- 5 • Missing- 3	• Psychosis- 27 • Mood disorder- 1 • Personality disorder- 8 • Mixed diagnosis- 27 • Missing- 3	Secure hospital
Batson et al. (2010)	67 Males Mean age 34.7	• 33% white • Black or Caribbean 30% • 16% black African	• 84% Violent • 9% theft • 7% Sexual	• 83% primary diagnosis of schizophrenia • 11% schizoaffective disorder • 3% Delusional Disorder • 3% Depressive disorder	Secure hospital
Mandell & Dhami (2005)	90 Males Mean age 35.11	No details	• 36% offence against the person (murder, rape, robbery) • 31% drug offences • 16% property offences • 3% fraud • Remaining other not specified.	No mental health reported.	Prison
Fox et al. (2003)	65 Males Mean age 36.4	No details	• 26% - murder/ manslaughter • 18% attempted murder, soliciting to murder or arson • 20% GBH • 17%-Armed robbery or threat of harm • 18% ABH	• 63.1% schizophrenia • 18.5% personality disorder • 10.8% Major mood disorder • 6.2% Schizoaffective • 66.2% psychotic at time of offence e	Secure Hospital

Fox & Leicht (2005)	65 Males Mean age: VMK – 35.1 VA: 31.9 VS: 28.3	37 White 15 Black 3 Asian 1 other	• 12- ABH • 11- Armed robbery/ threat to harm or kill • 13- GBH • 12 Attempted murders • 17- murder/ manslaughter	• 63% had schizophrenia • 18% personality disorder • 11% major mood disorder • 6% schizoaffective disorder • 2% unspecified psychotic disorder	Secure Hospital
Xereub et al. (2009)	339 males Mean age: 37.9 years.	No details	• 132 sexual offences • 104 violent offences • 82 general offences i.e. drugs • No index offence details for 21 individuals	No mental health reported.	Medium secure prison.

Measurements of Shame and Guilt Used

How shame and guilt were measured requires consideration, noting issues surrounding reliability and validity and the impact this can have on findings. As later discussed in Chapter Four, psychometrics utilised with this population surrounding guilt or shame are limited, which is noteworthy.

There was some consistency in the measures used. The GBAI-R (Gudjonsson & Singh, 1989) was used in four papers (Batson et al., 2010; Crisford et al., 2008; Fox et al., 2003; Fox et al., 2005). The next most used was the ORSGS (Wright and Gudjonsson, 2007) in Wright et al. (2008) and Fuller et al. (2019). Xuereb et al. (2009) was the only paper that did not use an established measure due to developing their own.

It is noteworthy that the GBAI-R only considers guilt and assesses an individual's attribution for their crime. The subscale 'Guilt feeling attributes' captures regret and remorse, which are accepted components of guilt. The ORSGS, however, incorporates both shame and guilt and it explores these feelings in the context of having committed an offence. Thus, this offers a possible reason for any difference in outcomes seen across papers. However, as per Chapter Four, the guilt feeling subscale of the GBAI-R was used to develop the ORSGS, and was validated against the GBAI-R, which suggests consistency across these measures. Table 4 outlines the measures used by each paper.

Table 4
Measure of Shame or Guilt

Study	Measure
Crisford et al. (2008)	G-BAI (Gudjonsson Blame Attribution Inventory-Revised) Trauma Related Guilt Inventory
Wright et al. (2008)	ORSGS (Offence- related guilt and shame scale)
Fuller et al. (2019)	Test of Self-Conscious Affect (TOSCA) ORSGS
Batson et al. (2010)	G-BAI
Mandell & Dhami (2005)	No relevant scale
Fox et al. (2003)	G-BAI
Fox & Leicht (2005)	G-BAI
Xuereb et al. (2009)	No measure

Methodological Considerations – Quality Assessments

An overview of the quality ratings is presented in Appendix C. Three papers were rated as meeting five of eight criteria on the JBI cross-sectional (Batson et al., 2010; Fuller et al., 2019; Wright et al., 2008). Three papers met six of eight criteria's overall with, Fox et al. (2003), Fox and Leicht (2005), and Crisford et al. (2008) meeting seven.

For Mandel and Dhami (2005), which was rated against the JBI RCT appraisal, seven out of 13 criteria were met, one criterion was not applicable, and five were unclear. In agreement with the research supervisor, who completed dual coding, it was agreed, although the paper did not meet the highest standard, it remains a well-designed RCT study that allows for stronger causal inferences; therefore, the findings can be deemed trustworthy. Similarly, for Xuereb et al. (2009) it was difficult to score fairly, given the paper is oriented towards the development of a new measure.

The main strength of the included papers was the use of appropriate statistical analysis, which increases the weight of findings. All papers except one (Xuereb et al., 2009) used well-known measures, considered reliable and valid. Although it is noted the ORSGS requires further development.

Whilst most papers had the essential methodological strengths, there was an overall theme in limitations concerning confounders. Crisford et al. (2008) was the only paper to mention this. Six of the papers acknowledged confounding variables often associated with a heterogeneous sample, such as age, mental health, and offences, but did not suggest any attempts to control for these. This is, however, understandable given the difficulties in recruiting for research within forensic populations; findings can still be considered reliable. However, generalisability can be difficult due to the impact confounding variables can have on establishing clear causal links (Skelly et al., 2012).

Narrative Synthesis

Six papers reported findings relevant to feelings of guilt, and two reported on shame (see Table 5). Emotions are explored in turn, with its relevance to the aim of this review. Factors were generated by grouping papers based on themes of ideas and conclusions as per Popay et al. (2006), noting similar points and discrepancies in findings.

Table 5
Study Themes

Offence- Related Guilt	Offence- Related Shame

Mental Health	**Mental Health**
Crisford et al. (2008)- Trauma	Mandel & Dhami (2005)- Distress
Fox et al. (2003)- Depression	Wright et al. (2008)- Anger
Wright et al. (2008)- Anger	
Offence Circumstances	
Crisford et al. (2008)- Severity of violence and victim type	
Fox & Leicht (2005)- Severity of violence and victim type	
Xuereb et al. (2009)- Sexual offences	
Personality Styles	
Batson et al. (2010)	
Fox et al. (2003)	

What are the factors associated with offence-related guilt?

Mental Health

Across three papers, a theme concerning mental health as an associated factor was found (Crisford et al., 2008; Fox, 2003; Wright et al., 2008). In this context, mental health is considered an overarching term for mental health difficulties and the associated symptoms.

Crisford et al. (2008) reported a positive correlation between offence-related guilt cognitions and offence-related trauma symptomatology. This suggests symptoms of trauma are associated with increased feelings of guilt. Specifically, a positive correlation was found between guilt cognitions and the PTS-T (r=.43, *p*=.003). This scale is from the Detailed Assessment of Posttraumatic Stress (Briere, 2001), which measures PTSD symptomatology. This finding suggests individuals who experienced more guilt also experienced higher symptoms of PTSD.

Similarly, Fox et al. (2003) found higher guilt attributions were associated with increased depression scores (r= 0.19, p<0.05). The authors note this is a weak association but suggest individuals who feel more guilt may simultaneously feel more depressed. Fox et al. (2003) scored highly when quality assessed, which further supports these findings. The findings of both suggest feelings of guilt may coincide with negative mental health outcomes.

Moreover, Wright et al. (2008) found an association between offence-related guilt and anger regulation. However, they found higher levels of offence-related guilt were positively associated with the ability to control anger. Contrary to the two papers above, this outcome suggests guilt may, in some circumstances, relate positively.

Offence Circumstances

Three papers reported findings concerning circumstances surrounding an offence and feelings of guilt (Crisford et al., 2008; Fox & Leicht, 2005; Xuereb et al., 2009). Crisford et al. (2008) found the severity of violence within an offence did not affect guilt (r=.01, p=.87). Conversely, Fox and Leicht (2005) found the highest feelings of guilt for the most severe offences, namely murder. However, a psychologist, not the individual, completed the associated measure.

Both papers also explored the impact of victim type on subsequent feelings of guilt. Crisford et al. (2008) found unknown victims to be associated. T tests indicated participants who did not know their victims had higher levels of guilt. It was, however, suggested this caution should be taken because the sample consisted mainly of individuals with sexual offences against unknown victims, and this may account for elevated guilt cognitions. Interestingly, Fox and Leicht (2005) somewhat contradict this finding, proposing higher guilt attributions are observed when victims are well known (F (2, 62) = 2.80, $p=0.07$) although this finding is not statistically significant. This suggests victim type may benefit from further exploration.

Both papers scored highly when quality assessed, although Crisford et al. (2008) scored one criterion more. The difference being they suggested some control for confounding variables, although details of this were limited. Both papers also used the GBAI as a measure, so any differences cannot be attributed to this. However, in acknowledgement of Crisford et al. (2008)'s caution for the sample, this may pose a reason for the difference in findings, particularly as Fox and Leicht (2005) had no sexual offences due to intentional exclusion. Thus, depending on the offence type, the victim type may impact feelings of guilt. Offence type appears important, and this is consistent with the final paper within this theme. Specifically, Xuereb et al. (2009) concludes individuals with sexual offences had higher feelings of guilt. Thus, offence type appears an important consideration.

Personality Styles

Personality styles emerged as a theme across two papers, which focused on feelings of guilt (Batson et al., 2010; Fox et al., 2003). Both reported on different personality styles; Batson et al. (2010) reported on psychopathy, whilst Fox et al. (2003) reported on psychoticism. Whilst different constructs, Fox et al. (2003) suggested psychoticism on the EPQ-R (The Eysenck Personality Questionnaire-Revised) is construed as a psychopathic trait, thus there is some overlap.

Batson et al. (2010) reported no positive correlation between psychopathy and feelings of guilt (r=-.018, p>0.05). Fox et al. (2003) reported a negative correlation between psychoticism and guilt (r=-0.39, p<0.05), a medium strength correlation. This suggests when one increases, the other decreases, implying individuals with such traits may be less likely to experience guilt. As mentioned, psychoticism and psychopathy are not the same constructs; although some overlap (Eysenck & Gudjonsson, 1989, as cited in Fox et al., 2003).

There were many similarities between the two papers in terms of population group, offence type, and both used the G-BAI. However, different measures were utilised, and there

was no direct measure of psychopathy in Fox et al. (2003). Batson et al. (2010) used the Psychopathy Checklist- Screening (PCL-SV), a scale considered to have good to excellent reliability (Maguire et al. 2025). Whilst Fox et al. (2003) used EPQ-R, which, although replicated across cultures, appears less reliable (Wilson & Doolabh, 1992; Scheibe et al. 2023) and is not intended to measure psychopathy. Thus, the findings from Batson et al. (2010), which suggest no significant correlation, may be best evidenced, although the authors raise this finding as surprising and suggest the distinction between primary and secondary psychopathy is noteworthy. Further exploration seems necessary.

Unsurprisingly, Fox et al. (2003) also found those who scored more highly for psychoticism were also more likely to attribute blame externally for their offence. Similarly, Mandel and Dhami (2005) also found higher feelings of guilt are associated with attributing blame for an offence to oneself.

Overall, this section suggests mental health is associated with feelings of guilt. Individuals who experience trauma or depression difficulties, considered collectively as mental health, may also be experiencing guilt. Controlling anger can be a problem, however, guilt appears to have a positive association with anger regulation. The other factors around offence circumstances and personality styles require further exploration. Victim type seems to be an associated factor, although this differs depending on offence type. Offence type appears important to consider when exploring feelings of guilt. Similarly, features consistent with a diagnosis of psychopathy may be associated with feelings of guilt, but exploration of primary and secondary psychopathy appears necessary.

Lastly, while the above associations and correlations are noteworthy, they do not establish causality, and it is likely other, unexamined factors also play a role.

What are the factors associated with offence-related shame?

Mental Health

In line with the above findings, mental health was also found to be associated with offence-related shame in two papers. Mandel and Dhami (2005) found shame was positively correlated with psychological distress (r =.27, p < .02). This finding was established using the 20-item distress subscale of the Custodial Adjustment Questionnaire (Thornton, 1987, as cited in Mandel & Dhami, 2005), which measures the levels of distress experienced in prisons. Within the study, participants were directed to reflect on when they were caught for their offence. This finding suggests psychological distress, which is hereafter labelled under the theme of "mental health", may be an associated factor with offence-related shame.

Another paper explored the relationship between shame and anger (Wright et al., 2008). The authors reported offence-related shame was found to be associated with elevated levels of anger difficulties, suggesting the more shame felt by a person surrounding the offence, the more difficulties they may experience with anger. This finding further indicates a potential link between offence-related shame and negative mental health outcomes.

Taken together, these findings suggest offence-related shame is associated with mental health difficulties; however, given the limited number of studies and the correlational nature of the data, the direction and nature of this relationship remain unclear.

Potential Factors

The remaining factors are considered in isolation and so not reported as a theme. However, the findings of these papers still offer helpful insights, with further exploration necessary. One paper considered treatment motivation and its association with offence-related shame and guilt. Fuller et al. (2019) found offence-related shame was positively correlated with treatment readiness. However, the correlation between offence-related shame and treatment readiness was reported as small, but significant (r=0.130, p<0.05). Given this is the only paper

to report this finding, it would benefit from further exploration. Offence-related guilt was found to have a stronger correlation with motivation for treatment (r= 0.333, p<0.01) and readiness (r=0.383, p<0.01). These findings suggest offence-related shame and guilt may be associated with treatment readiness and motivation. However, in the absence of further papers, this association cannot be reliably concluded.

Another factor considered in isolation was thinking styles reported by Mandel & Dhami (2005). The authors found individuals with counterfactual thinking reported feeling more guilt than individuals with factual thinking styles. This suggests individuals more prone to consider alternatives to their actions, i.e., "what if", tend to experience higher offence-related guilt. This may be an expected finding, as guilt is often focused on behaviour, and this style of thinking emphasises alternatives to behaviour. There was, however, no reported association with shame. This finding raises the possibility that encouraging counterfactual thinking about alternatives to crime could be associated with greater feelings of guilt. It is necessary to explore this further, but this offers a helpful consideration.

Given these findings, mental health emerged as the most prominent theme in this review's synthesis of offence-related shame and guilt. This prominence reflects the larger number of studies that have examined mental health directly, indicating it is the strongest factor overall. Offence circumstances was the next most evident theme, though this requires further exploration, as will be discussed below.

Discussion

This review focused on exploring the factors associated with offence-related feelings of shame or guilt in individuals with a conviction. Findings suggest mental health is the most associated factor with offence-related feelings of guilt and shame. Findings thereafter were less prevalent but noteworthy. Offence-related guilt was also found to have some association with offence circumstances and personality styles. No other themes were found for shame. These findings enrich knowledge of the prevalence and potential impact of moral emotions and their role in psychological interventions. Professionals may consider using this information to support individuals more effectively who access psychological support within the criminal justice system.

The review included eight papers, all quantitative. There was some overlap across the papers in identifying factors associated with offence-related guilt. The main themes were mental health, supported by three papers (Crisford et al. 2008; Fox et al. 2003; Wright et al. 2008). With offence circumstances a further identified factor across three papers (Crisford et al., 2008; Fox & Leicht, 2005; Xuereb et al., 2009) and finally, personality styles identified across two papers (Batson et al., 2010; Fox et al., 2003). The latter two, however, included mixed findings.

For offence-related shame, factors associated with mental health were again found (Mandel & Dhami, 2005; Wright et al., 2008). No other themes were identified, with two different factors suggested in isolation, treatment motivation and thinking styles (Fuller et al., 2019). These, require further exploration and will therefore not be reported on in the preceding section.

There was considerable gender disparity, with only two female participants, which is noteworthy. Similarly, there were differences across papers in the measures used. The ORSGS was used by two papers (Fuller et al., 2019; Wright et al., 2008) and the GBAI by four (Batson

et al., 2010; Crisford et al., 2008; Fox et al., 2003; Fox & Leicht, 2005). Both are well-established in the field, but as noted the ORSGS requires further validation.

Associated Factors to Offence- Related Shame

Offence-Related Shame is Associated with Mental Health

Mental health and the characteristics considered within this were the only emerging theme in relation to offence-related shame. Mandel and Dhami (2005) found shame was associated with psychological distress. This aligns with research that outlines the negative impact shame has on well-being (Lateef et al., 2023; Tangney et al., 1996). Similar findings have also been found in the general population (Candea & Szentagtai- Tatar, 2018), suggesting this is a well-supported finding. This speaks to the recognition that perpetrators of crimes can be affected by mental health difficulties such as PTSD (Soh et al., 2023). This knowledge is necessary to ensure trauma-informed approaches are taken in forensic settings. Similarly, the sense of being trapped can arise from feeling shame for an offence has been depicted as "moral pain" (Roth et al. 2021). The use of pain coincides with the findings of this review, whereby words such as distress and pain all highlight the negative association of shame and mental health.

Similarly, Wright et al. (2008) found offence-related shame was associated with increased levels of anger. This included the tendency to become angry and the expression of anger. As above, Hosser et al. (2008) have demonstrated the negative impact this has on well-being and risk. This suggests other emotions exist alongside feelings of shame. As before, moral emotions can be expressed through other emotions, such as anger (Seidler et al., 2022). Thus, anger and the difficulties that come with this are concerned with mental health and are associated factors.

This coincides with research in the general population where symptoms of anger were correlated to a range of mental health disorders (Barrett et al., 2013), which further demonstrates this link between anger-related difficulties and mental health. Research has shown heightened anger can increase difficulties relating to aggression and self-hatred, which are related to feeling shame (Hosser et al., 2008). This has significant implications for the individual and others. The reference to self-hatred may suggest where shame is present, exploring self-view may be beneficial. Research has shown shame is concerned with the view of self (Niedenthal et al., 1994; Tangney et al., 1996). This suggests it may be helpful for practitioners to explore this. There are many ways to do this. A commonly used psychometric is the Rosenberg Self-Esteem Scale (RSES) (Rosenberg, 1965). Given shame's link with a negative view of self and subsequent impact on mental health, this appears important.

The identification of this theme suggests mental health is an important consideration for practitioners. This theme coincides with existing knowledge in the general population and suggests this is shared by individuals with offences. Both papers scored well when quality assessed. Wright et al. (2008) found anger as an associated factor using a reliable and valid tool, ORSGS, although it was in the early stages of development. As above, many of the papers in this review did not specifically measure shame, therefore any findings relating to this emotion appear neglected. Despite this, mental health and feelings of shame surrounding offences are associated, with such feelings leading to negative implications for mental health. Both these papers suggest practitioners working with those who have committed a crime and who present with difficulties relating to mental health may also be experiencing shame. Thus, mental health should not be considered in isolation.

Associated Factors to Offence- Related Guilt

Guilt is Associated with Mental Health

Mental health was also found associated with offence-related guilt. Whilst three papers report on different elements of this, collectively they support mental health and the related difficulties as an associated factor. For instance, Crisford et al. (2008) found trauma symptoms to be associated, suggesting individuals who have committed an offence can experience trauma from this as well as guilt. Research has shown traumatic events have a transdiagnostic mental health consequence (Olff et al., 2025), and Crisford and colleagues' findings extend this to a forensic population. More specifically, they found increased guilt in participants with higher symptoms of PTSD, and this has been defined as trauma-related guilt (Browne et al. 2015). Similarly, Fox et al. (2003) found increased guilt in individuals with higher depression scores. Both suggest an increase in mental health difficulties is seen where individuals report higher levels of offence-related guilt. Like shame, this is not an exclusive finding to forensic populations.

In addition, Wright et al. (2008) findings demonstrate contrary to shame, guilt and its helpful association with anger. This was an important finding, where higher levels of guilt were found associated with the ability to control anger. Once again, this suggests guilt has an adaptive function in forensic settings. This supports the suggestion interventions aimed at increasing guilt, which decreases the likelihood of further harm (Taylor & Hocken, 2021), may be enhanced by managing anger.

The implication of mental health with guilt appears well established, and literature extends this to a range mental health difficulties. Browne et al. (2015) reported a correlation between distress, PTSD symptoms, depression, and guilt cognitions with veterans. Interestingly, they suggested demographic factors, such as age and gender, were not related, which is important to consider, given this review features males heavily. Regardless, the

findings of these papers, like in the general population, suggest mental health and guilt are associated, and this may also be applied specifically to offence-related guilt.

Offence Circumstances as an Associated Factor

Circumstances surrounding the offence were a further identified theme by three papers (Crisford et al., 2008; Fox & Leicht, 2005; Xuereb et al., 2009). Across these papers, the severity of the offence was considered. Interestingly, Crisford et al. (2008) did not find severity of violence to be associated with guilt, whilst Fox & Leicht (2005) found higher guilt for offences ranked more severe. These papers differ in that a psychologist conducted the severity ranking for Fox and Leicht (2005). This level of subjectivity means ratings can change depending on who is asked. Whilst not directly linked, research shows amongst psychologists, systematic errors of judgement are common (Iudici et al., 2015). Asking the individual may hold more relevance in understanding associated offence-related guilt. Further Crisford et al. (2008) scored more highly when quality assessed, although both scored well. For this reason, the findings of Crisford et al. (2008) could be considered more reliable, meaning severity of violence may not be associated with subsequent feelings of guilt, but this is not conclusive.

Both papers also explored victim type; however, they reported different findings. In Crisford et al. (2008) unknown victim was associated with higher feelings of guilt, whilst Fox and Leicht (2005) found higher guilt for known victims. Whilst they did not share findings, the differences seen suggest awareness of offence circumstances is important in this area and directly linked with guilt. Fox and Leicht (2005) excluded individuals with sexual offences and Crisford et al. (2008) cautioned their findings due to the inclusion of sexual offences. Similarly, the other paper in this theme, Xuereb et al. (2009), found those with sexual offences did score higher on guilt. Whilst it cannot be concluded which determines more feelings of guilt, this theme does suggest an association between offences and guilt.

Regardless, differences are seen across offence types, particularly in factors such as victim type. Offence type has been shown to hold weight in research. For instance, Espinoza (2020), a paper conducted outside the UK, found lower levels of guilt for those affiliated to a gang. This suggests this connection may protect against feelings of guilt regarding offences. As discussed, guilt has been seen to correlate with recidivism rates (Hosser et al., 2008) and so understanding how offence type implicates is crucial.

Personality Styles as an Associated Factor

Finally, personality, psychopathy, and traits related to this can be considered across two papers in relation to offence-related guilt (Batson et al., 2010; Fox et al., 2003). However, their conclusions differed. This is interesting as research has noted a connection (Gong et al., 2019; Nentjes et al., 2017). Batson et al. (2010) shared in the surprise of their finding, presumably also expecting to find reduced guilt in individuals with more psychopathic traits. They suggested their finding may be due to an absence of distinguishing between primary and secondary psychopathy. This indicates distinguishing may be important. Regardless, this theme is still presented as a potential associated factor, as there is a collective acknowledgement that psychopathy can be related to feelings of guilt about an offence and subsequently may inform treatment.

Fox et al. (2003) found guilt was associated with psychoticism. As discussed, this was not a direct measure of psychopathy; however, the authors suggest a connection between the two measures of these constructs. This has been found in further papers in which Hare (1982) reported psychopathy was significantly correlated with psychoticism but state this is likely due to The Eysenck Personality Questionnaire-Revised psychoticism scale and associated antisocial behaviour. Thus, the connection between these two papers and psychopathy is weak. Psychoticism, as a separate construct, however, is found to be associated with guilt.

Surprisingly, psychopathy did not feature more heavily, despite the research demonstrating well-established links between psychopathy and moral emotions. One reason for this may be the need to exclude studies outside the UK, where much of the research is conducted. For instance, Weizmann-Henelius et al. (2002) found women in a Finnish prison who scored high on psychopathy reported less guilt. Similarly, Johnsson et al. (2014) also found the same in their study of young males with violent offences in Sweden.

Further, much research appears focused on psychopathy in the context of adolescents who have committed offences. Spice et al. (2015) found an association between shame and behavioural features of psychopathy, whilst guilt was negatively related. Macías-Vasileff et al. (2025) also reported on an association of shame and guilt with psychopathy; however, this was in a community sample. Similarly, Mossiere et al. (2020) found a significant association between self-reported psychopathy and offence-related guilt, but not offence-related shame. This suggests psychopathy may be an associated factor when explored outside the UK and with population groups containing adolescents and community samples. This does represent a limitation to this review and an area for future research.

In summary, there was consensus among papers, and several factors were identified that can be considered associated with offence-related shame or guilt. Consistency across papers was limited; therefore, future research would benefit from exploring these factors further to determine if more robust themes can be identified. The predominant use of the GBAI and absence of specific shame measures, may reflect the unbalanced findings for shame compared to guilt. Therefore, consideration of shame appears quite absent.

The findings suggest areas critical to the clinical work completed with individuals in forensic settings, such as work around anger, trauma, and mental health, may be essential to understanding and working with shame and guilt. Further, understanding circumstances

relating to the offence may helpfully inform suspected levels of guilt. Similarly, whilst psychopathy appears inconclusive, this remains noteworthy. These findings can encourage the initiation of discussions surrounding certain areas (as identified) to better understand whether feelings of offence-related shame or guilt are present. Thus, in answering the aims, mental health is associated with offence-related shame. It is also related to offence-related guilt, as are offence circumstances and psychopathy, although need further exploration.

Strengths and Implications of the Review

A strength and practical implication of this review is it extends beyond these feelings in isolation. Instead, considering these feelings in relation to offences, which is crucial for more positive outcomes. Notably, it does so while including a range of offences, thereby extending the findings in Mottershead et al. (2024). This helps to explore the impact of guilt or shame regarding offences more closely, which is most important when considering the target population.

Awareness regarding offence-related shame and guilt is crucial. As discussed earlier, Fisher and Exline (2010) considered how individuals who have committed an offence may avoid expressing guilt rather than not feeling it at all. This was further highlighted by Mossiere and Marche (2021). They suggested shame is often the underlying state and is expressed through sadness and anger when avoided. Thus, if professionals do not acknowledge such feelings in interventions, this avoidance is maintained, and shame or guilt may manifest in further detrimental ways. Therefore, what clients outwardly express may not represent the underlying difficulty, and so treatment may be ineffective. Consequently, recidivism may be more likely (Hosser et al., 2008). This review is a step forward in ensuring professionals working with those who have committed an offence are aware of shame and guilt and seek to explore this.

Treatment needs are an important outcome. This is an area of increasing interest, whereby it is recognised individuals who have committed an offence can also experience difficulties, such as trauma, from offences (Soh et al., 2023) and, therefore, require support. The findings from Crisford et al. (2008) raise awareness of the repercussions of engaging in offence-related work and the risk of inducing guilt and trauma symptoms. This point is essential when considering the implications of failing to acknowledge guilt and the unintended negative consequences of therapeutic interventions, with safety in the work crucial (Taylor & Hocken, 2021). As such, the findings of this review can support professionals in being more aware of guilt and shame and their implications, ensuring they do not cause more harm than good. This review suggests there is scope for further exploration of therapeutic interventions, as Goffnet et al. (2020) indicated.

Limitations of the Review

This review was limited to papers from the UK as there are cultural differences in experiencing and responding to shame and guilt. For instance, it has been suggested the consequences of shame vary depending on a person's self-construal and the level of connectedness promoted in their culture (Wong & Tsai, 2007). They further discuss how the distinction of shame and guilt may be less applicable in cultures where interdependent self is emphasised. Thus, cultural considerations are relevant and can alter how shame or guilt is experienced. Limiting this prevented unknown impacts of differences in how shame or guilt is conceptualised and subsequently experienced by participants. Therefore, whilst necessary, some papers may have been excluded. As discussed, psychopathy would be an expected theme. A search was conducted focusing on psychopathy, which did not present any further papers. It appears UK based papers are almost absent in consideration of offence-related shame and guilt.

A further limitation is that, although several important themes were identified, the number of studies supporting a single theme was limited. This is likely a result of the variance across papers due to the absence of stricter inclusion and exclusion criteria. The criteria was kept purposely least restrictive due to the limited scope of the literature. Whilst, as above, this can be considered a strength in extending beyond a specific population, it makes it difficult to conclude upon the associated factors between types and with a greater evidence base. Alternatively, gaining an overview of shame and guilt across a mixed group of offences may be helpful.

Similarly, sample sizes were small, and inclusion of females was extremely limited. An absence of female representation suggests when concluding the associated factors, this cannot be extended to females who have committed offences. Although demographic factors such as age and gender are considered not related to feelings of guilt (Candea & Szentagotai-Tatar, 2018). Furthermore, participation was voluntary likely representing a particular group from the target population. Those who agree to participate may not accurately reflect those who do not. This presents a difficulty when considering the motivation of shame to hide or conceal, as those who did not participate may be experiencing higher levels. This presents a challenge in research in this area, as participants may represent individuals at different stages through the criminal justice system, which may alter their attitudes and moral feelings. However, Merecz-Kot et al. (2020) found time spent in prison did not affect moral attitudes, so this might suggest otherwise. Despite this, the findings should still be taken with caution, considering the sampling strategies and response bias.

In addition, the papers included several mental health diagnoses, a variability that could not be controlled for. This means the findings of this review relate to a specific group of individuals with offence-related guilt or shame. This may offer some explanation for why mental health prevailed as an overarching theme. Of course, this extends the review to

individuals who have committed offences and have mental health diagnoses; however, the vast range makes it difficult to conclude. In particular, the diagnosis of Schizophrenia featured heavily although it's implications upon findings were not reported on by authors. This high prevalence may be due to the predominant inclusion of males. It is recognised they receive this diagnosis more than females with the ratio 1.4:1(male: female), (McGrath, 2008). Nonetheless, this could be a limitation of these findings.

Lastly, the author's potential bias due to their direct work with CFT and previous role is noteworthy. However, dual coding of the papers limited this potential. The quality assessment tool does not consider bias in-depth; so the biases the individual papers may have been subjected to was not explored in detail. Despite this, the factors found indicates feelings of shame and guilt within forensic populations are prevalent and complex. This is a significant strength of this review as it supports the need for awareness and understanding.

Future Research

It is suggested further research explore specific offence-related shame or guilt across types of offences using randomised controlled studies. This would enable the use of groups controlled by different offence types to allow for comparison. This could also include use of control groups receiving an intervention for shame or guilt. Similarly, future research should consider conducting qualitative research that focuses on hearing the voices of individuals experiencing offence-related shame or guilt. This would prove valuable in understanding the complexity of these feelings further.

Several papers demonstrated mental health to be a key associated factor to both offence-related guilt and shame. This finding suggests exploring the associated factors to mental health could be advantageous in providing a more in-depth understanding.

Furthermore, several studies recruited high proportions of participants with severe mental illness. Given the association between schizophrenia and guilt (Keen et al., 2017), estimates of offence-related shame/guilt may partly reflect diagnostic rather than offence effects. Future studies should report the diagnostic mix and, where feasible, recruit comparison groups without severe mental illness.

Findings on psychopathy were inconclusive. Future studies should distinguish primary from secondary psychopathy and examine cross-national samples. Although psychopathy may relate to offence-related shame and guilt, evidence here was limited.

Nonetheless, this review highlights the complexity of these emotions and identifies associated factors relevant to practice. Further work should map how shame and guilt present after an offence and test how interventions can respond. The importance of this has been demonstrated (Garbutt et al., 2023).

Recommendations for Practitioners

An interesting challenge for practitioners is ensuring they correctly distinguish between shame and guilt; considering definitions raised earlier essential. A simple distinguishment is that shame surrounds the view of self, and guilt surrounds the behaviour (Niedenthal et al., 1994). Distinguishing is important as prior research, and this review suggest guilt and shame affect treatment differently. The adaptive forms of guilt have been demonstrated to reduce factors that may be associated with increased risk of harm, i.e., anger (Wright et al. 2008). Shame, however, appears only to have difficult outcomes.

A recommendation for practitioners in practice is it may be helpful to routinely use measures that consider these factors to understand an individual's feelings of shame and guilt. Of course, caution is necessary regarding psychometric measures as issues such as response bias arise (Kreitchmann et al. 2019). However, psychometrics can still be beneficial in

recognising, working with and measuring reductions in shame and guilt; this review emphasises this is essential. The use of psychometrics in this area will be further explored in Chapter Four.

Furthermore, understanding the circumstances of an offence and seeking to explore the association with offence-related guilt is recommended for practitioners. This review demonstrated a mix of findings, suggesting this is complex and may vary. Alike, psychopathy also appeared complex. Where practitioners have an awareness of such traits, thought should be given to its potential impact on guilt and subsequent recidivism.

Mental Health

Throughout this review, the identified themes highlight factors practitioners may consider in practice. Mental health was a significant finding and suggests the presence of trauma symptomatology may indicate vulnerability to experience feelings of guilt or shame (Crisford et al., 2008). This poses an important direction for professionals, suggesting the importance of assessing the presence of trauma before the commencement of any work undertaken. There are several measures available, such as the Impact of Events scale (Weiss & Marmar, 1997), which may support more significant presentations of trauma symptoms relating to PTSD. Alternatively, the Adverse Childhood Experiences (ACEs) questionnaire may be more appropriate for understanding the presence of early adverse or traumatic experiences (Felitti et al., 1998). This is important to ensure the influence of trauma upon shame or guilt is accounted for.

Further, as discussed, practitioners should not consider mental health in isolation. This review has demonstrated that this is often associated with both offence-related shame and guilt. Thus, to only address more obvious mental health difficulties, such as anxiety, would do a disservice to the difficult and often more discrete shame and guilt. Again, the use of measures to initiate discussions within practice supports this. The ORSGS, which seeks to explore

offence-related shame and guilt specifically, may be a helpful tool and will be explored in Chapter Four.

Conclusion

This review suggests factors associated with offence-related shame and guilt. Mental health was found to be related to offence-related guilt. Circumstances surrounding the offence and personality style, specifically traits consistent with psychopathy, were also linked to guilt, but this appeared less robust and requires further exploration. For offence-related shame, mental health emerged as the only consistent factor.

Importantly, this review highlights guilt can have both positive and maladaptive outcomes, reinforcing the importance of considering this in practice. Furthermore, findings suggest offence types and victim characteristics may influence how guilt is experienced and should be considered in clinical practice.

This review highlights the importance of feelings of shame and guilt in forensic populations. Whilst subject to limitations, to our knowledge, this is the first review to consider offence-related shame and guilt across a range of offences. Therefore, it begins to expand knowledge in this area. It is hoped this review can help professionals support those accessing psychological support in the criminal justice system more effectively.

This review suggests we must continue to explore and understand shame and guilt in forensic clients, as without this, we may not be targeting core difficulties. In support of this, Chapter Three will focus on participants' lived experience of shame. This will give further insight into the phenomenon.

CHAPTER THREE

Research Project

Understanding Shame Experienced by Clients Engaging in a Mental Health Treatment Requirement (MHTR)

Abstract

Feelings of shame are often associated with negative self-perceptions and have a negative impact on a person's ability to seek help. This research aimed to understand how shame manifests in participants' lives and how shame influences their engagement with the Mental Health Treatment Requirement (MHTR). These entail the delivery of 6-month therapeutic interventions aimed to improve the mental health of individuals who have committed an offence. Feelings of shame in this context have not been explored; however, research has demonstrated their presence in the process (Tremlin & Beazley, 2022). Semi-structured interviews were conducted with five MHTR clients who each committed various offences. Interpretative Phenomenological Analysis (IPA) revealed three themes: *Stuck in Feelings of Shame, Experiences of Opening up,* and *Moving Through Shame.* Participants spoke about the difficult impact of feeling shame and their experiences of being open about their offences and feelings. Participants also shared their personal experiences of moving through shame, instilling hope for the change that can be seen. This research demonstrates the crucial role shame can play in therapy and forensic populations. Facilitating openness is one clinical implication of these findings. This and other implications are elaborated on for practitioners within MHTR services and beyond.

Introduction

Mental Health Treatment Requirements

Mental Health Treatment Requirements (MHTRs) were introduced in 2003 in the United Kingdom's Criminal Justice Act. MHTRs are one of three possible treatment requirements that can be given as part of a community or suspended sentence court order (Callender, 2022). MHTRs consist of psychological interventions over six months on a 1:1 basis delivered by an MHTR practitioner, often an Assistant Psychologist. A clinical lead, usually a qualified Psychologist, supervises practitioners and oversees treatment delivery. Individuals sentenced to the court requirement have pleaded guilty in court for an offence for which community sentencing is appropriate and are believed to experience mild to moderate levels of mental health difficulties. This means the mental health needs of the individuals are not deemed to require secondary care input and can be supported through primary care services. MHTR services aim to improve individuals' mental health where there is a link between their mental health and offending behaviour.

The Importance of MHTRs for Individuals and Society

MHTR services intend to address underlying factors such as mental health difficulties that may contribute to offending risk, with the hope of reducing the likelihood of re-offending behaviour. Additionally, MHTRs aim to prevent the use of short custodial sentences. The Ministry of Justice (2015) found individuals who receive short-term custodial sentences are more likely to re-offend. Whilst limitations are noted, such as the sole use of administrative data to obtain these results, this suggests the benefit of addressing offending behaviour whilst remaining in the community.

The importance of MHTRs has also been highlighted through research. For example, Callender (2022) stated few community services offer appropriate treatment for individuals who require mental health support and have committed an offence. This remains a problem as it is well documented that individuals with mental illness are disproportionately represented at all stages of the criminal justice system (Vogel et al., 2014). Furthermore, the National Institute for Health and Care Excellence (NICE, 2017) estimated 39% of people in police custody have some form of mental health disorder. This largely supports the provision of MHTRs and emphasises the need to support those with both mental health and offending difficulties.

In further support, Pope (2013, p. 44) reported, “Individuals with serious mental illness are overrepresented in the criminal justice system and face difficulties accessing mental health services”. It could be speculated through a lack of the right treatment and access to services, mental illness becomes more severe. Moreover, research has demonstrated time spent in prison worsens mental health and the effects of this experience persist after release into the community (Cunha, 2023). MHTRs can be viewed as a proactive approach to preventing the worsening of an individual's mental health by addressing underlying factors early, potentially reducing the need for imprisonment. Such factors include homelessness, substance misuse and general well-being. Supported by a collaborative approach with MHTR practitioners, probation and partner agencies, these efforts can improve mental health. Therefore, MHTRs can proactively address gaps in service provision by supporting those with mental health and other vulnerabilities. Thus, this research is part of an evolving and essential service.

Previously Published MHTR Research

To date, there is little research in this area; however, some existing research has explored the use of MHTRs (Fowler et al., 2020; Long et al., 2018) and the experiences of engaging in an MHTR (Butler & Ledwith, 2021; Manjunath et al., 2018). Findings generally

show positive outcomes; Fowler et al. (2020) found a significant improvement in anxiety, depression, general distress, and social functioning at six-month follow-up. Long et al. (2018) also found similar significant findings, including improvement across problem-solving, emotional regulation and self-efficacy measures. Both studies used the same psychometrics pre-intervention and post-follow-up, and it is positive findings were replicated. Whilst there was some consideration of the validity of measures, there use with a forensic population was not. Thus, their application with this population would benefit from further exploration. Additionally, as with all MHTR research, small populations were used, which the authors noted as a limitation. Despite this, it is promising that initial research has reported such improvements for MHTR clients.

An overall positive view of engaging was reported by MHTR clients in Butler and Ledwith's (2021) study, including being able to open up, trust and develop enlightening connections with their practitioner. Similarly, Manjunath et al. (2018) found improvements in overall motivation levels among participants. It is important to note Butler and Ledwith (2012) suggested a limitation in which individuals were contacted one month following completion. They suggested a study of the longitudinal impact would be more beneficial. However, MHTRs remain relatively new, so with time longitudinal research could be more easily carried out. Manjunath et al. (2018) also noted an important consideration, the experiences of those choosing to participate may differ from those unwilling to share their story. Despite the identified limitations, each study demonstrates the profound impact engagement with an MHTR service may have and further highlights the importance of MHTRs.

Although promising, there is limited published research surrounding MHTRs, which informed the rationale for this research project. It is crucial to note MHTRs are reported to represent less than 1% of all community sentences (Saleem & Blott, 2022). Thus, increasing research in this area can raise more awareness of this sentencing option. Whilst this research is

not necessarily aimed at increasing awareness, this qualitative piece of research is hoped to positively contribute to the evidence base. The current research explores experiences of shame among individuals engaging with a six-month MHTR. Manjunath et al. (2018) considered the views of individuals engaged with an MHTR and found most felt it helped their motivation and access to services. However, there was also a sense of stigma surrounding being under an MHTR order, which may have impeded outcomes. This is relevant to the current research, where shame and stigma may overlap.

The Distinction Between Shame and Guilt

Shame has been labelled the "master emotion" (Martens, 2005), the underside of narcissism (Morrison, 2014), and as discussed in Chapter Two, has been considered to fall under the category of *moral emotions*. Moral emotions can include guilt, shame and embarrassment and have included other emotions such as gratitude and pride (Tangney et al. 2007). Tangney and colleagues have suggested moral emotions are important to upholding moral standards and decision-making which impact behaviour. Hence, research is essential, particularly when considering offending behaviour. Similarly, Kroll and Egan (2004) emphasised the importance of moral emotions, how they arise from life experiences and daily choices and how they impact perceptions of the rightness or wrongness of actions. All these authors emphasise the need for greater understanding of moral emotions critically within forensic practice.

Shame is often used interchangeably with guilt (Nouri, 2013). The dimensionality of both emotions has been explored, for example, Harris (2003) suggested a distinction between guilt and shame is unnecessary, whereby in their study of 900 individuals, a large sample size, they found no distinction. This interesting debate does not appear well supported however, as most research continues to emphasise a distinction. Miceli and Castelfranchi (2018) outlined

that whilst guilt and shame hold similarities, the distinguishing factors are the type of self-evaluation, where shame focuses on the ideal self, and guilt, is about moral standards and responsibility. The current study maintains the distinction, considering shame in isolation. It's important, however, to remember that the dimensionality of shame and guilt may influence the responses given by participants. This may also be relevant when considering participants' knowledge of the two emotions, which may be unclear (Tangey, 1996). However, at the start of the research interview, participants were provided with a definition and distinction of shame and guilt to address this.

Aside from the above, there is a growing interest and research surrounding shame. As Velotti et al. (2016) depicted, interest has been increasing in experiences of shame and its association with psychological functioning, well-being, and maladaptive outcomes. They found that shame was consistently associated with low self-esteem, hostility, and psychological distress. This suggests the need to acknowledge shame within intervention planning, as targeting factors such as self-esteem without understanding the underlying cause may make psychological treatment ineffective. This was further supported by Gilbert et al. (1994), who considered the importance of being aware of shame. They found shame was associated with feeling helpless, self- conscious and inferior as well as angry at self and others all of which can have pernicious effects. Similarly, Matos and Pinto-Gouveia (2010) found early shame experiences hold traumatic memory characteristics and found shame and depression are significantly related. Both studies emphasise the impact of shame, separate to guilt, and the importance of research in this area.

The Impact of Shame on Mental Health

Davidoff (2002) stated shame is "the elephant in the room" (p. 623), describing it as both big and disturbing and something frequently encountered. He suggested shame leaves a

person feeling exposed, inferior, or degraded and is the dark side of self- improvement, a slow and difficult process. Whilst in medical context it does give insight into the importance of shame more widely across fields. Gilbert et al. (1994) also considered the views of shame across research, with the main points being shame is a disturbance of self, public self-consciousness, self-other comparisons, and status judgements. The consequence being behaviours such as fear, avoidance, inhibition, compliance, and aggression. Each of these are likely to impact mental health significantly and subsequently may impact engagement with and outcomes of any psychological work as provided by MHTRs. This is supported where the impact of avoidance in therapy has been shown to interfere with emotional and cognitive processes and therapeutic progress (Meier, 2014). Behaviours such as avoidance may have adverse effects on treatment outcomes. Whilst concerning a different research area, Suurvali et al. (2009) found barriers to seeking help for gambling difficulties included shame. This is an example of how shame may prevent individuals from seeking and engaging in help, which is essential to MHTRs. Research has shown the impact on treatment (Glazier et al., 2015; Gott & Hinchliff, 2003; Wild et al., 2019) supporting the importance of understanding shame.

Whilst research has demonstrated the significant impact shame may have, Nouri (2013) suggested, across licensed psychologists, there still needs to be more appreciation for the importance of shame with forensic clients. Nouri (2013) suggests focus tends to be on guilt and remorse, with the emphasis on risk, eliminating some psychologist's attention to areas such as shame. Whilst some years ago, the suggestions remain notable. It is essential to support this awareness and understanding amongst practitioners. As a provider of mental health treatment, MHTR practitioners' awareness and understanding of shame is vital, as these findings suggest that shame can directly affect treatment outcomes.

Shame in Therapy

As outlined, MHTRs are a form of low-level psychological therapy offered to individuals who have committed an offence and experience difficulties in their mental health. Chapter two considered therapeutic interventions for working with feelings of shame noting that little has been specifically designed with forensic consideration. Nonetheless, shame more generally has been shown to play a significant role in therapy. Gilbert (2011) considered how shame influences the therapeutic process and how this may represent engagement difficulties. Importantly, shame also presents in the form of therapist shame. This has been defined as the "intense and enduring reaction to a threat to the therapist's sense of identity…" (Ladany et al. 2011, p.308). It manifests in different ways, including feeling shame if a client implies inadequacy. Therapists can react with external shame, a concern for how their client perceives them, as well as internal shame by reflecting on this inadequacy (Dearing & Tangney, 2011).

Further, Dearing and Tangney (2011) recognise shame may be the reason individuals seek therapy, but also be the reason why clients experience it, noting that needing therapy can induce shame. They note that clients who experience unacknowledged shame may feel misunderstood, and the importance of recognising and addressing within therapy. This supports one aim of this study, which is to explore how clients perceive the influence of shame on their MHTR.

As noted, engagement is significant, but this is further relevant given the court-ordered aspect of MHTRs. Shame defences in therapy have been explored, noting shame is often masked and can manifest as silence or compliance, which a therapist can misinterpret as a "good client" (Sanderson, 2015). Sanderson notes clients who use avoidance as a defence may present as challenging, thus creating barriers to developing a therapeutic relationship, which, as suggested, is crucial to working with shame (Clark, 2012). The literature supports why shame in therapy is a significant area and should be extended to forensic populations.

Feelings of Shame in Forensic Settings

Whilst there is little research on MHTRs and none considering shame, drawing on research that provides an understanding of the experience of shame in individuals on probation may offer relevant insights. In a study by Durnescu (2010), one participant reported feeling ashamed and being unable to discuss what they had done. In terms of interventions for mental health or offending programmes, if shame is felt, individuals may want to hide or conceal the shameful part of their offence. This may prevent resocialisation, exacerbate mental health difficulties, and interfere with the support offered as part of a probation order. Applying this to an MHTR context, which aims to address mental health difficulties where this is linked to offending behaviour, shame could impinge on the aim of addressing both mental health and offending. Exploring this further would be helpful.

Interestingly, Molyneaux et al. (2021) explored the views of professional stakeholders and found challenges were noted, including the complexity of clients' needs and the variation in motivation to engage with an MHTR. Exploring shame may support the understanding of how challenges with engagement in an MHTR can be addressed, with the possibility shame may be a contributing factor. As Durnescu (2010) suggested, those on probation may feel ashamed, which could be a cause of motivational issues; this may also apply to MHTR services. Despite these challenges, MHTRs are well-regarded by those aware of their service provision. Pycroft and Clift (2012) indicated MHTRs represent a rare, bespoke sentencing option that brings health and criminal justice together, something considered fundamental. Interestingly, they further proposed a need to explore how MHTR clients look to improve the quality of their lives. In fact, research has shown shame to be a predictor of scores on a measure of quality of life (Singh et al., 2016). The current study may highlight how shame is associated with a sense of quality of life and how a MHTR can support in improving this.

There is limited research on MHTRs and therefore, examining shame within the broader context of forensic populations provides insights relevant to the current study. Some time ago, Braithwaite (1993) presented two components to shame: *reintegrative shaming* and *stigmatisation shaming*. He stated reintegrative shaming communicates shame in a way that encourages desistance. The suggestion is that reintegrative shaming still communicates respect for that person. Stigmatisation shaming, however, worsens things when the person is treated as bad. Theoretically, this suggests societies will have lower crime rates if they communicate shame about crime effectively. Thus, it maintains a sense of respect for the person and encourages change. This adds weight to the need to be aware of the shame experienced by those who have committed an offence. Societal views on crime differ, and individuals who have committed an offence may often have experienced stigmatisation and shame and, therefore, have been treated as bad people. It should be noted, however, reintegrative shaming has been termed a "dubious concept" (Stokkom, 2002, p. 339). Regardless, it poses a thought-provoking point considering how MHTR services and the practitioners delivering interventions hold such experiences and feelings in mind. The idea of maintaining respect and encouraging change is a position practitioners should come from.

The key point Braithwaite (1993) makes is that others may treat individuals in a way that reinforces shame. In support of Braithwaite (1993), Knight et al. (2016) noted it is vital that a person responsible for harm is not shamed strategically. They suggested this results in stigmatising shame, reinforcing criminality and resistance to change. Furthermore, Mullins and Kirkwood (2019) concluded that criminal justice interventions might also strengthen shame by treating individuals as risky ("I am bad") rather than as having engaged in guilty actions ("I did wrong"). Individuals may feel hopeless if others do not distinguish between the two and consequently feel change is implausible. The narrative of being *trapped in shame* proposed by Roth et al. (2021), where feelings of shame can prevent individuals from moving forward, is

crucial. This is likely to worsen mental health difficulties and prevent work around offending, which may consequently increase the risk of re-offending. Mullins and Kirkwood (2019) however also highlighted the contentious issues of societal views on those who have committed offences. This speaks to the broader context which this research is situated. Nevertheless, this highlights one of the key reasons why the current study is essential for forensic psychology and the wider society.

In cohesion with society's views, those who have committed offences experience stigma; this is well known. Tremlin and Beazley (2022) indicated those who have committed a crime and have mental health difficulties are shown to elicit more negative stigmatic attitudes than those without. Clients of MHTRs have both committed an offence and experience mental health difficulties; such individuals may be some of the most stigmatised individuals in society. This places the role of the practitioner and the MHTR as vital to addressing and supporting individuals with such experiences, underscoring the importance of how practitioners relate to and leave their clients feeling. With stigma from others, self-stigma may also increase. This also overlaps with shame (Stynes et al., 2022) and has negative consequences. This may be important to treatment planning when considering compassion for self and inner- self-criticism.

The proposed area is meaningful when considering forensic populations, with the above demonstrating the potential impacts. Rew et al. (2022) explored offence-related trauma and found a theme of *Living with the Whole Me*. This considered the impact of offence-related trauma and shame on recovery and rehabilitation. Within the study, shame and the consequent anger towards the self, affected willingness to engage and a sense of being undeserving of help. They considered shame to be highly prevalent in forensic populations and played a role in treatment engagement, psychological recovery and offending. This links with findings of Suurvali et al. (2009) and suggests once more how shame can affect engagement with support. Lateef et al. (2022) also supported the need for research into shame in forensic populations,

where involvement in the criminal justice system and having mental health diagnoses resulted in increased shame. Thus, it is plausible that those engaging in an MHTR are quite likely to be experiencing shame.

The implications of shame in forensic populations are well-researched. Shame has been cited as essential in developing and maintaining aggression and offending behaviour (Geer et al., 2000; Owen & Fox, 2011). Similarly, research has previously found offence-related shame is associated with elevated levels of anger (Wright et al. 2008). Moreover, shame has been associated with denial, substance use difficulties, symptoms of psychological issues and predictors of offence rates (Tangney et al., 2011). Each of these are significant in treatment but most importantly in reducing the risk of ongoing offending and poor mental health. As Tangney et al. (2011) suggested, moral emotions of shame and guilt may be a critical steppingstone to the rehabilitation process and the interventions delivered for those who have committed offences. Further, Webb et al. (2007) found shame was consistently correlated to poor psychological functioning.

Exploring feelings of shame with forensic populations such as MHRTs is necessary. As outlined shame is understood to be associated with the potential for harm to others (Garbutt et al. 2023). Nathanson's (1992, as cited in Garbutt et al. 2023) framework for understanding shame demonstrates one pathway to harm through shame-attack-other which involves pushing away the distress of shame and projecting onto another. This is noteworthy when understanding what may lead to offences.

The literature outlined supports why shame should be a key consideration in therapeutic work for this population. For individuals with sexual offences, shame has been used within treatment approaches under the framework of 'reintegrative shame' (McAlinden, 2005). Reintegrative shaming is characterised by disapproval of the behaviour but ongoing inclusion

and respect for the person (Braithwaite, 1993). This balance is necessary between practitioners and those who have committed offences. Within interventions for sexual offences, it has been shown that shame is associated with limited capacity for victim empathy (Marshall et al., 2009); thus, in the absence of addressing feelings of shame, it brings into question whether risk may remain. It is therefore implausible to ignore the profound effect of shame. Understanding more about shame and how it can influence the process of an MHTR, amongst other areas significant to the individual, is an integral part of the work that should be delivered.

Understanding shame is crucial in the context of MHTRs for several reasons. MHTR clients represent a unique group from other groups with offences. While shame has been explored in other offending populations, MHTR clients represent a distinct group whose experiences warrant specific exploration - supporting the rationale for using IPA to capture their unique perspectives. More specifically, for some in this client group, it may be a first offence, or they may struggle with their mental health, now heightened by being sentenced to probation and hence, are vulnerable to feeling shame. Many MHTR clients experience other vulnerabilities, such as neurodevelopmental needs, homelessness and substance misuse. The isolation experienced by individuals on a community order highlights the uniqueness of this group. Shame is as a social emotion, marked by its feeling of threat to the social bond (Scheff, 2000). The isolation of being sentenced to a community order could be shame-inducing, whereas those affiliated with others having committed offences, i.e., in gangs, have been found to reduce shame (Espinoza, 2020). Similarly, participants have spoken about the transformational effects of being in prison, where they could work on their problems collaboratively, sharing emotional introspection and collective healing (Jewkes & Laws, 2021). This speaks to the principle of universality, something not afforded to those on an MHTR, leaving them potentially feeling alone in their experiences and ashamed.

A motivation for this study is that through experience of working in an MHTR service, the researcher has seen firsthand clients experience shame around the need for mental health support, but as demonstrated, this is not limited to MHTR clients (Rusch et al. 2014). The researcher also noted the shame experienced by clients, related to their mental health and was compounded by the knowledge this has, at times, led to their offences and the process of being arrested, charged and sentenced. Thus, exploring the role of shame could provide context for why and how to support individuals more effectively. As discussed, the influence of shame on self-stigma and barriers to help-seeking adds another layer of complexity to the feelings of shame MHTR clients may experience. Ultimately, the experience of shame has several consequences that, if ignored, will have significant implications for the individual and the systems surrounding them.

A review of the literature above clearly supports a need to better understand shame within forensic settings. Research has shown shame plays a part in re-offending and poor psychological functioning, both of which are reasons why an MHTR is given as a sentencing option. Thus, such outcomes may never be achieved without understanding or working with shame. Therefore, research must explore how shame relates to an MHTR and how it impacts the outcomes of interventions. Additionally, exploration with this specific group of people is valid because it supports the development of MHTR services. An in-depth exploration of this group's experiences of feeling shame is essential.

Research Aims

The discussed research has demonstrated shame as a critical area for individuals in the criminal justice system. As both Braithwaite (1993) and Mullins and Kirkwood (2019) suggested, how we treat individuals largely impacts feelings of shame. Furthermore, Roth et al. (2021) suggested individuals can become trapped in this feeling. Thus, understanding how

shame manifests in participants' lives and its influence on the MHTR process is essential. As chapter two demonstrates, literature concludes less on associated factors to feeling shame, this supports exploration of this feeling in research.

As the literature above indicates, shame can impact treatment uptake (Glazier et al., 2015; Gott & Hinchliff, 2003; Suurvali et al., 2009; Wild et al., 2019) as it may prevent individuals from seeking help. In the context of MHTRs, it is essential to consider experiences of participants and the role of shame in this. As Gilbert (1994) outlined, the consequences of shame can have a profound effect which may be detrimental to mental health if not considered. Thus, understanding how feelings of shame relate and if they were constructive or destructive within therapeutic work, and how this influences engagement in MHTRs and treatment outcomes, is important.

This research explores the lived experiences of shame among clients currently engaging in a six-month MHTR order. More specifically, the aim is to understand how shame manifests in participants' lives and how shame influences their MHTR. Two research questions were formulated to address these aims:

- How do participants experience and make sense of their feelings of shame?
- How do participants perceive the influence of shame on their MHTR?

Methodology

This study aimed to gain a rich understanding of the experiences of shame among MHTR clients. To achieve this an Interpretative Phenomenological Analysis (IPA) approach to data analysis was used (Smith et al., 2009). IPA analysis enabled the researcher to explore participants' individual experiences of shame while undertaking an MHTR, a unique group that had not been explored previously.

This analytical approach ensures a detailed exploration of the uniqueness of individualised experiences whilst capturing the convergence of lived experiences amongst the group. Whilst shame has been studied in forensic populations, this has not been done within this distinct group. IPA enables a deeper understanding and interpretation of how these individuals make sense of shame within this specific context. This is especially important where shame is often hidden or concealed and so interpretative engagement with the participants narratives is crucial. Existing research has shown insight into shame in offending populations, but these have not examined how shame is experienced within and through the therapeutic journey of individuals engaging in the MHTR service. For this reason, IPA allows for what is already known to be set aside and instead focuses on the individual participants' meaning making. Smith et al. (2021) support this, suggesting there can be a more open question as per this research: *How do participants experience and make sense of their feelings of shame?* Followed by a more theory-driven question- *How do participants perceive the influence of shame on their MHTR?,* which can then be answered at the interpretative stage. Thus, IPA allows for an existing understanding of a phenomenon and to engage with the theory surrounding this after the phenomenological account. As Smith et al. (2001) illustrate, IPA facilitates comparison between the understandings gained from the participant and constructs in the literature, and this is often elaborated upon in the discussion. Thus, IPA is well supported for the aims of this research.

This qualitative approach can also capture the variance of experiences seen amongst MHTR clients, such as offence type and mental health needs. As Noon (2018, p. 75) stated, a researcher using IPA aims to gain an "insider perspective" by "giving voice and making sense" of lived experience. As previously mentioned, shame is a complex emotion, and the qualitative approach to this research ensures that each unique voice is heard.

IPA holds three theoretical underpinnings: phenomenology, which focuses on studying an individual's lived experience; hermeneutics and idiographic (Smith, 2017). These underpinnings felt essential to the research as a framework whereby it was hoped to understand better the personal, lived experiences of participants engaged with an MHTR and their feelings of shame; a unique phenomenon to be explored. An idiographic approach ensured a focus on the subjective lived experience of a particular topic for each person, captured through interviews, while then noting similarities across the group (Love et al., 2020). Through the hermeneutics underpinning the theory of interpretation, IPA recognises the interpretation of the participant and the researcher. This double hermeneutic process by which the researcher interprets the participant's interpretation of their experiences (Montague et al., 2020) is particularly relevant when considering the researcher's previous role within an MHTR service and the potential for the interpretations of data to be influenced by this.

Participants

Five participants, three males and two females, between the ages 30 and 50, were recruited for the research. Their offences included sex offences, possession of a bladed article, drink driving, and arson. Their mental health diagnoses included Borderline Personality Disorder, Anxiety, Depression and Attention Deficit Hyperactivity Disorder.

Smith et al. (2009) suggested there is no ideal sample size for IPA, but smaller sample sizes are usually utilised. Clarke (2010) indicated between four and ten participants is advisable for professional doctorates; this study interviewed five. A small size was expected due to the nature of the research, and although there were difficulties in recruitment, this was not a result of participants declining but due to one service having an entirely new team of practitioners.

All participants were meticulously selected by their practitioners, who were instructed to use detailed inclusion criteria to reduce potential biases (Appendix H). All participants who

met the criteria were approached and they all accepted to participate. Thus, there was no self-selection bias. The inclusion criteria were established to prevent selection based on perceptions of suitability, which can be influenced by factors such as engagement, thus introducing selection bias.

Table 6
Inclusion and Exclusion Criteria

Inclusion and Exclusion Criteria	Rationale for Criteria
Low-level risk of harm and no alcohol or drug difficulties.	This was necessary given the acknowledgement of the harmful impact of shame and the recognition that, by the nature of talking about this feeling, can induce it. Thus, the researchers felt it would be irresponsible to include anyone where there is a level of instability that, in talking about shame, could be destabilising and increase the potential for harm. Whilst this could be considered as potentially excluding some participants, which will be considered later, it is important to be reminded that this research was being conducted within a primary level service. Primary level services are the first line of support for more common mental health issues that do not require secondary, more specialised input. By nature of a primary level MHTR, clients should not have a high level of risk; thus, this research should not have excluded anyone on this basis. Similarly, participants should not be experiencing significant levels of difficulties

	with alcohol or drugs when attending their MHTR sessions. Instead, they will engage with an alcohol or drug treatment order before commencement of their MHTR.
Must also have attended at least two MHTR sessions	This was to ensure that practitioners a good understanding of the person and if they met the inclusion criteria.
Have capacity to consent and be English-speaking	To ensure participants understood the research and make an informed decision about their participation. English language was necessary due to translator restraints.
Not be pregnant	Due to ethical constraints.

Practitioners were asked to discuss any prospective participant with the clinical lead of the service to ensure the criteria were met. All participants except one engaged in a face-to-face interview; one was interviewed via Microsoft Teams.

All participants were clients on an MHTR receiving psychological input and were at least halfway through their MHTR sessions or near completion of their treatment programme. Thus, the sample was homogeneous in this regard. Beyond this, IPA does allow for some flexibility, and participants differed across offence type and mental health diagnosis or difficulties. Whilst IPA usually seeks a homogeneous participant group, this is difficult to arrange within an MHTR service due to multiple variations in offence type and mental health difficulties of clients within the service. However, homogeneity also emerged from being sentenced to an MHTR and offence-related experiences of shame. These qualities are directly related to the study aims.

All participants were given a pseudonym, and any further identifying information has been removed. Table 7 provides a complete overview of participant demographics.

Table 7
Participant Demographics

Participant No.	Age Range	Gender	Number of MHTR sessions
1	30-40	M	6
2	30-40	M	10
3	41-50	F	7
4	41-50	F	7
5	41-50	M	10

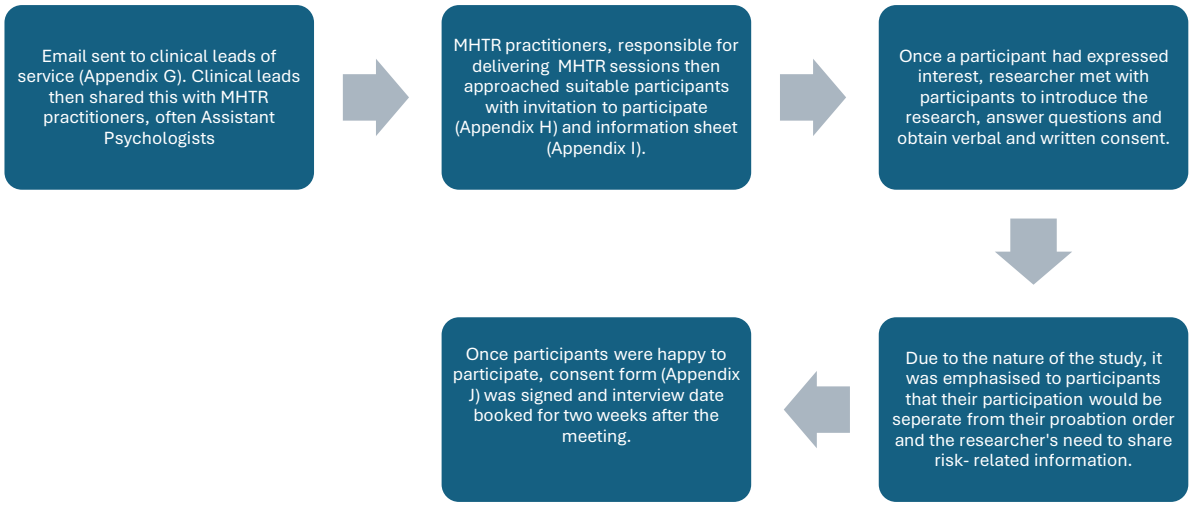
Note: M = male, F = female

Procedure

Stage 1: Recruitment and Consent.

Participants were recruited from two MHTR services in the UK, with whom the researcher had no prior relationship. The recruitment process is shown in Figure 5.

Figure 5
Stage 1: Recruitment Process

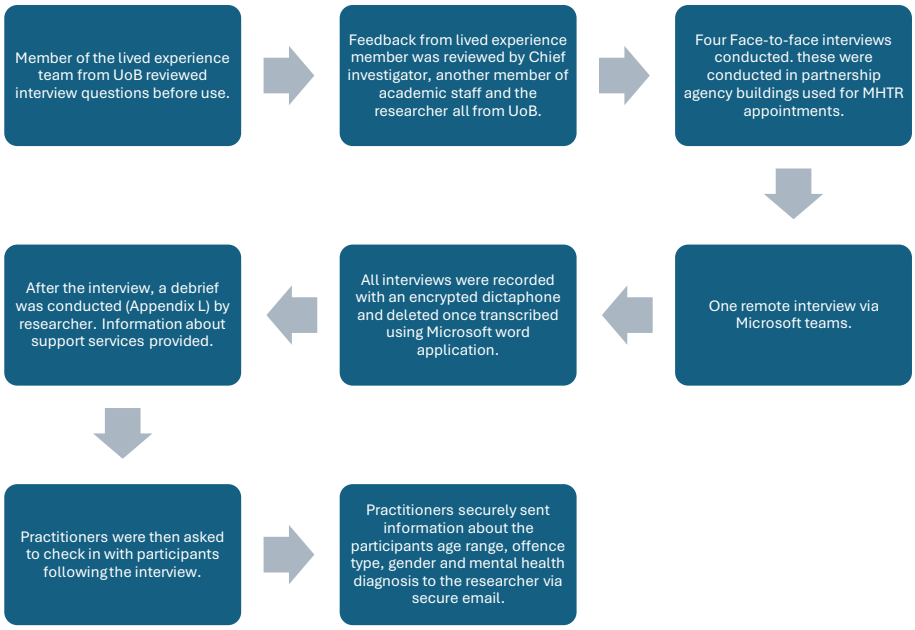


Note. This figure shows the process taken to recruit participants.

Stage 2: Data collection.

The process is detailed in Figure 6. Appendix L outlines the semi-structured interview, which aimed to guide the interview, rather than impose a rigid structure from which the researcher could not deviate. Therefore, further questions were asked to derive rich data. Interviews lasted between 26 and 45 minutes. One participant opted for his practitioner to be present in the room, whilst the rest were conducted privately. This is noteworthy regarding findings.

Figure 6
Stage 2: Data Collection



Note. This figure presents the process taken for data collection.

Data Analysis

Table 8
Step-by-Step Process of Analysis as Proposed by Smith et al. (2009)

Stage 1	Reading each transcript individually, line by line and several times. This ensured the researcher immersed themselves in the transcript by reading and re-reading
Stage 2	The researcher began to identify how a participant talked about, thought about, and experienced the topic. At this stage, exploratory notes were made and annotated directly onto the transcript. Exploratory noting helped to begin to construct experiential statements, statements relating directly to the participant's experiences. This then helped to begin identifying initial themes considered significant elements of the transcript, such as points that appear relevant to the research topic and aims.
Stage 3	Experiential themes were printed out and cut out, organised into groups of similarities and given an overarching name. This was how personal experiential themes (PET) were identified; a table detailing each PET and their subthemes for the participant was created (Smith et al., 2022). This was then repeated for each transcript. For the first participant this was then brought to

	supervision, to offer guidance on the process and consultation was sought with an experienced IPA researcher at the University of Birmingham, once again for guidance.
Stage 4	To generate group experiential themes (GETs), the individual PETs were explored to consider similarities and differences within the group. Similarities included the frequency of expressions across transcripts and the topic's relevance. Different groupings were conducted until those that fit together best were established when comparing themes.
Stage 5	A master table of GETs (Appendix P) was then generated that reflected the group's experiences while still noting the individual experiences. This was then brought to supervision to ensure accuracy.

Ethics

This study received ethical approval from the Health Research Authority and the University of Birmingham Research Governance (IRAS ID: 320029). All procedures followed the approved protocol, including informed consent, the right to withdraw, confidentiality, secure data handling, management of distress/risk, and researcher/participant safety. Participation was voluntary and had no bearing on criminal-justice order (See Appendices J, K, M). Appendix N details ethical considerations further.

Validity of the Research

The emphasis on interpretation within IPA presents a level of subjectivity to this research, and there was potential for the researcher's experiences to influence the interpretation of the results. As the researcher was previously employed in an MHTR service and worked directly with MHTR clients, there was potential for interpretative bias. To ensure the validity of this research, supervision with both the researcher's supervisor and an experienced IPA

researcher helped to mitigate any unhelpful influences. Similarly, a reflective diary was kept during the analysis to note where previous experiences of working with MHTR clients were being brought into interpretations made (See Appendix Q).

Further, as has been discussed conceptualising shame and guilt raises some debate. To ensure participants were clear on the descriptions of shame and guilt, how these differ and to support focusing on the correct emotion throughout the interview, descriptions were given at the beginning. These descriptions are included in the semi- structured interview outline in Appendix L. Throughout the interview participants were also reminded of the simple distinguishment by Niedenthal et al. (1994), shame – "I am a bad person" versus guilt- "I did a bad thing".

Researcher Position & Reflexivity

As a previous MHTR practitioner, I recognised the challenge of staying neutral, given I feel passionately about MHTR services and their benefits. I was aware previous client's openness regarding shame might not be reflective of participant's experiences in this study. This posed an interesting position, and both roles gave me a unique yet essential perspective in this research. Whilst I have never committed an offence or received an MHTR, I have a level of understanding many who have not been an MHTR practitioner would not. I have seen the distress underpinned by feelings of shame resulting from offences committed. I have seen the varied responses clients have at being sentenced "to do" therapy as well as the moment they realise it is not simply a task on the "to do" list but a shared attempt at making things better.

The ontological stance taken in this research was a critical realist position. The recognition that shame exists as a phenomenon, but is individually constructed through our unique experiences, which may result in it being interpreted differently by each person. This

research focuses on the deeper, underlying mechanisms that influence how each person experiences shame.

The recognition that shame may have different meanings and experiences for each participant was reflected in the development of this study. I recognised early on I believed shame would impact the MHTR. I have worked with several clients who presented with difficulties surrounding shame and have seen this as problematic to treatment outcomes. To minimise the influence of these preconceptions on data analysis, I engaged in close supervision to reflect on my interpretations and to ensure themes were grounded in the participants' accounts. Through this process, a collaborative agreement on themes was sought to maintain rigour and reduce the risk of bias.

I was also mindful as a psychologist in training, I needed to consider my role when conducting interviews, not as a psychologist but for research. As Noon (2018) noted, using active listening skills, empathy, and the ability to build trust and rapport with participants is essential, so core therapeutic skills were still required, but it was necessary to remain within the role of the researcher. Being aware of this before interviewing helped and a reflective diary was kept to further reflect on my position (See Appendix Q).

Results

Emerging from the interviews with the five participants were three group experiential themes (GETs): 1) Trapped in feelings of shame, 2) Experience of opening up, and 3) Moving through shame. The latter two GETs included subthemes. These themes illustrated a journey. Table 9 presents the GETs and a conceptual overview of each theme and subtheme.

Table 9
Group Experiential Themes, Subthemes and Descriptions

GETs	Sub Themes	Overview	Participant

Trapped in feelings of shame	N/A	This theme describes an overall sense of feeling trapped in feelings of shame, long-lasting effects, and shame being an all-consuming feeling.	Chris, Colin, Jane, James, Jenny
Experiences of opening up	Recognising a need to open up "It's a hard thing to talk about"	How participants experienced talking about feelings of shame, acknowledging a need to talk and the value of a stranger, "neutral perspective". Participants expressed opening up was a thing difficult to do.	Jenny, James, Chris, Jane James, Jane, Colin, Jenny
Moving through shame	Finding ways to look at it all differently	How clients worked through their feelings of shame by changing their perspectives and doing helpful things.	Jenny, James, Chris, Colin

	Feeling accepted	Participants appeared to have an overall sense of needing to feel accepted and to accept what has happened.	Jenny, Colin, Jane

A narrative summary of the themes is presented, and participants are referred to by pseudonyms rather than participant numbers because this presents data in a more personable way.

To start, each participant was asked to define shame and guilt. This was to ensure a distinction was established and to support participants in reflecting on shame, rather than guilt, during the interview.

Table 10
Participants Descriptions of Shame and Guilt

Participant	Shame	Guilt
James	"urm, you don't want to see anyone… urm you hid away, urm, you just, I don't know, you don't want to talk about, talk about it to anyone, it's a hard, it's a hard thing to talk about" (p.1)	"guilt is something you don't want to live up to… shame you want to work on it… but guilt is, you don't want to live to work on it" (p.3)

Jane	"shame is urm, err the feeling of being embarrassed to open up, to say how you feel" (p.1)	"I think there is a thin line, there is a difference but there is a thin line between the two of them. But urm, guilt I think is when you are found bang to rights on doing something and then urm, shame is completely different" (p.3)
Chris	"Shame, urm, not being proud of your actions, urm… so shame can mean different things to quite a lot of people, some it would be shame to themselves, to other people… I felt that they go quite hand in hand shame and disappointment" (p.1)	"Guilt is probably consciously doing something that you know you shouldn't, whereas shame, you could have done something" (p.4)
Jenny	"I would describe shame as being unhappy with a situation… shame I think is a personal belief of unhappiness, in choices" (p.1)	"I think guilt is a really hard thing because guilt you've got black and white, so you've got the law, so, whereas it's also down to someone's personal interpretation of what's right or wrong so what you believe someone's done wrong" (p.1)

Colin	"Not wanting to go out of my front door because people might know what I did"- couldn't separate self from the description. Immediately started talking about the shame he has felt" (p.2)	"Guilt is an admission, shame is something after the event, guilt would be admitting the event" (p.4)

Table 9 presents each participant's description. This supports the complexity of shame and guilt, with some descriptions indicating difficulty in distinguishing, or at least to articulate the two emotions. Two interesting patterns arose. Both James and Jane, once they had given their account of what shame is, immediately spoke of the importance of sessions. James stated, "maybe go to some more sessions… go to say talking therapy" (James, p.2). Similarly, Jane "People being able to open up in sessions like this is quite important" (Jane, p.1). This speaks to one of the GETs identified later.

A further theme was Chris and Jenny's account of shame as a personal experience. Both suggested this differs for each person. Although, there was consensus that shame is something to be hidden, unspoken, and difficult, which aligns with existing literature. Conversely, guilt appeared more difficult to describe and some participants appeared entangled in the realm of legal knowledge of guilt. The distinction between these emotions is noteworthy. Firstly, it demonstrates the importance of providing a definition to ensure a shared understanding of shame and a more accurate reflection of this throughout the interview. Secondly and, as will be discussed, issues around conceptualising shame and guilt remain significant in research.

Theme 1: Trapped in Feelings of Shame

This GET spoke to the overall impact of feeling shame and how this manifested in the participants' lives. Four participants, Chris, Colin, Jane and James, gave accounts suggesting an overall sense of feeling *trapped*. They expressed they experienced a period where they felt unable to move out of shame, with it being a long-lasting and an all-consuming feeling. Within this, there was an implicit understanding of the detrimental nature of the feeling of shame itself, as it negatively impacted their lives and well-being. The GET shows how these enduring feelings of shame affect participants' day-to-day lives, influencing their actions, interactions, and overall functioning.

James explained, "I don't think it's (shame) changed it; it's always going to be there" (James, p. 15). The expression of "always" suggests James sees it as a constant thing, which supports an overall sense of being trapped or kept in the feeling. This was echoed by Jane who stated, "you can get stuck in that feeling" (Jane, p.2). James also spoke of the feelings of shame being there every day:

> It (shame) will never change, that shame will never go… it will be there, probably for life, because you know if, you know, like you're really sorry about whatever happened that will be there for life you know you won't forget it. *(*James, p. 13)

This quote illustrates James's perception of shame as an inescapable presence in his life, suggesting he views it as an enduring burden. His mention of being "really sorry" introduces the possibility of guilt, reflecting feelings of remorse. However, James's entanglement of these emotions - feeling bad about what happened (guilt) and feeling bad about himself as a person (shame) - appears to blur the boundaries between the two. James emphasised his offence did not define who he is, yet he describes it as a recurring, daily thought, reinforcing a sense of

being trapped in this feeling and subsequent thoughts. This was a shared experience whereby Chris explained the detrimental impact of feeling shame on his view of self:

> If I sit down and wallow in my shame then it's just going to progress into more and more negative outcomes and it's going to make me, even if I'm subliminally talking about myself in a bad way it's just going to make me view myself as that. (Chris, p.17)

Like James, Chris viewed shame as a constant feeling that, if felt, has the potential to grow, his quote appears to represent internal shame. It may be Chris is suggesting a need to avoid engaging with feelings of shame due to this potential negative outcome. His thoughts highlight two potentially interconnected aspects: first, the risk of becoming "trapped" in the feeling of shame if he "wallows" in it, and second, the detrimental impact this would have on how he views himself, reinforcing a negative self-perception. Similarly, Jane talked about her feelings of shame leading to not feeling good enough and having thoughts of "I may as well, ppft, you know, not be around" (Jane, p.3). This suggests the intense feeling of shame as identified by Jane led her to feeling so trapped, she couldn't see her existence beyond it.

There was a consistent theme across Colin, James and Chris of shame being long-lasting. Colin also spoke of the negative impact of feelings of shame and how this is ongoing. Colin described himself as a "recluse" months on, which he considered may be a lasting result of feeling shame for what happened. Similarly, James spoke of the negative impact feeling shame has had on him moving towards his previously held future goals:

> I was quite a good footballer, urm and I just didn't want to pursue it anymore, because of that (shame)… just didn't want to leave the house, sort of get out of bed, or meet anyone (…) (James, p.16) I used to have a lot of dreams (…) (James, p. 6)

The above quotes represent how, for James, what happened and his subsequent feelings of shame prevented him from moving forward with his life and towards his goals. This again presents a sense of being held not only in the feelings caused by what happened but also in life.

Colin, however, was able to reflect on the change in feelings. He talked about shame being a big thing he had to deal with for months but being able to look back on it now. Again, the expression of months suggests the lasting effect of feeling shame, but contrary to the above, Colin appears to have moved through that feeling and sees it as something he looks back on rather than feels now. This felt poignant, as if feeling trapped in shame can and will change. Similarly, Jane appeared to find the initial feeling of shame so difficult that this motivated her to get out of it "I felt so much shame, it was so embarrassing, it kind of just spurred me on to not ever have that feeling again" (Jane, p.8). This suggests, instead of feeling trapped, the distress of shame provoked action, contrary to the known function to hide. Similarly, Jenny appears to suggest shame is a changeable feeling, pointing away from a sense of being trapped:

"So I can't change me feeling guilty, but I think shame is something that you can develop you can adapt, not adapt it, but you can kind of like work your way through your skills…" (Jenny, p.2).

This may represent what Chris and Jenny described in their descriptions of shame, it being something personal and unique. For three participants shame appeared long- lasting and enduring, for Jenny and Jane there is a sense of action and change.

For James, Colin and Chris, there was a consensus that feeling shame is negative. James reflected on how his feelings of shame manifested in "Isolation from people, urm not seeing my mates anymore [pause], urm not even talking to my family anymore, urm losing my jobs over it, yeah, just affected everyday life really" (James, p.6).

For James, shame affected his everyday life, again provoking thoughts of feeling trapped. This was a shared experience with Colin, who, as mentioned, describes himself as more reclusive due to his feelings. Similarly, Chris appears to suggest he avoids that "rabbit hole" of feeling shame, sadness and fear because of then being in it for "ages". Which once more, speaks to thoughts of being trapped in these feelings.

Overall, this GET presents the experience of feeling shame and how this manifested for these participants in their lives. Shame was described as a feeling that was long-lasting and all-consuming and had detrimental impacts on areas of life, that gave rise to a sense of being trapped. This was a shared experience between participants, although Chris appeared to place more emphasis on avoidance to reduce the potential for it to have a negative impact on him. Colin appears to have moved beyond his feelings of being stuck in shame - an emotion that was once all-encompassing for him. He now reflects on those experiences from a different place, suggesting that he no longer feels trapped by the shame in the way he perhaps once did.

However, James appeared to continue to experience shame and guilt, and he consistently articulated this had remained. Notably, James was at a slightly different session point in his MHTR, so it may be feelings of shame could continue to change, although James shared a sense of hopelessness about this being possible, "I'll always have, it'll (shame) always be there" (James, p.18).

This theme therefore represents the negative impact of feeling shame. It demonstrates, for these participants, how shame had a profound impact on their daily lives resulting from how they were feeling. Whilst this was not an everlasting impact for all participants, the strength and resilience shown by these participants when in the depths of feeling shame should not be underestimated.

Theme 2: Experiences of Opening Up

This GET points, in part, to the value of the MHTR services and how shame influenced the MHTR process. Participants spoke of finding it difficult to talk about their feelings of shame and what happened but recognised a need to do so. There were two subthemes within this overall GET, firstly, *recognising a need to open up* where four participants spoke of a need to acknowledge shame and talk about it, particularly finding talking to a stranger as helpful, pointing to their MHTR practitioners. The second subtheme highlights speaking about shame as difficult; "*It's a hard thing to talk about*" (James, p.1).

Subtheme 2.1: Recognising a Need to Open up

This first subtheme examines the participants' recognition of the need to speak about their feelings of shame, addressing the initial challenges they encountered and the significant sense of relief and personal growth they experienced because of opening up. Four participants contributed to this theme. Within this sub- theme, participants also go further to talk about the outcome of opening up. As Jenny stated, *"*I think it's good to be able to acknowledge it (shame) and have someone listen to you*" (*Jenny, p. 16). James also spoke of it being valuable: "I can see that it's helping… starting to help, letting your feelings out, urm speaking to people" *(*James, p. 11). Similarly, Jane said "I just wish everybody would see therapy and urm not feel shame at all in front of someone who is not your close friend, or you know, make it easier for people to speak about their shame" *(*Jane, p. 6).

For Jenny, James, and Jane, their own experiences of being able to open up in their MHTR sessions appear to have been helpful in their experiences of feeling shame, and there is a sense that this is needed. Chris shared a similar view when he talked about the impact of not opening up:

It's like for me, if I bottled all this up and felt about it, it would probably lead me to lash out and not control things because it would overtake your life a little bit if you keep worrying about it and worrying about it, it will ruin you (Chris, p. 23)

The opportunity to talk about their feelings and what has happened appears crucial. All four participants acknowledged this need, and as Jane suggests, "I would say open up, you won't lose anything" (Jane, p.9). Participants felt there was much to be gained from opening up. Interestingly, this group of participants were at similar points in their sessions where they have had several. This might be a need they can now recognise but may not have always been as open to. As Chris states, "yeah when I first started opening up and talking about what I had done, sure, it gets a bit like oooft, you do feel shame again" (Chris, p. 15). As such, initially, Chris felt at least an increase in shame at the point of starting to open up. However, he later reflects on this being helpful, which suggests he came to recognise the need;

Once you've told that and you realise no one will judge you any different it's like oh ok, I've been bottling that up and sitting on it for all this time and I've not needed too, so yeah, in my case, just getting out, be like, taking it, not trying to deflect it or justify your actions, or whatever, just say I've done it. (Chris, p. 12)

A big part of recognising a need to open up appeared to be about the person they opened up to. There was a general theme in Jane's experience where she spoke throughout of the value of talking to someone separate: "What helped was possibly urm speaking to someone who wasn't, urm, personally involved in my life, I was able to go, you know, this is me" (Jane, p. 5). She went on to say, "They have helped me a lot, because it's easier to open up to someone who is not urm immediate family or friends" *(*Jane, p. 6)*,* again supporting the notion of an MHTR practitioner, who is separate to her personal life, as helpful to be able to be herself and

open up. James echoed this when he expressed the advice he would give to future MHTR clients:

> Talk about how you feel all the time and or even talk to a stranger would be better than talking to someone you know, that might be yeah... a better way of coping with it, so it lets it all out. (James, p. 2)

For James, talking to his MHTR practitioner, initially a "stranger", allowed him to "let it all out", something he felt was valuable in coping. Again, this suggests that being open was needed for James, as it was for the other participants. Chris's advice was also to encourage others to seek help but from a "neutral perspective" as he found this helpful. Chris acknowledged that talking to certain people can be shame or guilt-inducing, but with a professional, he reflected, "You'll see how quickly it improves you" (Chris, p. 24).

Within this, participants reflected on the value of acknowledging shame as part of openness. Jenny reflected on other people's experiences, saying, "Some people choose not to acknowledge it (feeling shame), which in itself is sad" *(*Jenny, p. 5). She also said, "The system is so overwhelmed which [pause] if something could be done to fix it people would learn to acknowledge shame and talk about it which I think is really important" *(*Jenny, p. 7).

It felt for both Jenny and James through their experiences, they had come to appreciate the opportunity to be open and the importance of acknowledging feelings of shame and being able to talk about that with someone. As part of this, Chris and Jenny spoke about being honest and acknowledging it with themselves. Chris spoke at length about the importance of accountability, which is both helpful and unhelpful. He reflected on looking at himself in the mirror and this being where the shame came in; however, Chris also reflected:

It's just like, it's just bite the head off the snake, if someone doesn't want to hear it, even if it's not, just get it out there and tell it straight and you'll feel everything just start to relax a little bit."(Chris, p.10).

As mentioned above, Chris initially had increased feelings of shame from being open, but this was needed for things to feel improved. Similarly, Jenny reflected on the impact of not being open: "because if you're not honest, because the only person you're lying to is yourself and you're not going to get the right support" *(*Jenny, p. 22).

Overall, as part of this group of participants, the experience of opening up was firstly recognising a need to. However, as initially suggested by Chris, this was not always easy, which is further explored in the next subtheme.

Subtheme 2.2: "It's a Hard Thing to Talk About".

This subtheme explores participants' experiences of the challenges involved in talking about shame, including the emotional barriers and underlying reasons that make it difficult. For three participants, James, Jane, and Colin, opening up required overcoming feelings of fear, embarrassment, and the instinct to hide, which are deeply tied to the experience of shame. James, early in his interview, stated: "You just don't want to talk about, talk about it (shame) to anyone, it's a hard, it's a hard thing to talk about" (James, p. 1).

Jane shared this; she reflected on the initial experience of opening up, stating, "It was so difficult, obviously, seeing somebody new and say, oh this is how I feel to a complete stranger, it's hard" (Jane, p. 2). This was a particularly interesting reflection from Jane, whereas, above, she had consistently said it was helpful that it was a stranger. This quote, however, would suggest this perhaps was more difficult initially and possibly seen as part of a journey. For Colin, again, he shared the difficult experience, particularly highlighting how shame motivates a person to hide or conceal those shameful things: "it's going to be difficult

you know, you have to talk about things you don't want too you have to open up and say things you hoped people would never hear" (Colin, p. 15).

In line with this, Colin spoke during his interview of admitting his offence immediately. However, he noted following admitting to it, he tried to hide away as "the shame set in" *(*Colin, p. 4). This suggests each of these participants took courageous steps to battle against their feelings of shame and the desire to hide from it and instead, they were open and talked about it, which was difficult. Jane suggested shame is a feeling of being embarrassed to open up, "to say how you feel," (Jane, p. 1) which can make it difficult to talk about and recognise that shame prevents that openness; "People go into themselves and then just, or keep things to themselves and then don't want to because of the shame of it all" *(*Jane, p. 2). Chris did not speak to this theme, although he shared talking openly about his shameful experience to prevent incorrect facts being relayed, representing external shame. It seems for Chris, it was less difficult to do, as doing so felt necessary to preserve the facts – something that might prevent more shame. To the contrary, Jenny said she did not tell anyone about her offence due to feeling shame, stating "hated myself" (Jenny, p.5). This suggests whether it is the specific feeling of shame or the shameful experience itself, it is difficult and personal.

James also gave a further interesting reflection; he talked more specifically about the MHTR and how this was a new experience:

> Just not used to it, just not used to being in this situation… it's like alien to me, so it's hard to speak about it, haven't really done it my whole life either, I've bottled everything up, and that's probably, that didn't help either (James, p.13).

Therefore, for James, the element of this being new and his past patterns of not opening up emphasised it being a difficult thing to do. Similarly, Jane spoke also about, more specifically, the experience of being on an MHTR and opening up. She acknowledged "it's

hard to open up to things, oh no you're a thief aren't you, you know, you're a bad person" (Jane, p. 2) and this appeared to be more due to the fear of what others may then view her as. This suggestion of being a bad person is consistent with shame and again points to how shame can prevent a person from opening up. Jenny shared due to different processionals involved, she had to relay her story several times which increased feelings of shame. This suggests talking was difficult to do, but for a different reason to that experienced by other participants.

In terms of it being a hard thing to talk about, Jane also made an interesting reflection on her own experience of the MHTR sessions and feelings of shame. She commented "I never thought about speaking about the shame, it was the other feelings that have made me not feel the shame (. . .)" (Jane, p. 9); "I think probably sometimes people don't feel, don't feel they should talk about that bit of how they are feeling (. . .)" (Jane, p. 8) and "I've got more sessions and that would be quite interesting to discuss (shame) really" (Jane, p. 9).

This suggests a potential alternative barrier, as it is difficult to talk about and possibly some may feel they should not. Jane's comments suggest shame may not always be recognised as something to discuss, with other emotions potentially taking precedence, adding another layer of complexity to the difficulty of addressing it directly.

This subtheme highlights the many challenges participants faced when attempting to discuss shame, potentially revealing how deeply ingrained feelings of fear, embarrassment, and self-judgment create barriers to openness. Despite these difficulties, their reflections also point to the potential for growth and transformation through the act of confronting and sharing their emotions. It is important to note the impact the presence of a practitioner in one of the interviews may have had on this theme.

Theme 3: Moving Through Shame

This GET reflected on how four participants navigated their experiences of shame and the steps they took to move beyond the feeling. Two sub-themes emerged: *Finding ways to look at it all differently*, which focuses on the shifts in perspective participants adopted to reduce feelings of shame, and *Acceptance*, which centres on their journey toward self-forgiveness and being at peace with what happened.

Subtheme 3.1: Finding Ways to Look at it all Differently.

This sub-theme captures how four participants changed their perspectives as part of their journey to move through shame. For some, adopting a new outlook through realising they are not alone in their experiences, reframing their experiences positively, or viewing shame as a learning opportunity, was an important part in reducing the emotional weight of shame.

For James, it felt it was important for him to not feel alone in what happened. He described:

> I felt more shame, then, but now I'm not the only person, I don't think, so that's kind of made me, alright I shouldn't be on an MHTR anyway but I'm not the only person so that's kind of pushed me a bit… like a lot of people go on them, for all different reasons (James, p.12).

For James, this commonality perspective has had a de-shaming effect for being on an MHTR. He considered there are many different reasons as to why someone may be placed on a MHTR, which perhaps helped him move away from a more shameful stance such as "I am bad". This appeared to be a common theme for James, in which he also reflected on looking back and thinking, "That wasn't the sort of person I was" (James, p. 4). This may serve as a helpful coping mechanism for James where he can separate himself from what has happened to reduce strong feelings of shame and the sense that this defines him as a person. Similarly,

Colin and Jenny spoke about what they had done, for instance, helping others, which may combat feelings of shame "Because if it can help anyone else if it can give anyone advice or guidance I've got something out of it" (Jenny, p. 16). Jenny felt she had "always been very good at being an advocate for other people" *(*Jenny, p. 16) and Colin spoke of giving back: "I'm just guessing and that but with doing the community service and the like making do you know I mean it feels like not paying something back that I've done something good" (Colin, p. 8)*;* "It's (shame) not as a bad because I feel I've given something back" (Colin, p. 1).

Colin and Jenny appeared to need to feel they had done good, which may help them change their perspective on everything that has happened and feel less shame. Similarly, several participants spoke about viewing the things that happened more positively, in a way that suggests it was a blessing. Chris, for example, said: "Obviously I do feel shame, but I also think it was a bit of a blessing to get me a final kick up the arse to say come on mate what are you doing" *(*Chris, p. 15) and "I am actually grateful it all happened, you know, fucked up, urm I got my diagnosis, I'm on medication… I'm kind of grateful for it, it's given me a big change of perspectiv*e" (*Chris, p. 5).

Similar to this, Jenny also reflected on what happened being an opportunity, like a "sliding doors type of thing" (Jenny, p. 12) and went on to say:

> I mean I'm very lucky that in my instance no one got hurt so I think that's one of the main things that I in a weird way take as a positive, so I think that's just one of the key things I take from this whole process I'm getting the support I need now. (Jenny, p.20).

For Jenny, the MHTR feels essential, and her expression, "I'm getting the support I need now" (Jenny, p. 20)*,* evokes an emotive response. It gives a sense that her offence and subsequent placement on an MHTR have been significant for Jenny. It also supports the idea

that viewing it this way and looking at what has happened more positively helped Jane overcome her shame.

Another way participants altered their perspective was by considering events as a learning opportunity, particularly when feeling shame. Jenny said:

I'll never be able to get rid of that particular day in my head so but it's also I think it's also a learning curve for you to learn through how it feels and I think everyone at some stage in their life must feel shame (Jenny, p.5).

This was also shared by Chris, who said:

I feel like you have to go through rough stages and shame, experience it all before you can just be at one with yourself because it's like you don't really know yourself until you have been in that deepest darkest bit of shame. (Chris, p.11).

Interestingly, they both suggest the importance of experiencing shame. They reflect on it as a needed experience, and Chris suggests it helps people know themselves. Jenny also indicates this when she said, "I don't like to say I regret things because I believe regret is you wish you'd never done it, but it makes you into who you are today" (Jenny, p. 5). This makes sense as a way of coping with those problematic experiences of shame they have spoken about, to see it as something that needed to happen and as an opportunity to learn and improve themselves. James shared a similar view in that he spoke about learning from mistakes in that "you've got to live though them… learn from them and carry on" (James, p. 3). The notion of carrying on also came up at other times for James;

Don't give up, pursue it, urm always think that, no ones in your life really, like no ones in your head, it has to be, you and you only in your body so you need to look, carry on with life as much as you can and just, everyone finds shame, just try and work through it,

yeah, if that makes, yeah I would say so, yeah work through it, try not to hide away because it will make you feel better. (James, p.20).

Similarly, Jenny spoke about needing to "keep trying" (Jenny, p. 21), when talking about changing feelings of shame. For Jenny and James, there is a sense of not giving up attempting to change a more hopeless perspective and instead viewing it as something changeable. When asked what helps to change feelings of shame, James responded with: "It's just time, you can't live like that for the rest of your life because you're just not going to get nowhere" (James, p. 8). Similarly, Jenny shared her view of shame as changeable:

I think shame is something that you can develop you can adapt, not adapt it, but you can kind of like work your way through… ok I didn't do the right thing but I'm working on coping with the decision I made. (Jenny, p.2).

In summary, for these participants, altering their perspective appears to have been an essential component of coping with shameful experiences, allowing them to reframe their emotions and experiences in a way that reduced the weight of shame and supported their journey toward feeling accepted by themselves and others.

Subtheme 3.2: Acceptance.

This subtheme explores how three participants worked toward accepting themselves, their decisions, and their experiences as part of their journey through shame. Acceptance emerged as a highly personal process, sometimes intertwined with being able to forgive themselves and the need to feel validated and understood by others. This sub-theme highlights how the process of acceptance is, for these participants, integral in moving through feelings of shame.

In their own ways, Jenny, Colin and Jane spoke of accepting themselves and their decisions. Jenny talked about a need to accept what happened: "it happened however many

months ago… and I'm learning to accept it" *(*Jenny, p. 7). Within this, she spoke of needing to remind herself at times: "You've already visited this before there's no point in beating yourself up anymore about it" *(*Jenny, p. 13). Forgiveness formed a part of this for Colin. He spoke at different times about working towards forgiving himself: "I mean I've worked with my practitioner, I've done my community service and helping out in the community, I've worked on myself to forgive myself" (Colin, p. 1).

Linking back to subtheme 3.1, Colin's actions to give back have also given him a sense of being able to accept and forgive himself for his actions. This feels important to achieving an overall feeling of acceptance and reducing or removing feelings of shame. Colin later spoke about his own experience of seeking ways to help others, which supported his ability to forgive himself and overcome feelings of shame.

For Jane, acceptance formed a big part of her overall experience. She talked about this in the context of her MHTR sessions and feeling accepted by her practitioner, "I was like, you know, you're going to take me or leave me, but this is it" (Jane, p. 5) and "I was able to go, you know this is me, shameful me, this is me" (Jane, p. 5). This may be considered in the context of external shame and the refusal of focusing on the practitioner's potential to judge, criticise or reject.

Janes's reference to "shameful me" and her continued use of the word "me" felt particularly powerful in driving that overall sense of acceptance. When Jane spoke about this it felt this was so important to her. On reflection, perhaps this represents an underlying fear of being rejected due to what happened. This is a likely outcome of feeling shame, so for Jane to face that fear and present herself openly to her practitioner is quite remarkable. Thus, for Jane to work through her shame, she needed to feel accepted; her fear of rejection needed to be

challenged. Similarly, Jenny and Colin discussed accepting themselves to move through and away from their feelings of shame.

Together, these sub-themes illustrate the complex process of moving through shame. Participants found that shifting their perspectives and coming to a place of acceptance were essential steps in reducing the emotional weight of shame and supporting personal transformation.

Overall, the GETs provided above illustrate the multifaceted experience of shame, from feeling trapped in it to the transformative processes of opening up, reframing perspectives, and achieving acceptance. These findings, in part, shed light on the importance of therapeutic interventions that provide safe spaces for exploration, validation, and self-forgiveness, ultimately supporting individuals in their journey toward emotional recovery and personal growth.

Discussion

This research aimed to understand how shame manifested in participants' lives and how shame influenced their MHTR. Through IPA, these aims were met and three themes were identified: *Trapped in Feelings of Shame, Experience of Opening up and Moving Through Shame.* Participants shared their experiences of feeling shame and the impact of these feelings on their lives. Participants also spoke of how feelings of shame related to their MHTR sessions. Their individual stories came together to form a shared understanding of how some MHTR clients may experience feelings of shame and how they have moved through this feeling, reporting changes in the feeling over time. These findings expand existing knowledge on how shame presents for forensic populations but also show differences when compared to earlier research that suggested experiencing shame may prevent openness (Durnescu, 2010). The GETs identified support earlier findings regarding the negative impacts of shame (Tangney et al., 2011). Each research question is explored in turn.

Given earlier discussions surrounding the conceptualisation of guilt and shame, it is helpful to first reflect on participants' descriptions. As research has demonstrated there is much debate around distinguishing these emotions and the difficulties in doing so (Harris, 2003; Miceli & Catelfranchi, 2018; Tangney, 1996). There appeared considerable difficulties for participants in describing these feelings and how they differed. This supports the complexity of these emotions in practice and research. These descriptions suggest the importance of establishing shared understandings of these emotions – ensuring an accurate account of experiences. In this research participants were given a description at the beginning of the interview and again throughout if necessary.

Importantly, while distinguishing proved more difficult, participants' descriptions of shame were consistent with how the literature defines it. There was an emphasis on a desire to "hide", like the definition by Niedenthal et al. (1994), as well as feeling unhappy with oneself,

in cohesion with Tangney et al. (1996) account of shame leading to self-directed hostility. Two participants also reflected on a desire not to talk or feeling embarrassed, which Gilbert et al. (2011) suggested is a consequence of the defensive strategy of concealment or avoidance.

How do Participants Experience and Make Sense of Their Feelings of Shame?

Theme 1: Trapped in Feelings of Shame

The first GET, *Trapped in Feelings of Shame,* suggests a trajectory participants might follow and demonstrates an inability to detach themselves from their feelings of shame. As research has demonstrated, shame can have detrimental impacts, including worsening of mental health and drives a sense of needing to escape (Kroll & Egan, 2004; Niedenthal et al. 1994; Tangney et al., 2007). This sense of escape can relate to the feeling of being trapped. Three participants spoke of how they either experienced a sense of becoming consumed and trapped by their feelings of shame or consciously avoided them to prevent this. On the one hand, there was a tendency to feel long-lasting shame, which had an ongoing and constant impact on their life. One of the participants, James, spoke about how it had affected his ability to dream about his future and move towards his goals, impacting his state of hope, which reinforced this overall sense of being trapped. As previously mentioned, this has been noted in the literature, as Roth et al. (2021) considered how forensic patients can become "trapped in their shame" where feelings of shame can prevent individuals from continuing with their lives. This expression is also noted in the current research, which supports the findings of Roth and colleagues, while extending beyond their sample, which was primarily limited to white, male-identifying individuals.

On the other hand, Jane and Jenny's experiences of shame appeared to be in an alternative direction, one away from feeling trapped. Jenny spoke of shame as something she could work through with coping skills and similarly, Jane felt her experience of feeling such

intense shame "spurred her on" never to feel it again. The use of spurred provokes a sense of action and possible urgency. Whilst there's an acknowledgement that shame is a feeling to be "stuck in" by Jane, the predominant sense was that, although negative, it was not lasting.

There was, however, an overall sense that feeling shame can be negative and impact participants' quality of life. Participants Colin and Chris spoke of the long-lasting effects of feeling shame, such as Colin's ability to leave his home still now, despite feeling overall, he has moved through his shame and forgiven himself. Mirroring previous research (Singh et al., 2016) the findings in this study show shame to impact upon quality of life. Distress caused by shame was a shared experience, even if its meaning differed.

How do Participants Perceive the Influence of Shame on Their MHTR?

Theme 2: Experiences of Opening up

It is clear from their experiences shame negatively impacted the participants' lives in this research, which is consistent with the literature (Candea & Szentagotai-Tatar, 2018; Seidler et al., 2022; Tangney et al., 1996). Such difficulties were raised again in the context of opening up and discussing their shame within their MHTR sessions which three participants noted. However, participants did not experience any overall negative influence on their engagement with their MHTR. Instead, participants appeared to develop a recognition of the need to open up through their own positive experiences of doing so. They acknowledged how shame can make a person "go into themselves" with the tendency to "bottle things up", which likely represents fears of external shame and may drive a sense of being alone (Gilbert, 2022). They noted saying things they hoped no one would hear was a hard thing to do, and these reports are consistent with the literature on shame. As Durnescu (2010) outlined, individuals may feel unable to discuss their actions. Whilst MHTR clients in this research acknowledged how difficult this was, they reported being able to eventually open up. Thus, shame did make it

difficult for participants to talk about their feelings and what had happened, but they were able to, contrary to the findings of Durnescu (2010), which included only male participants engaged in highly intensive probation monitoring. This level of monitoring may have impacted the levels of shame experienced, and subsequently, why participants were less able to talk openly. This is a common difficulty with research of this nature, whereby the group of participants are unlikely to be representative and therefore findings cannot be generalised. However, as one participant (Chris) noted in their interview, there can be more significant psychological difficulties from burying feelings of shame, potentially leading to wider complications and challenges further impacting well-being. Importantly, the MHTR participants were able to prevent these challenges having a negative influence by addressing them. Indeed, there was a sense feeling shame can be positive.

It was considered that feelings of shame would impact willingness to engage with MHTR sessions in line with the literature suggesting shame may prevent individuals from seeking help (Glazier et al., 2015; Gott & Hinchliff, 2003; Suurvali et al., 2009; Wild et al., 2019). However, this was not a finding in this research. All participants were beyond the midpoint of their sessions, which implies the development of readiness to engage as the sessions progressed. Whilst participants acknowledged it was not easy to talk, all participants expressed this was helpful and needed. Participants' did not provide detailed reasons for this. Validation may have been crucial in enabling participants to feel comfortable discussing their experiences. Research has shown when a therapist validates the pain and suffering, it creates opportunities for openness (Greenberg, 2014). Further, the findings reported by Wild et al. (2019) were found within a group of individuals with internet sexual offences. This represents a particular, highly stigmatised group (Ricciardelli & Moir, 2013) for which shame may be higher and subsequent help-seeking lower.

This GET presents a narrative of participants going through a journey of first recognising a need to open up, finding it difficult but then helpful overall. Participants spoke of being able to express their feelings, acknowledge their shame, and how important this was for them. As part of this, being able to do so with a professional, someone separate from their personal lives, appeared to be the most important thing, which supports the therapist's role in providing the space for this. Three participants emphasised the value of talking to their practitioner and recommended this to others. Emotional containment helps to understand this process. This refers to a therapist's ability to hold a client's difficult feelings, allowing the client to feel safe exploring their emotions. Reynolds (2007) outlined an example of this, where the client recounted troubling details and as the therapist, Reynolds did not express distress and instead sat with and listened, which the client found containing.

This highlights the importance of the therapeutic relationship, which has been largely studied in research. Research has consistently demonstrated how a deep sense of being understood, connected and empowered is fundamental to openness (Noyce & Simpson, 2018). This finding was also reported by Butler and Ledwith (2021), who explored the overall experiences of MHTR clients. They too emphasised the importance for clients of being able to open up, trust and develop enlightening connections with their practitioner. Similarly, research on positive regard posed by Rogers (2020) as one of the necessary conditions for therapeutic outcomes offers helpful insight. Suzuki et al. (2021) found clients who scored highly on the Working Alliance Inventory perceived high degrees of positive regard from their therapists. This suggests effectiveness in the relationship and a sense of collaboration within therapy are supported by the therapist's positive regard towards their clients. It is likely doing so supports the perception of safety and encourages openness. For MHTR clients in this research, it suggests feelings of shame did not act as a barrier to engagement or openness as may have been expected (Durnescu, 2010).

It is noteworthy that Jenny's feelings of shame appeared directly impacted by her need to repeat her shameful experience to different professionals during the process of her MHTR. This presents a critical point for professionals to consider the need to encourage recounts of experiences. This aligns with literature on the potential for further trauma through retelling narratives (Kaminer, 2006). Similarly, openness with the interview is another critical point to consider. One participant had their practitioner present during the interview which may have altered their responses in relation to this theme.

In relation to the above, it is important to consider the variance in offences amongst this group of participants. Offences included varying degrees of severity, and therefore, the impact of feeling shame and the duration of this experience may vary depending on the severity. Durnescu (2010) suggested those on probation had been unable to talk about what they had done due to feeling shame for their offences. However, this was not found in this study. This poses an important consideration for future research, where it may be informative to repeat this research with individuals with other offence types to see if the influence of shame differs.

Furthermore, willingness to engage did not appear impacted by shame. Although, MHTRs are court-ordered, and thus non-engagement can have negative implications for clients. This suggests openness may be altered by a participant's sense of needing to and therefore may not represent genuine openness. However, clients are given opportunities to revoke their MHTR, noting therapy is not something that can be forced. Additionally, MHTRs are only court-ordered on agreement by the person. Of course, there are varying complexities within this, and so willingness is important to consider.

Theme 3: Moving Through Shame

This GET reflected how participants' feelings of shame changed over time and how they overcame it. Some participants suggested shame is a feeling everyone should experience

to better know themselves and to learn from this experience, which speaks to the potential for personal growth. Previous research supports this notion, where the experience of going to prison forced change in a group of individuals with sexual offences (Vanhooren et al., 2015). For participants in their study, there was a sense of finding new meaning in their lives, particularly in developing insight into their own stories and the importance of social and emotional support to do so. For the MHTR participants in this study, the impact of feeling shame because of their offences and the opportunity to access support also encouraged change, which suggests whilst an incredibly difficult experience, the ability to make positive changes meant feeling shame had a more positive impact. This speaks to the narrative of post- traumatic growth. The idea that difficult, traumatic experiences can be the catalyst for positive change, including changes in relationships, personal strengths, and greater opportunities (Henson et al., 2021). Participant accounts of their experiences as a "blessing" and an "opportunity" support this.

The reduction in levels of feeling shame were reported in relation to participants' moving through their feelings of shame by finding ways to look at their feelings and experiences differently. This reappraisal of their experiences appears to have been helpful, as supported by Krishnamoorthy et al. (2020), who reported an individual's ability for positive reappraisal can reduce negative emotions. Although found with a group of undergraduates, the participants also appeared to have identified positive reappraisal as a key component of their healing. This relates to the aim of narrative therapy, where the focus is on recognising how the narratives, we create for our experiences are often problem-saturated (Merscham, 2000). The focus is that through therapy, the narrative is reconstructed, moving away from more harmful versions. In this research, participants actively moved away from the narrative of being trapped and instead viewed their experience through a more positive lens.

For the participants in this research, the current findings do not explain whether their ability to look differently at their situation and feelings of shame came from their MHTR sessions. Whether this was an intended goal for the sessions is down to the individual work facilitated by the practitioner and was not something explicitly explored in this research; however, reappraisal may be an important focus for MHTR sessions. Participants agreed that the MHTR had been helpful, and some described their offences as presenting new opportunities. One participant spoke of "getting the support now", and another spoke of how he felt grateful as he got his diagnosis and medication following his offence. In this way, MHTR sessions are seen as valuable, but it is more difficult to say precisely how they address feelings of shame.

One of the subthemes was about acceptance. Jane, particularly spoke about showing up to her MHTR sessions saying, "This is me". There was an overall sense that how the practitioners made participants feel was integral to their experiences of feeling shame and was a significant part of how feelings of shame related to MHTR sessions. Braithwaite (1993) and Mullins and Kirkwood (2019) suggested that how we treat individuals largely impacts feelings of shame, considering the potential for stigmatising shame. No participants spoke negatively about their practitioner, although one participant did have their practitioner present. They all reported a positive account of being able to open up and talk, linking to the previous discussion surrounding the importance of the therapeutic relationship, positive regard and validation. This suggests practitioners, perhaps, made participants feel safe and, as per Jane's account, not rejected, which would implicate feelings of shame (Zaslav, 1998). Participants being able to be open and consistently engage with their practitioners suggests shame did not have a negative impact on their MHTR sessions. However, it is noted participants may not have been honest. By nature of shame, a person may hide or conceal those parts, so it is entirely plausible participants may not have been entirely truthful or open in this research. Additionally, MHTR

sessions provide a platform for discussing difficult feelings and events, which could increase shame, which Chris briefly discussed.

Understanding more about shame and how these feelings may relate to MHTR sessions is essential for the work that is delivered by MHTR services. Participants were asked if they felt their MHTR had acknowledged their feelings of shame. The findings from Nouri (2013) suggested licensed psychologists do not always appreciate the importance of shame. Interestingly, shame did not appear to have an explicit role in the MHTR sessions, but most participants felt it had been reduced, evidenced by the GET of *Moving Through Shame*. It could be suggested, however, participants' limited reports of shame being explicitly discussed or targeted in their sessions is a finding in itself and may support Nouri's (2013) account of addressing shame being a gap in psychological practice. Of course, this research was published some time ago, but the findings of this research suggest there may be a need for an updated view.

As previously discussed, Gilbert (1994) outlined the consequences shame can have on anger and feelings of helplessness which may be detrimental if not considered. Thus, it was important to understand how feelings of shame relate to engagement and if they were constructive or destructive in this process. In this research, there was no sense feelings of shame had been destructive to the MHTR sessions. Instead, participants spoke positively about moving through their feelings of shame, noting the levels of this feeling had reduced for most, where they described not "feeling as bad" or discussing levels of shame in the past tense.

Overall, shame can have negative impacts, which was research finding. Some experienced a sense of being trapped, and there was a consensus that shame is an all-consuming and long-lasting feeling. Others had found a more positive way to view feelings of shame and create opportunities from this. This would suggest the impact of shame is individualised, which

is why IPA was an essential method for conducting this research. The researcher could hear each participant's individual stories and how it was for them. IPA is intended for small groups as it allows for an in-depth analysis of personal experiences. Without this, the individual meanings and experiences found in this research would not have been captured, limiting the exploration level this research required.

Additionally, IPA is not intended to have empirical generalisability, as Noon (2018) stated, the focus of IPA is not to uncover what happens in all settings, but the understandings for a particular group. The transferability of these findings could be considered with individuals in other isolated pathways within the criminal justice system. Feelings of being trapped in shame are not unique and represent findings of previous studies, thus supporting the potential transferability. Similarly, the theme of opening up is rooted in the well-established humanistic model of therapy, and its application to groups beyond should not be dismissed.

Limitations

Despite the importance of these findings, this research has limitations. By the nature of shame, a person may hide or conceal feelings of shame or even themselves. It is noteworthy for one participant, their practitioner was present during the interview, which may have had an effect due to the interpersonal nature of shame, although alternatively, it may have made them feel safer to engage. Additionally, this group of participants may represent a unique group willing to share their experiences and feelings about shame. This group of participants may be experiencing reduced difficulties of shame and have reached a different stage in this process, which may offer a different perspective to someone still experiencing heightened shame. In addition, participants may have wanted to project themselves more favourably, which is an understandable response to feeling shame.

In line with IPA's idiographic focus, the small sample limits generalisability; however, this is by design, as IPA prioritises depth over breadth. Sufficient context is provided to support transferability to similar settings. The analysis centres on how shame operated for each participant; the small number of participants is a feature of the approach rather than a flaw.

One further limitation that should be considered is earlier discussions surrounding the dimensionality of shame and guilt (Nouri, 2013). Whilst this research ensured participants were given a description of guilt and shame and how these differ in definition, it is possible these feelings became entangled when they discussed their experiences. The descriptions provided by participants supports the complexity of defining shame and guilt and suggests entanglement of these feelings may be inevitable. For this reason, it cannot be said with certainty whether the experiences depicted by participants reflected individual feelings of guilt and shame, or a combination of both. Throughout, participants were directed to the definition of shame, but common entanglement, may have made this more difficult for participants to hold in mind. As Harris (2003) suggests, distinguishing shame and guilt may not be necessary; however, this is not well supported in research. This poses a future consideration.

Willingness is an important aspect of shame and the court-ordered aspect of MHTRs. It was anticipated shame would negatively impact engagement due to the concealing nature and thus would be a barrier. However, this was not found. A limitation, however, is the court-ordered aspect of this service. This is an unavoidable limitation as it cannot be guaranteed engagement represents a genuine desire to. As noted, the researcher has worked within the service and clients who do not wish to engage can usually be identified, but this is not grounded in strong evidence. This represents an area for future research. For this specific MHTR group, shame was not a barrier, nor did the court-ordered aspect raise any problems.

Furthermore, as earlier acknowledged, the exclusion criteria may have led to the exclusion of individuals with risk or substance misuse. Both issues may relate to shame, given the knowledge shame is grounded in avoidance, which is linked with alcohol abuse (Hruska et al., 2011). However, as explained, primary level MHTRs should not be accessed by individuals with these difficulties; thus, this may not be a limitation, but remains notable.

Finally, by the nature of MHTRs, having a homogeneous group was challenging. MHTR services include clients with a range of mental health needs, ages and offences. Heterogeneity of offences could be considered a limitation, noting there may be variations in experiences of shame, which makes it more difficult to draw specific conclusions. However, the use of IPA was well suited, as it seeks to address the diversity observed in specific research populations, with a focus on individual experiences. Homogeneity was achieved through the shared experience of being on an MHTR. With the use of IPA, the focus was on exploring this shared experience in a unique and meaningful way for each participant.

Practical Implications

As per the aims, it is hoped this research supports an understanding of how shame manifests in participants' lives and, if at all, influences the process of an MHTR. The subsequent findings may form an important guide for practitioners and hold crucial practical implications, which is a significant strength of this research. Considering the limitations discussed, it is acknowledged these practical implications are founded on a small group. Despite this, each finding, and the accompanying recommendation are outlined.

Facilitating Opening up

A crucial finding of this research is the participants' positive experiences of opening up. Research has previously shown shame can pose a barrier to treatment, particularly

concerning openness (Rusch et al., 2014; Suurvali et al., 2009). Contrary to this, whilst participants spoke openly about the negative impacts of shame and how difficult it is to talk about, such difficulties did not appear to overtly prevent them engaging in their MHTRs. Instead, participants had a positive experience of being open.

However, this remains a possible barrier for future MHTRs and should still be carefully considered in treatment planning. The participants in this research represent a small, unique group, and for other MHTR clients, discussing this may feel too difficult. Although participants did not discuss their feelings of shame as a barrier to open engagement, this is unlikely always to be the case. This research can provide a starting point for the developed awareness and understanding of how shame may influence MHTRs.

A key takeaway for practitioners is the importance of facilitating openness. As previously discussed, the therapeutic relationship is a powerful mechanism for working with individuals who are feeling shame. To achieve this, this research has demonstrated the importance of validation, active listening, and conveying understanding, which enables clients to feel seen, valued, and respected, thereby increasing their trust and openness (Greenberg, 2014). Similarly, there needs to be a demonstration of mutual respect and empathy and be communicated that the client's perspective holds value (Brown et al., 2014). As Gilbert (2009) noted, compassion should be a key component of therapeutic engagement. The client should experience the therapist as de-shaming, compassionate and safe, which supports improved engagement and thus, openness. De-shaming is a critical element to openness, considering how shame can often hinder therapy (Kleiven et al., 2020).

Interestingly, research has shown openness can be facilitated when a therapist shares something meaningful. In their meta-synthesis, Noyce and Simpson (2018) found participants reported self-disclosure from the therapist as helpful in assessing their therapist's authenticity

and trustworthiness. However, self-disclosure in therapy should be carefully considered, with research showing mixed views. For instance, research has indicated therapists may be viewed as less experienced, whilst conversely, they may be viewed as warmer and more trustworthy. Crucially, the 'what, when and to who' of disclosure is essential (Henretty & Levitt, 2010). Regardless, the warmth, authenticity and overall compassion shown by a therapist support trust, and subsequent openness.

Thus, the relationship between client and therapist is central to facilitating openness. The therapist plays an essential role in ensuring both the therapeutic space and their own presence are experienced in the ways outlined. Consideration can also be given to the appropriateness of self-disclosure, although it is recommended supervision be sought for this. The consideration of the therapeutic relationship will hopefully inform treatment delivery and prompt thought for MHTR services as to how well-considered facilitating openness about shame is in their services.

Alternatively, how professionals respond to openness is also crucial. Professionals have a responsibility to be aware of how to maintain safety in the face of openness, which was outlined by Kaminer (2006). Whilst this paper was about narrative therapy surrounding trauma processing, it is applicable within this context, considering the distress reported by participants when experiencing shame. As discussed, the negative impact on Jenny of recounting experiences is something to consider in practice, and this is necessary beyond MHTR services.

Help to Reduce Feeling Trapped in Shame

The literature has shown shame can have significant implications for the well-being of individuals, but it may also have more significant consequences, such as the possibility of reoffending (Roth et al., 2021; Tangney et al., 2011; Webb et al., 2007). Therefore, this research has significant practical implications for future delivery of MHTRs. Most participants in this

research spoke of the negative impact of feeling shame including hopelessness, feeling trapped, difficulties functioning in their day-to-day and an overall negative impact on their quality of life. For the two participants who didn't appear to experience a sense of being trapped, they still acknowledged the possibility this could happen. As an MHTR practitioner focusing on improving mental health, areas such as these would be targeted. However, practitioners need to be aware that these may be a consequence of feelings of shame. To improve daily lives and alleviate the daily suffering of feeling trapped in such feelings, practitioners must first recognise the presence of shame. This also provides insight for practitioners within MHTR services to consider shame as part of their treatment outcomes. As Chapter Two demonstrated, several factors are associated with shame, mental health and difficulties with anger being two key factors. To reduce the negative effects of shame, these factors may also need to be addressed.

Beyond this, improving daily lives and moving through feeling trapped is also necessary outside the therapy room. As earlier noted, shame is a social emotion (Scheff 2000), and feeling trapped may drive motivation to hide away. Thus, individuals may find it beneficial to secure a support system and engage in meaningful activities to challenge feelings. The development of self-compassion may be an important factor in this, directly mitigating against shame and leading to improved changes in well-being, motivation, and overall positive behavioural changes (Cepni et al., 2025). Practitioners can introduce self-compassion, but it requires ongoing practice by individuals outside the therapy room.

Acknowledging the Positive Side

Participants in this research spoke positively about their personal growth through feelings of shame. This felt particularly powerful where participants spoke of helping others and giving back as well as using their experiences as an opportunity for change and learning in

their lives. Participants used words such as “grateful” and “blessing”, which created a powerful sense of hope. This demonstrated a change of perspective, which challenged and reduced feelings of shame. Practitioners may wish to explore the value found in the experience that provoked shame, in terms of skills and knowledge a client acquired (Kaminer, 2006). By incorporating this view, the narrative of the experience can be altered to one that aligns with post-traumatic growth. Of course, this may not always be appropriate and requires a good understanding of the client’s readiness to view a distressing experience in an alternative way.

This aligns with the literature on post-traumatic growth, which describes the positive change that can result from a traumatic experience. Several factors are associated including sharing negative emotions, developing helpful coping strategies, and seeking social support (Henson et al., 2020); all of which can be addressed by someone without professional input. Aside from this, it is hoped for MHTR clients, reading about the positive side of what has happened, and the subsequent hope felt by the research participants, can help promote hope and growth in their own experiences.

Overall, this research may influence and improve the delivery of MHTRs by encouraging MHTR providers to give thought and effort to addressing and working with the shame experienced by their clients, where this may be a current gap in service delivery, as Nouri (2013) suggested. This research indicates for this group of individuals, this was not experienced as problematic, and only one participant felt shame had been explicitly discussed in their MHTR sessions. Depending on the person practitioners work with, the absence of explicit consideration for shame could be detrimental.

Furthermore, as considered earlier, shame and MHTRs are gaining research interest. However, MHTRs remain a service provision many know little of (Saleem & Blott, 2022). This is despite MHTRs being an essential move towards integrating mental health and the criminal

justice system, which there appears to be a drive for (Grudzinskas et al., 2005). The research holds the potential to raise awareness of MHTRs and expand the existing literature on this service. Whilst not the aim of this research, the interviews demonstrated the participants found the MHTR helpful and would recommend it. Callender et al. (2022) have shown good outcomes from MHTR services data collections also.

Aside from MHTRs, professionals who read this research may reflect on shame and its impact on their work within forensic populations. Research such as that by Velotii et al. (2016) and Matos and Pinto-Gouveia (2010) indicate the mental health implications of shame for individuals; therefore, shame can be considered fundamental to any work undertaken with individuals in forensic populations struggling with their mental health. The more published research that demonstrates this, the more likely shame will be addressed.

As discussed, generalisability is not a primary aim of IPA, although the applicability of findings can be considered. MHTR services represent a unique forensic population, whereby individuals are isolated in their community order and have the absence of connection with others experiencing similar. James reflected on his realisation that he was not the only person on an MHTR. Thus, the relevance of findings could be considered in other forensic services where individuals feel isolated. Research has shown individuals in community forensic mental health services may be at risk of increased exposure to social and structural stigma (Livingston et al., 2011), which is associated with shame (Braithwaite, 1993; Stynes et al., 2022). Therefore, the practical implications discussed may apply to other settings where isolation is a factor.

Future Research

This research is the first in this area. As a result, future research would benefit from advancing these findings. It may be beneficial to extend this research to a larger sample size and control for offence types. This would support a greater understanding of how shame

manifests across different offences, which would give professionals a more specific understanding of the individual and the offence they are working with.

Conclusions

This research aimed to develop the understanding of how shame manifests in MHTR clients' lives and how shame may influence the process of an MHTR. The research participants courageously shared their experiences of a complicated feeling. The collected data provided insight into how clients experienced shame, their challenges, and the positive outcomes of the treatment. Using IPA, the research identified three themes: *Trapped in Feelings of Shame, Experience of Opening up* and *Moving Through Shame.* Contrary to expectations, shame did not appear to have a negative impact on the MHTR, but it did emerge as an important feeling. This research supports the need to look beyond the initial difficulties which clients typically express willingly. Indeed, practitioners should consider some clients may be in the depths of shame but cannot speak about it. Hence, this research holds potential implications for practitioners in ensuring they facilitate openness, help with feeling trapped in shame and acknowledge the potentially positive elements of experiencing shame. As will be explored in Chapter 4, measures can assist practitioners in identifying these feelings. Crucially, it should not be forgotten shame is a common human emotion and likely plays a part in every MHTR client's story.

CHAPTER FOUR

Critique of a Psychometric: The Offence-Related Shame and Guilt Scale (Wright & Gudjonsson, 2007)

Abstract

This critique aims to explore the reliability and validity of a unique scale intended to measure feelings of shame and guilt experienced by individuals with offences. The Offence-Related Shame and Guilt Scale by Wright and Gudjonsson (2007) was developed in order to support the understanding of these important feelings in forensic work. This has been shown to be important due to the negative implications of shame and guilt. This critique concludes that, whilst the developers of the tool refer to acceptable internal reliability and moderate external reliability, this has not been confirmed by any other paper. Furthermore, whilst there appears to be support for the validity of the tool, there are larger challenges surrounding this including how shame and guilt is conceptualised. Recommendations are made for consideration of adaptations to the tool to mitigate such challenges as well as to consider cultural differences, its use where there are additional learning needs and to test the scale with a larger, more diverse population. Despite this, the scale is an essential move towards working more directly with such feelings and its importance should not be minimised by its limitations.

Introduction

Both shame and guilt are increasingly well thought out in forensic settings, with several studies considering such emotions across mental health and offending (Buck et al., 2022; Mottershead et al., 2024). As previous chapters show, shame and guilt are prevalent in forensic populations and should form part of assessment and intervention work. As depicted, shame has been defined as the evaluation of the self, such as "I am a bad person"; whereas feelings of guilt have been framed within the context of bad or unacceptable behaviours (Niedenthal et al., 1994). It is important to understand moral emotions as the negative consequences of such feelings have been increasingly researched. Shame is associated with denial, substance use difficulties, symptoms of psychological issues and predictors of offence rates (Tangney et al., 2011). Similarly, Tangney et al. (2011) found moral emotions such as shame and guilt are critical steppingstones to the rehabilitation process and the interventions delivered for those who have committed offences. They noted while guilt is considered less disruptive, it draws individuals to consider their behaviour and its consequences, which is considered an essential need for those who have committed offences. In their paper, Tangney and colleagues also noted, however, guilt can cause people to ruminate over their behaviour. Similarly, individuals have been found to become stuck in their feelings of shame (Roth et al., 2021). This can be a significant barrier, preventing individuals from moving forward. As earlier chapters have considered, the consequence of such feelings is profound, so understanding experiences of shame and guilt and addressing this in work with individuals who have committed offences is crucial.

Measuring Shame and Guilt

Measuring shame and guilt presents significant challenges due to their partial conscious nature and potential to function outside of awareness (Lewis, 1971). This is a crucial consideration for psychometrics, as these feelings may not be fully known or understood. Moreover, acknowledging feelings of shame can trigger further shame (Lansky, 2005), adding another layer of complexity to the measurement process. These challenges underscore the intricate nature of measuring shame and guilt, requiring careful consideration and methodological rigour. This is considered throughout this chapter.

The ORSGS by Wright and Gudjonsson (2007) was developed from the knowledge that feelings of shame and guilt about a crime impact behaviour. However, Wright and Gudjonsson (2007) noted the absence of a dedicated measure affected understanding of these feelings. The scale, therefore, aimed to measure feelings of shame and guilt about a crime committed and formed the basis for the construction of the ORSGS which is the focus of this chapter. The ORSGS sits amongst several shame, guilt or combined (shame and guilt) scales; however, few are specifically relevant to forensic populations. For example, the Guilt and Shame Proneness Scale (GASP) by Cohen et al. (2011) was developed to address the disagreements surrounding guilt and shame and how they should be defined, differentiated, and measured. The scale aims to measure individual differences in the propensity to experience feelings of guilt and shame. This scale, however, includes items that may not be relevant to a forensic population, such as "Your home is very messy and unexpected guests knock on your door and invite themselves in" and "What is the likelihood that you would avoid the guests until they leave?". This poses yet another challenge for measuring shame and guilt specifically for those currently living in forensic settings.

Cohen et al. (2011) noted the Test of Self-Conscious Affect-3 (TOSCA) was considered the most widely used guilt and shame-proneness scale when introducing the GASP. The

TOSCA was initially developed in 1989 and has been updated twice, with the most recent being the TOSCA-3, which is intended to capture affective, cognitive and behavioural features associated with shame and guilt (Tangney et al., 2000). Once again, although widely used, the measure was not generated directly considering forensic populations, and some items may not be relevant. Therefore, the ORSGS is the most relevant tool when working with a forensic population.

This chapter examines the ORSGS, considering its validity and reliability and its use within forensic settings. Importantly, to our knowledge, it is one of few measures that specifically considers shame and guilt felt because of involvement in the criminal justice system. The need for such a measure must be highlighted, as per the earlier chapters, there can be mental health implications of experiences of feeling shame (Tangney et al., 2011; Webb et al., 2007) as well as trauma responses from one's own offence (Chuan Soh et al., 2022).

Overview of the Scale

The ORSGS is a 16-item scale designed to capture the conceptualisation of shame and guilt as depicted by Lewis (1971) and Gilbert (1992, as cited in Wright & Gudjonsson, 2007). The measure has five reversed items, and participants are asked to score each of the 16 items on a Likert scale of 1 to 7; 1 = not at all and 7 = very much. Participants are advised each item reflects how a person may feel after being apprehended for a crime and are asked to score how well each item describes their current feelings. No manual accompanies the scale.

Guilt Subscale

The scale consists of items primarily concerned with guilt, identified through exploratory factor analysis. Items 4, 8, 12, 14 and 16 are considered the guilt factors. Item 11 was initially intended to be a shame factor; however, it loaded positively on the guilt subscale (r=.66) and was therefore retained for this subscale.

Shame Subscale

Items 2, 5, 7, 9 and 13 belong to the shame subscale. Two items were removed through factor analysis: “Despite what I did, I feel equal to other people”. This was removed as Wright and Gudjonsson (2007) found it did not substantially load on either factors, shame or guilt. The second item removed was “I feel no need to make amends (make-up) for what I did”, which was intended to capture the inverse of guilt but instead loaded upon the shame factor. This item did not correlate well with the other shame items and held poor face validity, so it was excluded.

Development of the Measure

The initial study for testing the ORSGS was conducted with 65 men detained in specialist forensic psychiatric units in England. All were over the age of 18, with a criminal conviction and not acutely unwell or expressing suicidal intent. Five were then excluded due to not meeting the last criterion. The group of participants had a mix of diagnoses: Schizophrenia or Schizoaffective Disorder, Personality Disorder, and Bipolar Disorder. Of the participants, 87% had committed a violent index offence. Thus, the measure was developed with a group of individuals with mental health difficulties as well as an offence. This is important to note when considering this specific population and if this is transferable to other population types.

Each participant completed the ORSGS as well as the TOSCA- 3 (Tangney et al. 2000), The State Shame and Guilt scale (SSGS; Marschall et al., 1994, as cited in Wright & Gudjonsson, 2007) and the GBAI-R (Gudjonsson & Singh, 1989). All were noted to have adequate internal consistency. Approximately one month later, participants completed the ORSGS once again. Following this, exploratory factor analysis was completed as detailed (see Guilt and Shame subscale), which identified factors for removal. Test-retest reliability and internal consistency were then explored. Further, validity was examined between the ORSGS, TOSCA-3, SSGS, and GBAI-R; these existing measures were used to validate the ORSGS.

It should be noted there are no specific reports of how the authors developed each item. However, they indicated that the conceptualisations of shame and guilt formed by Lewis (1971) and Gilbert (1992, as cited in Wright & Gudjonsson, 2007) formed the basis for constructing the scale. Additionally, the "guilt feeling" subscale of the GBAI- R was used due to its inclusion of shame and guilt items in response to an offence. This means it is difficult to critique the development of this measure fully given the limited information available. However, Wright and Gudjonsson's (2007) use of well-established measures such as the TOSCA- 3 is positive, as this suggests the ORSGS has been developed with the help of important measures in the field.

Characteristics of the Psychometric Measure

Level of Measurement

The level of measurement used in ORSGS is ordinal data as there is no clearly defined interval across the Likert scale, with 1 representing “not at all” and 7 representing “very much”. There is some debate about using ordinal Likert scales, as parametric statistics cannot be used due to the possibility of reaching incorrect conclusions, but this has been argued against (Norman, 2010). Bishop and Herron (2015) have suggested care must be taken when analysing such data. Thus, in terms of critiquing the ORSGS, this is an important debate to consider further.

Self- Report

The ORSGS utilises a self-report method whereby participants complete the scale themselves. This can simplify scale administration by quickening the data collection process. It is considered most helpful to go directly to the person through self-reports to understand someone or the concept being measured (McDonald, 2008). This becomes more difficult when measuring a construct such as shame. The nature of shame means an individual experiencing such feelings may wish to hide or conceal themselves for what they feel shameful for. This was considered in an earlier chapter, whereby Niedenthal et al. (1994) noted the response to shame could be a desire to hide or escape. Thus, asking participants to demonstrate openness in their responses may be problematic and could lead to response bias.

Response bias is considered a source of error in responses due to different factors; these can lie in the individual or the situation (Bognock & Landrock, 2016). Response bias is commonly known in psychological research, but the ORSG's intention to explore shame relating to an offence is further complex. The stigma associated with offences and those who

have committed offences means this may be even more difficult to measure accurately. Shame has been described as painful and disruptive and can prompt feelings of being small, worthless, and powerless (Tangney et al., 2011). As suggested, this will likely limit the openness regarding experiencing shame and the context surrounding such feelings. This, therefore, increases the possibility of response bias.

A further influencing factor may be the type of offence. This may prompt social desirability error, the idea that someone may want to make a favourable impression on others (Tan & Grace, 2008). However, in an extensive study of 1730 adult males who had been convicted of sexual offences, socially desirable responses were smaller than expected (Mathie & Wakeling, 2011). The authors examined self-report measures used to identify treatment needs and progress, concluding self-report questionnaires used in forensic populations may be accurate and valid. Tan and Grace (2008), however, had previously concluded there is a significant relationship between social desirability, risk factors and recidivism and therefore supported the need for measures to determine the presence of social desirability. They noted those who have committed sexual offences against children are most likely to "fake good". As such, given the mixed view, it would appear necessary to exert caution when using self-report measures, but this does not suggest they should be excluded from use entirely. As mentioned above, self-report measures represent a simplistic, sometimes helpful way of measuring a certain concept and understanding a person. Both errors are possible, confirming the challenging but important area of measuring shame and guilt. Such challenges should not prevent attempts to measure and understand such feelings.

Psychometric Properties

Reliability

Reliability concerns whether the measure can be repeated and present consistent results. There are two components to this: internal and external reliability.

Internal Reliability

Internal reliability looks at how consistently different items within the scale measure the same concept. Wright and Gudjonsson (2007) calculated Cronbach's alpha to identify overall variance. For shame, Cronbach's α= .78, N=60 was found; for guilt, Cronbach's α=.79, N=60. These are considered acceptable for internal consistency, where it has been suggested that values below α= .7 are acceptable when dealing with psychological constructs due to the expected diversity (Kline, 1999, as cited in Field, 2013). There are no other papers known to have tested the ORSGS's internal reliability. Therefore, internal reliability, whilst considered acceptable, is limited by no other confirmation of similar findings for the ORSGS.

External Reliability

External reliability measures how consistently the scale produces the same results over repeated administration. One way to test this is a method called test-retest reliability. This involves a participant completing the measure on two separate occasions. The authors conducted a test-retest method and reported finding moderate reliability, reported as (shame ICC: r= .60, n=52, p<.0001; guilt ICC r=.60, n=52, p<.001). A debate has arisen concerning levels of reliability and what constitutes moderate reliability (Matheson, 2019); Wright and Gudjonsson (2007) did not report evidence for their conclusion of moderate reliability, which does complicate conclusions on whether this should be considered an acceptable level of external reliability.

As above, there does not appear to be a significant number of papers that have further tested the scale's reliability. It has, however, been adapted for an Indonesian version with reported Cronbach's alpha reliability of (α=.65) and excellent item reliability (.99), (Salma et al., 2022). Item reliability was assessed using Rasch model which assesses how difficult items are to agree with, which is repeated with respondents to see consistency of results. .99 suggests high consistency.

The study comprised 510 male prisoners, mainly aged between 25-34 years old (34%) and involved in drug crime (53%). The study aimed to test if the adapted Indonesian version was valid. Salma et al. (2022) concluded the adapted version was acceptable. This suggests the test has been repeated and continues to show acceptable reliability. However, as the tool was adapted, this still limits the conclusion that the original ORSGS has good external reliability.

It is noteworthy that treatment or therapy may impact test-retest reliability. For example, if treated, feelings of shame or guilt may be reduced, or participants may become more open during the course of therapy. Additionally, a participant's mental state at the time of completing the scale may influence the ratings. As such, their scores may alter over time. Thus, the time with which scales are repeated is significant. This is important when considering the development of the ORSGS. Wright and Gudjonsson (2007) did not report when participants in their sample completed the test. Test-retest was done, but again no reports were made on any changes that may have been seen in the month from the first completion. Given participants were in a specialist psychiatric unit, they may have started a therapeutic intervention or seen a change in medication that altered their mental health. This affects how accurate reports of reliability are and, thus, the overall effectiveness of this measure. This suggests external reliability remains an area for further exploration.

Validity

Face Validity

Face validity concerns whether the scale is measuring what it is supposed to. It considers whether the scale is appropriate for what it intends to measure and uses the correct terminology within the scale. The authors of the ORSGS used factor analysis to ensure that each scale item measured what it intended. For example, items were excluded from the final scale where poor face validity was found. The authors ensured that each item correctly loaded onto the construct (shame or guilt) that it intended to measure. Items with loading greater than .4 were retained, which is supported by Field (2013).

The ORSGS is considered a relatively short scale, with 16 items, which is supportive of face validity, and for the most part, the wording is simple. It is noted they have made attempts to simplify wording further, such as supplementing the word “amends” with the words “make up” written in brackets; however, there remains some complicated wording, such as the word “conscience”, which, someone may misinterpret if they do not have the opportunity to ask for clarification when completing the questionnaire on their own.

Shame and guilt are complicated concepts, often confused, which may make it more difficult for participants with intellectual difficulties to complete the psychometric and suggests a need for an adapted form to be used with this group. This has been supported by Marriot et al. (2020), who concluded the need to develop interventions targeting shame in this population. However, it does not appear completion of the ORSGS requires individuals to understand shame and guilt in the theoretical sense and instead simply requires them to distinguish between these feelings when reading the statements. It is, however, worth noting adaptations may still be relevant when considering face validity. Thus, face validity is highly dependent on the individual completing the ORSGS and may be impacted by factors such as learning.

Concurrent Validity

Concurrent validity considers the extent to which the ORSGS's outcomes relate to another measure, also measuring shame and guilt. The authors conducted a Bivariate correlational analysis and found positive correlations with the ORSGS's shame and guilt proneness as measured by the TOSCA-3. As noted earlier, the TOSCA is one of the most widely used measures, supporting the idea that the ORSGS has good concurrent validity.

The authors also tested concurrent validity with the SSGS (Marschall et al., 1994). A significant positive correlation was found for SSGS state guilt and ORSGS shame, this was also found between ORSGS guilt and SSGS state guilt. The part correlational analysis, however found significant positive correlation between SSGS guilt and ORSGS shame but not with ORSGS guilt (r= .45, p<.001). They also considered the GBAI-R, which contains a subscale regarding feeling guilt. The ORSGS shame and guilt and GBAI-R guilt feeling scale significantly positively correlated (shame: r= .45, N=60, p<.001; guilt: r=.66, n=60, p<.001). No other studies were found that considered concurrent validity of the ORSGS. However, the above supports concurrent validity in the specific sample tested and suggests the scale may indeed measure what it intends to when administered simultaneously with previously established measures. Once more, the specific sample with which the ORSGS was tested limits the overall soundness of any conclusions.

Predictive Validity

The authors of the ORSGS did not state that the measure was intended as a predictive measure. There has been some exploration surrounding shame, guilt, and predictive values of recidivism or self-forgiveness. One such example is Tangney et al. (2014), who found guilt proneness negatively and directly predicted offences in the first-year post-release, but shame proneness did not. However, findings were found using the TOSCA. Therefore, whilst the

measure is not intended to support the prediction of future behaviour or feelings, it could inform some understanding.

Content Validity

Content validity concerns how well a scale represents the construct it is measuring, in this case, how well feelings of shame and guilt relating to offences are covered by the ORSGS. A difficulty with this is the range in definitions of shame and guilt; for example, as mentioned in an earlier chapter, Niedenthal et al. (1994) considered a simple distinction between them as guilt, a bad action vs shame, the self as bad. On the contrary, Harris (2003) suggested no distinction between guilt and shame, a statement that does not appear well supported in research. Instead, there is much agreement shame and guilt are distinguishable, but there is debate as to how (Miceli & Castelfranchi, 2018). Miceli and Castelfranchi (2018) considered several other factors to help define shame and guilt, including inadequacy vs harmfulness, actual and ideal self vs perceived responsibility, and the differing domains of self-esteem. This emphasises the complexity of the measured constructs and the difficulties of a measure grasping the subjectivity surrounding this whilst maintaining some face validity. It would appear, given the complexity surrounding shame and guilt, content validity is hard to achieve.

Construct Validity

Construct validity considers how well the scale measures the concept it is intended to measure. Like the above, the difficulty with this is the range of understanding for shame and guilt, which creates difficulties in ensuring the scale measures precisely what is intended. Thus, there appears to be a degree of subjectivity depending on the author's perception. Early on, Wright and Gudjonsson (2007) noted the substantial investigations had previously been sought to define shame and guilt. Lewis's (1971) focus on negative evaluation and Gilbert's (1992) evolutionary model were depicted by the authors as the critical conceptualisations for the basis

of the ORSGS. Considering the differences in conceptualising shame and guilt, it is essential to note that it would appear impossible to include every possible item relevant to measuring such feelings. There does, however, appear to be a good balance between items concerned with the view of self and the view of others, which has been noted as a crucial distinction between the two feelings (Goss et al., 1994; Niedenthal et al., 1994). As the authors noted, several emotions may overlap with the concept of shame and guilt such as regret and humiliation. Shame and guilt fall within the collection of "Moral emotions" and consider an array of emotions (Tangney et al., 2007). It is difficult to ascertain, therefore, if participants think about the correct emotions when completing it. It would have helped if the authors included a clear description of shame and guilt to limit discrepancies. Although the scale does not explicitly state what emotions it explores, this may not be a significant issue as the statements are meant to lead participants to think about shame and guilt.

An important factor affecting construct validity is those who complete the scale may represent a select group of participants who are more open about their shame or guilt. The function of shame is hiding and concealing, which raises questions about how willing individuals may be to complete a measure intended to get them thinking about such feelings and related experiences. Further, shame is said to create pessimism and hopelessness, creating treatment resistance and denial (Taylor, 2017). This indicates further potential for unwillingness to engage in such measures or, crucially, to be honest during completion.

Similarly, difficulties in exclusively measuring shame and guilt alone are problematic, whereby they are said to be intercorrelated with cognitive distortions, self-esteem and empathy. This has been reviewed in relation to those who have committed sexual offences (Marshall et al., 2009) but may represent other groups of people also. This is also relevant to response bias, which was discussed earlier, particularly social desirability errors. This is likely an issue with

this scale. This presents another complicating factor in construct validity, where it may not be possible for the scale to measure the intended construct accurately.

Moreover, in the development of the ORSGS, the test was carried out on a small sample of males with offences and a psychiatric diagnosis. Thus, as the authors noted, there is a need to investigate the properties of the scale with a larger sample size, including both men and women, as well as a population without psychiatric diagnoses. This significantly impacts the scale's validity when considering the very particular population the scale has been tested against. Mental health and particular psychiatric diagnoses may affect a person's ability to complete such scales where a diagnosis may impact someone's thoughts and perception, such as Schizophrenia. Furthermore, psychosis has been found to correlate with an increased tendency to attribute blame externally for an offence committed (Carlin et al., 2005). If someone does not take responsibility for their offence, how much offence related guilt and shame they feel compared to others who take responsibility will likely be different.

In addition, particular mental health difficulties may have a significant effect on the experiences of feeling shame and guilt, whereby such feelings may be elevated. For example, those who have been diagnosed with Schizophrenia and Depression are said to experience higher levels of feelings of guilt and external shame overall, and the associated stigma can have a negative consequence (Keen et al., 2017). In consideration of this, a further difficulty in terms of construct validity is the issue of ensuring participants complete the scale considering their offence only. Such stigmatised groups may find it difficult to separate their overall feelings of shame and guilt from those directly related to their offence, as the scale intends to measure. It is well-researched those with mental illnesses experience shame resulting from stigma and prejudice by society (Carr & Ashby, 2020). As such, caution is necessary when interpreting the results of scales completed by individuals who may have experienced shame separate from their offence.

A further important consideration within construct validity is cultural differences. Likely, shame and guilt are conceptualised differently across cultures (Fessler, 2004). In his review of two cultures, Fessler (2004) suggested guilt overshadows shame in individualistic cultures. Other studies have supported the notion that such feelings differ cross-culturally (Crowder & Kemmelmeier, 2017; Szyncer et al., 2012), an important point when critiquing the validity of the test but also for the use of the test in practice. This highlights a key point when considering the value of psychometrics: the information that is gathered from completing scales such as the ORSGS is not the whole picture, and further discussions are necessary. Such discussions allow for further exploration, for example, to understand cultural differences in the way in which someone experiences shame and guilt.

The authors also indicated the use of the ORSGS to investigate feelings of shame and guilt in relation to denial and confessions. While the scale does not intend to measure denial and confessions directly, it was suggested this could be an outcome from using the scale. It is therefore necessary to consider how well the ORSGS supports the understanding of denial and confessions. One scale that measures confessions is the Gudjonsson Confession Questionnaire-Revised (GCQ-R), which was considered a reasonably reliable tool (Gudjonsson & Sigurdsson, 1999). Within this scale are inhibitory factors related to feelings of shame, difficulties in accepting what someone had done, and concerns over being viewed as a criminal. The ORSGS appears to relate to these factors with statements such as “I can’t help worrying about what people must think of me after what I did”, which links to the possibility of being seen as a criminal and “I would do anything to undo what I did” which links to acceptance. Therefore, it can be considered the ORSGS makes note of factors relevant to considering confessions and denial.

Conversely, direct denial does not appear to be considered within the scale, and it assumes those who complete the measure accept their offence. This is essential when

considering its implications for measuring shame and guilt. Without accounting for denial, the responses gathered need to be carefully used. Participants may respond “not at all” to statements such as “What I did was very much out of character” if they feel it was out of character or, if they categorically deny responsibility for their offence. The scale, however, does not allow for this sort of clarification to be recorded. Equally, denial is likely to prevent openness and honesty regardless, so completion of the scale is likely to be unhelpful. Again, this supports the above consideration for wider discussions that must accompany the completion of such scales.

Conclusion

The ORSGS is one of the few scales explicitly designed for use in a forensic population. It is, therefore, a helpful tool to introduce a better understanding of feelings of shame and guilt by those who have committed offences, something there has been a growing drive for. However, as indicated above, the ORSGS was tested on a specific, small population of males. To increase validity and reliability, further validation is necessary with a larger, more diverse population. Given the limited evidence base, a compelling critique of the tool is challenging at this stage. The authors of the ORSGS recommended that a larger sample be used in future validation studies; this has not yet been done to our knowledge.

The above points regarding validity and reliability appear to have demonstrated both but should be taken cautiously. The authors found acceptable internal reliability and moderate external reliability; however, no other papers have confirmed this. There appears to be some evidence of support for validity; however, construct validity is challenging when noting the variances in conceptualising guilt and shame (Harris, 2003; Miceli & Castelfranchi, 2018). The authors of the OSRGS noted this in their paper with the potential overlap of emotions, so the scale may benefit from future adaptations to include descriptions of these feelings to limit such overlap and guide responders on what to think about when answering. Further, there are several noteworthy factors, such as cultural differences (Crowder & Kemmelmeier, 2017; Fessler, 2004; Szyncer et al., 2012), adaptations for learning needs and the overall characteristics of the original population the tool was based on, when critiquing this measure.

As discussed, the authors suggested using the ORSGS to investigate the importance of shame and guilt in relation to confessions and denial, but this was not the intended construct to be measured from the outset and so was only reviewed briefly. However, it does appear that the ORSGS links with the GCQ-R (Gudjonsson & Sigurdsson, 1999) and the items within this scale that were considered relevant to confessions. On the contrary, denial appears to be a

crucial factor that is not considered by the scale. It may be that the authors intended for the scale only to be used by those accepting their offence, and this does seem plausible, given the likelihood that someone in denial of an offence may not be experiencing shame. However, outward denial is not the same as the internal thoughts and feelings one might have about their offence but be unwilling to share. Denial can be driven by shame, with it being an attempt to separate self from a label i.e., "sexual offender", which can neutralise the feeling of shame (Harder & Hasinoff, 2021). The neutralisation theory is centred on this concept of how a person may rationalise their behaviour through forms of denial intended to be protective from difficulties such as shame, guilt, and stigma (Maruna & Copes, 2005). When completing such measures, such considerations are noteworthy.

As discussed above, denial does have significant implications for the ORSGS in measuring what it intends to, but this is not something the scale could have addressed and is a consequence of self-reporting. Thus, this scale relies on a significant degree of openness from the person completing it, which may pose a vital consideration as to when to complete such a scale. It would appear, perhaps, once rapport has been built. Crucially, however, the scale cannot be considered in isolation. Given the outcome of this critique, it very much supports the need for the ORSGS to be used as part of a wider discussion with a person.

In addition, Wright and Gudjonsson (2007) also felt the scale could be used to assess treatment needs and outcomes. This relies on a degree of openness and honesty by the individual, which, as discussed, may be problematic given the responses of emotions such as shame (Tangney & Gavanski, 1994). However, if individuals are open and honest, this scale certainly would be a helpful tool for practitioners to identify areas of difficulty with shame and guilt simply by taking each answer in turn to the statements presented. The knowledge of a client stating "not at all" to "I feel comfortable when I'm with someone who knows what I did"

may be important when developing therapeutic rapport, openness and safety in the therapy room. Again, the scale can be a tool to facilitate more in-depth discussions.

To conclude, whilst the scale undoubtedly requires further testing of its reliability and validity and use with a larger, more diverse population, it remains one of few that have attempted to bring shame and guilt awareness into working with those who have offended. As such, this scale, could, form an essential component of forensic work if tested further. If used, practitioners are urged to be mindful of the wider discussions that should be had with responders.

CHAPTER FIVE

General Discussion

Restatement of the Aims of the Thesis

This thesis aimed to contribute to knowledge on shame and guilt within forensic populations. The SLR aimed to review the associated factors of offence-related guilt and shame. The research chapter then aimed to qualitatively explore shame in a forensically linked setting. Both chapters highlighted the need to explore shame and guilt in valid and reliable ways. Therefore, chapter four focused on a critical appraisal of a scale used to measure these feelings in forensic settings.

More specifically, the aim of Chapter Two was to develop knowledge regarding the factors associated with feelings of shame or guilt surrounding an offence committed. This was important to better enable practitioners to recognise the presence of both emotions to effectively work with them. It was hoped that it would also support a greater understanding of the prevalence and potential impact of such feelings and the link with psychological interventions. Most importantly, awareness of the associated factors may encourage practitioners not to treat factors in isolation. Implementing the findings can help professionals more effectively identify at-risk groups and inform the direction of psychological work.

Furthermore, chapter three presented research conducted with a group of clients from two MHTR services. The research aimed to explore the lived experiences of shame amongst these clients and sought to understand how shame manifested in participants' lives and how shame influenced their MHTR. As literature indicates, shame has been found to impact help-seeking and engagement (Durnescu, 2010; Molyneaux et al., 2021). Thus, understanding if this would be replicated in other settings was important. The research in this thesis provides specific recommendations for practitioners in identifying and working with feelings of shame, noting how to address shame if it poses a barrier to treatment.

Findings from both the research project and SLR highlight the prevalence and negative influence of shame. This informed the decision to conduct a critique of one of the few scales

designed to measure such feelings in a forensic population. The aim was to examine the reliability and validity of this scale, ensuring its application. The chapter highlights the need for such measures and how this can assist in practice.

Discussion of Main Findings

Chapter 2 - The SLR

Shame and guilt are prevalent in forensic settings; however, it is unclear what factors might be associated with these feelings. Eight papers were included in the review, which were selected using a standardised procedure. SPIDER protocol was used to develop the inclusion and exclusion criteria, and search terms were agreed upon between members of the research team. To ensure quality, all papers were quality-appraised and dual-coded.

Firstly, for offence-related guilt, mental health was the main identified theme, which included anger, trauma and depression. For individuals experiencing trauma and depression related difficulties, this suggested offence-related guilt may also be present. Alternatively, guilt and anger control were associated, supporting earlier considerations for guilt's helpful mechanism in rehabilitative outcomes. This theme highlights the challenging impact of guilt, but also demonstrates how it can be beneficial with careful consideration in practice.

A second finding related to offence circumstances, including the severity of the offence, victim and offence type. This indicated that victim type, whether known or unknown, may be linked to subsequent guilt. Interestingly, there were mixed findings regarding whether victim type was associated with increased feelings of guilt or not. Therefore, it is recommended that this area be explored. Similarly, the severity of the offence also produced mixed results but might be considered related to guilt in some manner. One paper specifically suggested that individuals with sexual offences tend to experience increased feelings of guilt. Another

acknowledged that the presence of individuals with sexual offences may have contributed to elevated guilt levels. Consequently, offence type also seems to be important.

Finally, personality styles and traits relating to psychopathy were found in two papers, although their findings differed in their measurement of traits and impact. It was acknowledged that an absence of findings regarding psychopathy was surprising. This appeared to be a result of the necessary exclusion criteria. The findings of these papers suggest the association is worthy of further exploration.

Alike to offence-related guilt, only one theme was found for shame, and this was mental health. Psychological distress and anger were both found associated with increased feelings of offence-related shame. Two other factors were also identified, but they were found in isolation. These were treatment motivation and thinking styles. However, only one paper has reported on this, suggesting a need for further research to provide more conclusive findings.

The findings reported support the presence of guilt and shame as well as increasing knowledge of what factors may be associated for an individual who has committed an offence. Awareness of this supports that whilst practioners explore such factors, the possibility that they may hold relevance to shame or guilt should be kept in mind. As outlined earlier, recognising the presence of mental health and subsequently working with these factors may be integral to successfully working with shame or guilt.

Chapter 3- Empirical Research

Chapter three presents the first known research to explore feelings of shame within a group of participants from MHTR services. Two aims were explored: how shame manifested in participants' lives and how shame influenced their MHTR. As literature has suggested, the presence of such feelings can be impactful so understanding this within a specific forensic

context was considered important. Five participants engaged in a semi-structured interview. Following this, IPA was conducted to identify themes.

Three GETs emerged from the interviews: *Trapped in Feelings of Shame; Experiences of Opening Up* and *Moving Through Shame.* The latter two GETs contain two subthemes. The themes indicate a journey that participants took which started with the negative impact of feeling shame and a sense of being trapped by this feeling. Participants then spoke of beginning to open up and talk to their practitioner, initially finding this difficult to do but recognising how helpful and important this was. Finally, participants described a final stage of this journey, whereby they moved through their shame by finding ways to view it differently and feel accepted.

In terms of understanding how shame manifested in participants' lives, the first GET, *Trapped in Feelings of Shame,* incorporates participants' experience of feeling shame and the negative impact this had on their lives. Three participants spoke about shame as a long-lasting and all-consuming feeling that affected their overall functioning. Interestingly, one of the participants spoke about avoiding feeling shame due to the fear of becoming trapped in this. This theme addresses the detrimental impact of shame, providing insight into how feelings of shame have manifested in their lives, in line with existing research on the negative effects of shame (Tangney et al., 1996; Gilbert et al., 1994).

The second GET, *Experiences of Opening up* highlights the influence of shame on MHTRs with two subthemes: *Recognising a need to open up* and "*It's a hard thing to talk about".* In this group of participants, although they initially found talking openly difficult, which is grounded in research about shame (Suurvali et al., 2009; Rusch et al., 2014), they came to recognise the need for this and reflected positively on their experience of doing so. Thus, no negative influence was found, although it is acknowledged that it is a difficult thing

to do. Participants spoke of needing to overcome emotional barriers and the instinct to hide within the subtheme "*It's a hard thing to talk about"*.

Within the subtheme, *recognising a need to open up,* participants spoke about the importance of opening up but also the importance of who they opened up to, where someone separate from their lives, a "stranger" was key. This may be important when considering the aforementioned barriers. Importantly, this GET demonstrates the value of the MHTR service and practitioners, particularly with reference to therapeutic rapport (Clark, 2012).

The final GET portrays a sense of hope as participants talked about *Moving Through Shame.* Within this, two subthemes demonstrate how participants came to do this: *Finding ways to look at it all differently* and *Acceptance.* The first subtheme captures how participants shifted their perspectives to reduce feelings of shame. Participants spoke of adopting a new outlook on what happened i.e., as a learning opportunity or realising they are not alone which was helpful. Similarly, to do this, two participants talked about doing good and giving back, which again helped change their perspective and feel less shame. The final subtheme explores how participants accepted themselves intertwined with feeling validated and understood by others. This acceptance from themselves and others was integral to their final stage of the journey of moving through and beyond feeling shame.

The findings of this research provide helpful direction for practitioners, highlighting the need to facilitate openness. In doing so, positive outcomes can be sought from difficult feelings of shame. It is necessary that practitioners consider how to reduce their client's feeling of being trapped by shame by reframing their experience and the impact of this in a helpful way.

Chapter 4- Critique

The ORSGS is one of few scales intended for use within forensic populations. For this reason, it is considered important in helping practitioners explore the potential feelings of guilt or shame experienced by those who have committed offences. Thus, this chapter explored the many factors within reliability and validity to determine its use. Whilst the ORSGS was able to demonstrate acceptable validity and reliability during its development, it is noted that this finding should be taken with caution. As the authors recommended, testing its use with a larger sample is needed and further testing of reliability and validity is important. This, however, does not mitigate that it remains a unique and essential scale. In practice, it is recommended that it be used as part of wider discussions within therapeutic work.

Synthesis of The Findings

Shame and guilt in forensic populations are complex emotions that can hinder rehabilitation and have a negative and lasting impact on individuals. Through the preceding chapters, the importance of such emotions has been shown. Knowing the factors that may be associated with experiencing shame or guilt is shown to be helpful for professionals. The following factors were shown to have some association with offence-related guilt: mental health, offence circumstances and personality. This supports the need for professionals to consider more closely the mental health of individuals they are working with, whilst also considering traits associated with certain personality styles and thus the impact this may have on feelings of guilt. This is important considering the negative impact guilt has been shown to have on mental health, and for personality styles, the impact it has on an individual experiencing helpful guilt that is important to future harmfulness.

For shame, mental health has been demonstrated as an important factor. Like guilt, individuals expressing mental health difficulties may also be struggling with shame beneath

more obvious difficulties that are more easily expressed. This review is a step toward greater awareness and direct engagement with these emotions and their associated factors. Access to validated measures can provide a pathway for exploring these feelings, particularly since distinguishing shame or guilt can be challenging and this was demonstrated in chapter three.

As the SLR demonstrates mental health is implicated by shame. Once identified, as the research shows, providing a therapeutic space to address such feelings can be important. This thesis demonstrates three key considerations for shame: facilitating openness, reducing the sense of feeling trapped, and acknowledging the positive side of difficult experiences that may occur, allowing for emotional processing, building resilience, and supporting reintegration into society, if relevant. For the participants in the research, while shame itself was not a positive feeling, it encouraged change and growth, and participants were able to reflect more positively on their offence and themselves through this.

Thesis Strengths and Limitations

The main strength is the focus on extremely challenging emotions that can be difficult to explore with participants in forensic settings. In this thesis, the empirical research was able to explore the lived experiences of a group of people who have experienced feeling shame. This represents a unique research area and one not done before in this type of service. Few published papers have explored the experiences of MHTR clients, and this remains an important area to research. As discussed earlier, MHTRs are an essential service and the more that is known about it, the more the strengths and areas for development can be explored and actioned. This then supports the service being accessed by others in a more evidence-led manner.

An overall strength of this thesis is its contribution to an increasing area of focus in forensic work. This thesis adds to the developing knowledge that individuals who have

committed offences can experience difficulties resulting from their crimes, including trauma (Soh et al., 2023) detrimental feeling of shame and the more difficult side to guilt when there is an absence of means to repair (Taylor & Hocken, 2021). These feelings can be obstacles to successful reintegration into society. Thus, professionals supporting such groups need to be aware of shame, guilt, and the findings of this thesis. This also ensures professionals recognise the possibility of inadvertently inducing guilt and shame when conducting offence-related work (Taylor & Hocken, 2021).

This thesis, however, is limited by the amount of existing research. For example, the SLR is limited in the number of papers supporting each identified theme. However, it was still able to include an appropriate number of papers to offer a starting point from which to form some conclusions on the associated factors to offence-related shame and guilt. It, however, highlights a clear need for replication of this review once more research becomes available. The limited available research contributes to the thesis's large variance of offence types which limits understanding more specifically for the impact of such feelings across different offences. Nonetheless, this thesis is informative as to the current state of knowledge and lays the foundation for future research.

Implications for Practice

As demonstrated, shame and guilt are crucial emotions in forensic settings and have significant practical implications for professionals. The findings of this thesis speak to CFT as a framework. CFT is grounded in evolutionary theory and as outlined Gilbert (2005) connects shame to humans evolved need for attachment and belonging. The outcome of this thesis suggests settings can take a structured approach to working with these emotions, holding in mind these fundamental human needs.

Firstly, practitioners can be trained to identify the factors that may indicate the presence of shame or guilt. The existence of trauma related symptoms and other powerful emotions such as anger, as identified in the SLR, may suggest to practitioners the individual may be experiencing these feelings. Thus, professionals should, if they identify these factors, give thought to how they can then explore shame and guilt. Rather than to consider these factors in isolation. This may support identifying at-risk groups such as those with diagnoses of PTSD and encourage thought to the approach taken. As discussed earlier, when working with moral emotions, the therapeutic relationship is crucial.

To support this, routine screening can be done with measures such as the ORSGS by Wright & Gudjonsson (2007) which can support practitioners to detect the presence of these emotions. As demonstrated, the use of this scale supports the assessment of treatment needs and outcomes. This can be used in forensic settings such as prison, secure hospitals, and any other setting that works with individuals with a recent or historical offence. Thus, it could also be applied in work conducted with individuals on probation. Whilst as previously noted, it relies on reliable self-reports, the scale should be used to identify potential areas of difficulties concerning shame and guilt. It is recommended the scale be used as part of wider discussions with a client where the answer to each statement is taken in turn and then explored. Of course, this could be shame inducing so how this is conducted is crucial. For this reason, direct attempts for deshaming in therapy is crucial. Gilbert (2011) outlines how a therapist support deshaming including: psychoeducation, validation, distinguishing shame and guilt and using the therapeutic relationship which sits with the themes of this thesis.

Once initial screening and assessment is completed, intervention may be necessary. Holding in mind the work of Taylor & Hocken (2021) there are considerations necessary to undertaking interventions. Firstly, the availability or absence of support and if this would have a profound impact upon carrying out interventions. Secondly, as noted earlier, guilt is difficult

to tolerate, therefore the correct competencies need to first be developed. Finally, if the opportunity for repair is not possible this could be a barrier to guilt. These three aspects appear crucial to consider before commencing any work.

The empirical research began to identify what practitioners can do more specifically when individuals acknowledge struggling with shame. This posed key practical applications for professionals, beyond the practitioners in MHTR services. Firstly, the importance of facilitating openness, whereby practitioners need to give thought to the therapeutic relationship and hold in mind the awareness that individuals may struggle to talk about this feeling. As discussed in CFT, feelings of safety and well- being that lie in the activation of the motivational system- soothing, is poorly accessed for those experiencing high shame and self- criticism (Gilbert, 2009). Thus, developing safety in the therapeutic relationship as part of openness is crucial and can result in overall improved well-being also.

Once openness is established, the importance of working with shame and helping clients to no longer feel trapped by this feeling needs to be considered. The emphasis here, once more, should be on awareness of feelings of shame and recognising how shame may contribute to other mental health difficulties. Finally, the participants from the research demonstrated the positive side of feeling shame. They talked about how they moved through this feeling, and this gave a sense of hope that professionals could impart to their clients. Essentially, awareness and attempts to target shame and guilt is a significant direction that should be taken in practice as evidenced by this thesis.

As illustrated by Garbutt et al. (2023) working with shame in forensics and when this should happen needs to be considered. They demonstrated that through use of interventions targeting shame, the likelihood for further criminal behaviour can be reduced. Gilbert (2011) similarly illustrates the importance of working with shame or guilt in forensic settings. He suggested with a perpetrator of domestic violence, the therapist can support a shift from shame

to guilt, which allows for a move from self- focus and attack, instead understanding how they have come to be violent, the harm they have caused and how to change it.

Alternatively, as illustrated by Taylor & Hocken (2021) this work is difficult, and timing is important. As they outline it is necessary for the individual to experience sadness and guilt, both painful emotions and ones difficult to tolerate. Similarly, there is a possibility of an individual moving into shame instead which is said to compromise engagement with harm (Taylor & Hocken, 2021). Understandably so given shame's motivation to hide which prevents the necessary experience of guilt.

Therefore, there is question of how appropriate working with shame or guilt is. As per other areas of psychological work, a therapist should determine safety of the work. This thesis recommends that practitioners give careful thought to if a person can tolerate the distress that may come with discussing shame or guilt. Crucially, in the case of MHTRs, this work is often undertaken by Senior Assistant Psychologists, remit of work and guidance under the supervision of a qualified psychologist is essential.

Future Research

This thesis represents a unique opportunity to explore feelings of shame and guilt within forensic populations. For this reason, the reported findings would benefit from further exploration. More specifically, the SLR would benefit from being conducted again but focused on one specific population or offence type. This would support advancing more understanding of the associated factors of shame and guilt and how they affect different groups. However, to ensure that there is sufficient literature to include, forensic settings should continue engaging in research and develop effective ways of collaborating with external researchers. Researchers exploring moral emotions should shift focus on forensic clients as the group is at risk of

experiencing shame and guilt associated with their offences. This approach can lead to a larger number of publications and more accurate findings when updating the SLR.

A similar recommendation is made for the empirical research within chapter 3. Again, it would be beneficial to conduct further research that explores how shame manifests differently for different offence types. MHTR providers should seek to engage in further research that gives voice to MHTR clients' experiences, considering the influence of different offence types. In doing so, this contributes to a greater knowledge for professionals of how to effectively support their clients troubled by shame.

In terms of measures developed for measuring shame and guilt for forensic populations, as chapter 4 indicated, this is currently limited. This thesis highlights that individuals can feel trapped in feelings of shame and subsequently find it difficult to talk about this feeling. As such, future research could design and test a dedicated questionnaire that seeks to understand what increases the chances of feeling trapped as a means of understanding what practitioners may hope to target. Similarly, a measure considering the adaptive and maladaptive forms of guilt could be helpful. As previously discussed by Tangney et al. (2011), guilt can be considered helpful, encouraging motivation to make amends, however there can be unhelpful forms of guilt. Unhelpful guilt can promote a sense of being stuck and unable to move beyond the bad action, leading to rumination (Tangney et al. 2011). Knowing what type of guilt clients are experiencing would be informative for intervention planning. Both would support professionals to connect more deeply with an individual's inner experiences.

A simple but significant recommendation is that throughout this research the label "offender" has not been used. This is intentional to avoid the shaming effect this has and should be echoed across research and in practice.

Conclusion

This thesis enhances the understanding of shame and guilt in individuals convicted of offences. Chapter two deepens insight into the factors associated with shame and guilt, identifying mental health as a key area for both. Individually, guilt appears associated with offence circumstances and personality style also. Chapter three demonstrates that MHTR clients often feel trapped in shame but can benefit from opening up and progressing through it in therapy. To better support this group and mitigate the negative impact of shame and guilt, practitioners should consider assessing symptoms using The Offence-Related Shame and Guilt Scale (Wright & Gudjonsson, 2007) as proposed in chapter four. As shown, these emotions may be unspoken yet powerful barriers to improved mental health and rehabilitation, potentially undermining professional efforts. Therefore, practitioners must remain vigilant to their presence. It is acknowledged that working with shame and guilt can be distressing work and the appropriateness of this should be carefully considered, particularly noting safety and remit of practitioners conducting the work. This thesis also contributes to the essential work of professionals more widely by providing insights that can improve therapeutic interventions and support meaningful change, which may consequently lead to better reintegration into society and improved wellbeing for those who have committed offences.

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Appendices

Appendix A: Search Term Syntax

PsychINFO- 1967 to February week 2 2023: Results: 1684

offen* OR crim* OR prison* OR felon* OR inmate* OR delinqu* OR convict*) and (shame* OR guilt*) and (determin* OR predict* OR antecede* OR "risk factor*" OR precursor* OR correlat* OR factor*

Web of Science: 2217 results

offen* OR crim* OR prison* OR felon* OR inmate* OR delinqu* OR convict*) (Topic) and shame* OR guilt* (All Fields) and (determin* OR predict* OR antecede* OR "risk factor*" OR precursor* OR correlat* OR factor* (All Fields)

Scopus: 2693

(TITLE-ABS-KEY (offen* OR crim* OR prison* OR felon* OR inmate* OR delinqu* OR convict*) AND TITLE-ABS-KEY (shame* OR guilt*) AND TITLE-ABS-KEY determin* OR predict* OR antecede* OR "risk factor*" OR precursor* OR correlat* OR factor*

ProQuest: 2578

noft(offen* OR crim* OR prison* OR felon* OR inmate* OR delinqu* OR convict*) AND noft(shame* OR guilt*) AND noft (and (determin* OR predict* OR antecede* OR "risk factor*" OR precursor* OR correlat* OR factor*)

Databases:

Criminology Collection

Psychology Database

Social Science Database

Sociology Collect

Appendix B: Quality Assessment Form

JBI Appraisal Form for Analytical Cross Sectional Studies

[Redcated]

JBI Appraisal Form for RCTs

[redacted]

Appendix C: Overview of Quality Assessment Ratings

Table 11
Quality Assessment Ratings

Papers	Criteria for inclusion	Subjects and settings	Measure reliable and valid	Objective, standard criteria	Confounding variables	Strategies for confounding variables	Outcomes measured	Statistical analysis	Total
Wright et al. (2008)	/	x	/	/	x	x	/	/	5 of 8
Crisford et al. (2008)	/	/	/	/	/	/	x	/	7 of 8
Fuller et al. (2019)	/	x	/	/	/	x	?	/	5 of 8
Batson et al. (2010)	/	/	/	/	/	x	?	?	5 of 8
Fox et al. (2003)	/	/	?	?	/	x	/	/	5 of 8
Fox & Leicht (2005)	/	/	?	?	/	x	/	/	5 of 8
Xerueb et al. (2009)	x	x	x	x	/	x	/	/	3 of 8

Table 12
RCT Quality Rating

	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13

Mandel & Dhami (2005)	/	?	?	?	N/A	/	/	?	/	/	/	/	?

Appendix D: Data Extraction Form

Table 13
Data Extraction Form

Study information	Author Year of publication
Type of research	Quantitative Qualitative
Aims	What was the primary aim of the study? Were there any secondary aims? Were the aims clearly stated?
Participants:	• Are participants over 18? • Are participants adults who have committed offences? • Was sufficient information provided about the context and setting participants were in, for example forensic? • What was the environment? Was this explained and the reasons why? • If professionals were consulted, what professional population was used?
Methods	• What measures were used to identify guilt and/ or shame? • Were the methods clearly depicted? • How was data collected?
Outcomes:	• Were the outcomes clearly stated? • What did the study find? • Were conclusions drawn on the factors of shame and guilt?
Strengths and Limitations	• What limitations were identified? • What strengths were identified? • Were biases mentioned?
Future implications	• What practical implications did the authors suggest relevant to feelings of shame or guilt?

Appendix E: Excluded Papers and Reasons

Table 14
Excluded Papers and Reasons

Publication	Reason(s)
Hamzah, H. (2021). Shame as a predictor of the guilt of sexual offenders in the correctional institutions. *Jurnal Llmiah Peuradeun, 9*(2), DOI: 10.26811.	Wrong Country- Indonesia
Sajadian, M., Younesi, SJ., Jafari, P., Azkhosh, M., Yarandi, RB. & Kordbagheri, M. (2024). Shame, fear of compassion, self- criticism, and self- reassurance mediate the effect of early life events on emotional disorders among male prisoners: A structural equation modelling analysis. *Acta Psychologica, 242*(0), DOI: 10.1016/j.actpsy.2023.104116.	Wrong Country- Iran
Lateef, R., Moloney, F., Ali, A. & Jones, R. M. (2023) Shame among Forensic and Non- Forensic Patients and the Impact of the Social Determinants of Health: A Pilot Study. Journal of Forensic Psychology Research and Practice, 23(1), 92-111. https://doi.org/10.1080/24732850.2021.2016115	Wrong Country
Kovacs, Z., Kun, B., Griffiths, MD., Demetrovics, Z. (2019). A longitudinal study of adaption to prison after initial incarceration. *Psychiatry Research, 273*(0), 240- 246. DOI: 10.1016/j.psychres.2019.01.023	Wrong Country
Merecz- Kot, D., Wezyk, A., Waszkowska, M. & Anydsz, A. (2020). Shame, guilt, time perspective, time of imprisonment and PTSD Symptoms in sentence motor vehicle accidents perpetrators- a preliminary report. *Psychiatria Polska, 54(*6), 1163-1180. DOI: 10.12740/PP/113555	Wrong Country – Poland
Mossiere, A. M. & Marche, T. (2021) Emotionality during and after the Commissions of an Offence: A Look at Offence-Related Shame and Intrusive Memories in Justice-Involved Adult Males, International Journal of Forensic Mental Health, 20(2), 198-211. https://doi.org/10.1080/14999013.2020.1856978	Wrong Country
Espinoza, L. L. D. (2020) Examining the association of Guilt. Shame and Self-Efficacy with Goals for Parolees. (Unpublished Ph.D Thesis) University of Wyoming.	Wrong Country
Khalid, S. & Naz, M. A. (2019). Stress appraisal and related negative emotional experiences of females living in prison. Pakistan Journal of Clinical psychology, 18(2), 17- 31.	Wrong Country- Pakistan

Culda, G. L., Opre, A. N. & Miu, A. C. (2016). Social support and empathy as predictors for guilt-proneness in inmates. *Cognition, Brain, Behavior, An Interdisciplinary Journal, 3*, 195- 201.	Wrong Country
Naheed, J. & Spiker, b. (2014). The relationship of guilt and shame to posttraumatic stress among instrumental and reactive offenders. *(Unpublished Ph.D Thesis)* Northcentral University.	Wrong Country
Marsden, A. B. & Denise, B. (2011). The role of childhood sexual abuse in the development of maladaptive behavior in incarcerated males. (*Unpublished Thesis),*	Wrong Country & Unable to locate full text
Cima, M., Tonnaer, F. & Lobbestael, J. (2007). Moral emotions in predatory and impulsive offenders using implicit measures. *Netherlands Journal of Psychology, 63*, 133-142. DOI 10.1007/BF03061076	Wrong Country
Biron, D. & Johnson, J. (2006). Personality, substance abuse, and lack of self- forgiveness with incarcerated males. *(Unpublished Theses),* Resent University	Wrong Country
Mossiere, A. M., Olver, M. & Marche, T. (2020). Psychopathy, emotionality and offending. *The Journal of Forensic Psychiatry and Psychology, 31*(4), 520-540. DOI: doi.org/10.1080/14789949.2020.1772341	Wrong Country
Bridges, A. J., Baker, D. E., Hurd, L. E., Chamberlain, K. D., Hill, M. A., Karlsson, M. & Zielinski, M. J. (2024). How does timing affect trauma treatment for women who are incarcerated? *Criminal Justice and Behavior, 47*(6), 631- 648. DOI: **10.1177/0093854820903071**	Wrong Country
O'Brien, K. & Daffern, M. (2020). An exploration of responsivity among violent offenders: predicting access to treatment, treatment engagement and programme completion. *The Australian and New Zealand Association of Psychiatry, Psychology and Law, 24*(2), 259-277.	Wrong Country
Kaplan, S. P. (2024). Interpersonal violence, internal attributions, and social reactions as predictors of PTSD in women in jail. *Dissertation Abstracts International: The Sciences and Engineering, 85*(2).	Full paper could not be located
Butcher, E., Packham, C., Williams, M., Miksza, J., Kaul, A., Khunti, K., & Morriss, R. (2021). Screening male prisoners for depression and anxiety with the PHQ-9 and GAD-7 at NHS Healthcheck: patterns of symptoms and caseness threshold. *BMC psychiatry, 21*(1), 446. https://doi.org/10.1186/s12888-021-03453-2	Not relevant
Ivan, A. & Ivan, L. (2022). Do sexual aggressors have feelings of shame and guilt? *Romanian Journal of Forensic Science, 23*(130), 143- 150.	Includes under 18's

Weizmann-Henelius, G., Sailas, E., Viemerö, V., & Eronen, M. (2002). Violent women, blame attribution, crime, and personality. *Psychopathology, 35*(6), 355–361. **https://doi.org/10.1159/000068590**	Includes under 18's
Smith, D. R. (2012). Guilt and shame in regards to sex offender empathy. *Dissertation Abstracts International: The Sciences and Engineering, 72*(9), 5580.	Full paper could not be located.
Exposito, F., Valor-Segura, I. & Herrera, MC. (2013). Rape myths and sexism in victim blame in incarcerated males. *Psicologia Juridica Aplicada A Los Problemas Sociales, 0*(0), 119-128.	Full paper could not be located.
Brennan, C. L., Swartout, K. M., Cook, S. L., & Parrott, D. J. (2016). A Qualitative Analysis of Offenders' Emotional Responses to Perpetrating Sexual Assault. *Sexual Abuse, 30*(4), 393-412. https://doi.org/10.1177/1079063216667917 (Original work published 2018)	Wrong Population (Non- forensic)
Shanahan, S., Jones, J. & Thomas- Peter, B. (2011). Are you looking at me, or am I? Anger, aggression, shame and self- worth in Violent Individuals. *Journal of Rational- Emotive & Cognitive- Behavior Therapy, 29*(2), 77-91. DOI: 10.1007/s10942-009-0105-1	Not offence focused
Morrison, D. & Gilbert, P. (2001) Social rank, shame and anger in primary and secondary psychopaths, *Journal of Forensic Psychiatry, 12(*2), 330-356, DOI: 10.1080/09585180110056867	Not offence focused
Milligan, R-J. & Andrews, B. (2005). Suicidal and other self- harming behaviour in offender women: The role of shame, anger and childhood abuse. *Legal and Criminological Psychology, 10*, 13-25. DOI: 10.1348/135532504X15439	Not offence focused
Garbutt, K., Rennoldson, M. & Gregson, M. (2024). Sexual Offending: Adverse Childhood Experiences, Shame, and Self-Compassion Explain the Variance in Self-Harm and Harm Towards Others? *Sexual Abuse, 36*(6), 662-691. DOI: 10.1177/10790632231201398	Not focused on offence- related shame. Explains why harm may occur, but not shame as a result of harm caused.
Dolan, R. & Staff Team (1995). The attribution of blame for criminal acts: relationship with personality disorders and mood. *Criminal Behavior and Mental Health, 5,* 41-51.	Quality
Shine, J. H. (1997). The relationship between blame attribution, age and personality characteristics in inmates admitted Grendon therapeutic prison. *Personality and Individual Differences, 23*(6), 943-947. https://doi.org/10.1016/S0191-8869(97)00128-1	Quality

Appendix F: Process for narrative synthesis

Popay et al. (2006) outlined the tools and techniques to conduct a narrative synthesis. Firstly, a tabulation of the main details and findings of each study. As Booth et al. (2016) suggest for a narrative synthesis such as this, tabulation can be used to ensure the reader can begin to identify the patterns across the included studies, which supports the development of the story being told. Table 3 presents the main characteristics of each participant group, including demographics and offence types. Following this, similarities and differences are noted across the data and the development of themes is conducted by grouping main ideas and conclusions.

Appendix G: Reflective Account

The process taken to synthesise the findings entailed grouping findings based on their similarities. Mental health was one of the identified themes. Its creation was partly informed by the researcher's clinical experience. The researcher recognised areas such as anger and trauma to be associated overall with mental health, and so it was decided that whilst these papers each spoke to something slightly different, they all supported an overarching theme of mental health being associated. The introduction of the researcher's clinical experience introduces the potential for bias; however, as per Popay et al. (2016), grouping based on thematic relevance is the approach taken. Similarly, papers were grouped where their findings in terms of a specific factor were the same, even if they did not necessarily agree. For instance, offence circumstances, as will be discussed, demonstrated a difference across the papers; however, they still discussed the same factor and so were grouped. Grouping the papers was made more difficult by the limited number of papers and the limited consensus across them. However, holding in mind the guidance by Popay et al. (2006), differences, as well as similarities, still provide patterns and support the intended storytelling to meet the aims of this review.

Appendix H: Email to MHTR Practitioners for Recruitment - - Sent by Clinical Lead

Hello everyone,

I'm conducting a study to understand how feelings of shame are linked with MHTR treatment. This research is incredibly meaningful for the clients and aims to enhance the service and its outcomes. By contributing to this study, you can make a real difference in our field. I would greatly appreciate it if you could review your current caseload against the following selection criteria to identify potential participants:

Selection Criteria:

1. Attended at least 2 MHTR sessions or have recently completed an MHTR.
2. English-speaking.
3. Must have the capacity to consent. If unsure, this should be checked against relevant records.
4. No concerns about severe alcohol or drug issues that may impact the interview.
5. Low risk to self or others. If not certain, this should be checked against relevant records.
6. The client is not recorded and did not self-identify as pregnant.

Please reach out to eligible clients, sharing the attached invitation and information sheet, and allow them up to a two-week period to decide. Should they agree to participate, I would be grateful if you could arrange a meeting with me, whether in person or online, so I can meet them and discuss the research in more detail. In addition, I am willing to join any pre-arranged meetings you may have to advertise the study further.

Should a client agree to take part in the research, you will be made aware of the interview date and time. For face-to-face interviews, your presence nearby for safety and to facilitate any necessary information exchange would be most helpful. For Microsoft Teams interviews, please be available afterwards for a short call to support sharing necessary information and to check-in with the client. I respectfully ask that participants be put forward only if these safety measures can be adhered to.

As a token of appreciation, participants will receive a £20 Amazon voucher for their valuable participation. For any queries or further discussions regarding participant suitability, please do not hesitate to get in touch with me. This research has received ethical approval from the North West - Greater Manchester East Research Ethics Committee (Ref 23/NW/0087).

Kind Regards,

Olivia Hopkins- Young- [email address]

Appendix I: Participant Advert Form

UNIVERSITY OF BIRMINGHAM

Invitation to Participate

Project Title: Understanding Shame Experienced by Clients Engaging in an MHTR

Dear potential participant,

I warmly invite you to participate in a research study I'm conducting as a doctoral student at the University of Birmingham. We are exploring the feelings of shame and their connection to Mental Health Treatment Requirements (MHTRs). Your participation, through a confidential interview lasting up to an hour, either face-to-face or via Microsoft Teams, would be immensely valuable in enhancing our knowledge regarding MHTR services and potentially aiding client recovery.

The interviews will be transcribed and all resulting data will be anonymised. All personal details such as age, gender, offence type, and mental health diagnoses will be securely handled and kept confidential. As a token of appreciation for your time and insights, we offer each participant a £20 Amazon voucher.

If this opportunity interests you, please contact your MHTR practitioner to schedule a meeting with me. We can discuss the study further and, should you agree to participate, arrange the interview and complete a consent form.

Please see the attached Participant Information Sheet should you wish to learn more about the study prior to arranging the meeting. Your consideration of this request is greatly appreciated.

Kind regards,
Olivia Hopkins- Young
Trainee Forensic Psychologist

Appendix J: Participant Information Sheet

UNIVERSITY OF BIRMINGHAM

PARTICIPANT INFORMATION SHEET

Project Title: Understanding Shame Experienced by Clients Engaging in a Mental Health Treatment Requirement (MHTR)

Before you decide to take part, it is important for you to understand why the research is being conducted, what it will involve, and why your participation is important. Please take your time to read the following information carefully.

What is the purpose of the study?

The purpose of the study is to explore feelings of shame and how these relate to mental Health Treatment Requirements (MHTR).

This study will contribute to the researcher, Olivia Hopkins-Young's doctorate in Forensic Psychology. The study is sponsored and insured by the University of Birmingham.

What will happen if I decide to take part?

Participating in this study involves an interview with researcher Olivia Hopkins-Young, focusing on shame and its impact on your Mental Health Treatment Requirement (MHTR). This one-hour interview can take place at the NHS or a charity organisation where you see your practitioner or via Microsoft Teams if preferred. Interviews will be audio-recorded for accuracy and transcription using a password-protected Dictaphone for both face to face and Microsoft teams interviews

We will ask you some questions about feelings of shame and how this feeling interacts with your MHTR.

If it makes you more comfortable, you're welcome to have your practitioner join the interview; just let them know. We have also asked that your practitioner be available after the interview if you want to discuss anything with them. Your probation officer will also be informed of your participation, but please do not worry; your participation will have no impact on your community order.

If interviews are conducted via Microsoft Teams, please ensure you are in a private and safe space.

Why have I been chosen to take part?

You are invited to participate in this study because you are currently engaging in a Mental Health Treatment Requirement (MHTR), have had at least two MHTR sessions. or you have recently completed an MHTR

What are the benefits of taking part?

Participants will receive a £20 Amazon voucher as appreciation for their time. This voucher can be spent on anything available via the Amazon website.

Your contribution to this study is also valuable for practitioners and services. The resulting knowledge could influence treatment approaches in MHTR services and, therefore, help others in the future. Study findings might be included in publications, reports, and presentations, ensuring anonymity in all formal outputs. We hope that through this approach we can reach a broader audience and create more positive impact.

Are there any risks associated with taking part?

Discussing experiences related to an offence can be difficult and might be distressing. If conducted face to face, the interview will take place in a secure environment, and you can choose to have your MHTR practitioner present. If the interview is remote on Teams, your

practitioner will be informed afterwards and will be available for support. You have the freedom to decide what experiences to share, but please be aware that any mention of risk to yourself or others or involvement in criminal activities must be reported to your probation officer and MHTR practitioner.

Do I have to take part?

Participation in this study is entirely voluntary. You can withdraw at any time without needing to provide a reason, either during the interview or within two weeks of participation. After this period, your data will be fully anonymised and cannot be removed. The nature of the research requires specific record management, so you won't be able to access or modify your data. If you decide to withdraw, please contact the researcher or your MHTR practitioner promptly. Withdrawing will not affect your community order or treatment.

Even if you withdraw, a debrief session with the researcher is available, allowing you to ask any questions. If at any point it's determined you lack the capacity to consent, you will be removed from the study, but your data collected until then will be retained. 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.

Withdrawing from the study will not impact on your community order.

What will happen next?

If you are still happy to participate, please let your MHTR practitioner know. A date will then be set to meet the researcher, Olivia Hopkins-Young so you can discuss the study and ask any questions. You will be asked to sign a consent form and then set a date for the interview.

Please make your MHTR practitioner aware if you would like them to be present in the meeting.

If you would like a copy of the research when completed this will be published on the University of Birmingham, eTheses- https://etheses.bham.ac.uk. Please note it could be a number of years before the research is published.

Data Protection and Confidentiality

The transcription of interviews will be done by the researcher, Olivia Hopkins-Young.

We will need to use information from you and your records for this research project.

This information will include your name, age, number of sessions attended, offence type and any mental health diagnoses. 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.

Everything you say/report is confidential unless you tell us something that indicates you or someone else is at risk of harm. We would discuss this with you before telling anyone else.

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.

If you agree to take part in this study, you will have the option to take part in future research using your data saved from this study.

Audio recordings of the interviews will be securely stored. The recordings will be typed up by the research team and then deleted. The transcribed and anonymised data may also be shared on an open-access repository for other researchers.

What if something goes wrong?

The University has in force a Public Liability Policy and/or Clinical Trials policy which provides cover for claims for "negligent harm" and the activities here are included within that coverage.

Future research:

If you agree to take part in this study, you will have the option to take part in future research using your data saved from this study. Only anonymised data from this project would be shared with other researchers for future research. Future research may recruit larger sample size and perform different analyses.

Where can you find out more about how your information is used?

- at www.hra.nhs.uk/information-about-patients/
- our leaflet available from **www.hra.nhs.uk/patientdataandresearch**
- by asking one of the research team
- by sending an email to email protection [email address]

What if I have any questions?

If you have questions about any aspect of this research, please contact the Lead Researcher Olivia Hopkins- Young, [email address]. However, you may also contact the project supervisor, Dr Artur Brzozowski at [email address].

If you decide to withdraw before the interview date, please contact your practitioner to make them aware.

Complaints

If you need to make a complaint, please use the contact details below: Research Governance [email address].

If you would like a copy of the research results when completed, please email Olivia, as above or inform your MHTR practitioner.

Olivia Hopkins- Young

Lead Researcher

University of Birmingham

Birmingham, B15 2TT

Email: [email address]

Sources of support

- Mental Health Hub- 0800 448 0828, this line is available to anyone residing in Northamptonshire and is available 24/7 and free to call.
- Text 'SHOUT' to 85258 – free, confidential 24/7 support service for anyone in the UK struggling to cope.
- Samaritans- 116 123
- Northamptonshire Healthcare NHS Foundation Trust Crisis cafes: https://www.nhft.nhs.uk/crisis-cafe. There may be crisis cafes in your local NHS trust, please ask your practitioner.
- MIND- 0300 123 3393 or visit mind.org.uk

Appendix K: Consent Form

UNIVERSITY OF BIRMINGHAM

Project Title: Understanding Shame Experienced by Clients Engaging in a MHTR

Participant ID:

Please read the following statements and initial the boxes to confirm you have read and understood each statement.

1. ☐ I understand my participation in the study is entirely voluntary. If I choose to participate, I understand the study will hold no implications for my community order. I can withdraw at any stage during the interview and up to two- weeks after without giving any reason, without my medical care or legal rights being affected.

2. ☐ I have read and understood the Participant Information Sheet and have had the opportunity to ask any questions I may have and have had these answered satisfactorily.

3. ☐ I am aware I will be asked a series of questions about my experiences of shame, and this may take up to an hour. Some of the questions may cause upset. If this happens, I know I can stop taking part in the study at any time.

4. ☐ I understand the interview will be audio recorded; this will then be deleted once typed up. I am aware that anything I say could be quoted in the research, but this will be anonymised.

5. ☐ I understand my answers will be treated confidentially and the information I provide will be kept anonymous. However, if I disclose information relating to risk to myself or others or that I am planning or have committed a crime, the researcher is obligated to action this information and share it with the professionals working with me or report this further.

6. ☐ I understand the data collected about me will include my age range, the number of sessions I have had, offence type and any mental health diagnoses.

7. ☐ I understand if I opt for a remote interview conducted on Microsoft teams I will need to share my email address so the link can be shared with me and relevant documents.

8. ☐ I understand, however, that all data will be made anonymous in the final output.

9. ☐ I understand that relevant sections of my data collected during the study, may be looked at by individuals from the University of Birmingham, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.

10. ☐ I understand that the information collected about me will be used to support other research in the future and may be shared anonymously with other researchers. **This is optional, and you do not have to agree to this.**

11. ☐ I understand my probation officer will be informed I am taking part in this study. What you discuss in the interview will be kept confidential, unless it concerns risk to yourself, others or in regards to a crime. We would discuss this with you before telling anyone else.

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

You will be given a signed copy of this consent form. A copy of the signed consent form will also be kept by the sponsor.

Name of Participant

Date Signature

Name of Person taking consent

Date Signature

If you have questions about any aspect of this research, please contact the Lead Researcher Olivia Hopkins- Young, [email address]. However, you may also contact the project supervisor, Dr Artur Brzozowski at [email address].

Thank you for taking the time to participate in this research. Your help is very much appreciated.

Appendix L: Interview Questions

As a reminder, this interview and your participation in this research is completely optional. You do not have to engage and there will be no consequences if you don't. If you would like to withdraw your participation, you can do this at any time during the interview and up to two weeks after.

I'd like to start by thinking more about shame and what it is, so we are on the same page.

1. What do you think shame is?

Prompt- Shame is a moral emotion that can make us feel bad about ourselves, that we are wrong or bad in some way. We may not want people to know the thing we feel ashamed about and so shame can motivate us to want to hide, escape or withdraw in some way.

Do you have anything you would add or change? Why do you think we experience it?

2. What do you think guilt is?

This research is focusing on shame, but as there is some overlap, we think it would be good to acknowledge the difference now. Shame is different to guilt and this research is focused on feelings of shame only. Guilt is different as it is the feeling of having done something wrong and is prompted by others.

3. Have you experienced shame after offending?

Prompt: Could you tell me a time that you particularly remember where you felt shame and what it was like for you?

4. Can you tell me what happened when you experienced shame?

Prompt: How it felt or what it made you want to do?

5. How does it feel now talking about shame?

6. Do you feel shame relates to your MHTR appointments in any way? Have your feelings of shame changed?

Prompt: Thinking about the earlier definition, we know shame may make us want to hide away or escape so this could be an influence. We may also experience self- criticism and feeling bad about ourselves from shame, this would also be an influence. People sometimes describe feeling stuck in shame, that having motivation to go toward or make changes is more difficult but not everyone feels like this, is there anything you wish to add?

7. Do you feel your MHTR addresses or acknowledges feelings of shame?

Prompt: Has shame been mentioned in your appointments? Do you feel the work you have done has helped with feelings of shame?

8. If you could share anything with someone feeling shame or who has just started an MHTR what would you say? Is there anything else that you feel is important for us to know in this research?

Appendix M: Debrief Form

Participant Debrief

Thank-you for taking part in our study. Your time is much appreciated.

The current study aims to explore individual experiences of shame of people engaged in a Mental Health Treatment Requirement. You were asked a series of semi- structured interview questions to explore and understand your feelings and experiences of shame and consider how shame interacts with and influences treatment. It is hoped this research will inform MHTR service providers and professionals to understand shame and the potential importance of this to treatment needs and engagement in therapy.

Researching the area of shame is important. People with high levels of shame can experience difficulty being kind to themselves and being self- compassionate (Gilbert, 2009). It could be considered that these influence overall wellbeing and mental health (Inwood & Ferrari, 2018). Moreover, shame is considered a difficult emotion and can be associated with an array of health outcomes, yet is considered understudied (Goffnet, Leitchy & Kidder, 2020). Shame has been found to be associated with psychological characteristics and are understood to hold an important part in the rehabilitation process (Tangney, Stuewig, Hafez 2011). Knowing more about shame supports the review of interventions. In this way, knowing how it can influence the process of an MHTR amongst other areas significant to the individual is an important part of the work delivered by services such as MHTRs and for clients of the service.

If you have any questions or would like to know more you can email the lead researcher Olivia Hopkins- Young, [email address]. If you wish to withdraw your data from the study, you need to email this address within 2 weeks of taking part. You do not need to provide a reason and there will be no consequences for this.

If you have any complaints about your experience participating in this study, please direct complaints to: Research Governance [email address].

If you would like a copy of the research when completed this will be published on the University of Birmingham, eTheses- https://etheses.bham.ac.uk. Please note it could be a number of years before the research is published.

We understand that talking about your experiences of shame may have felt difficult. If you require any support or help following participation, below are the organisations that you may wish to contact for support. We would also encourage you to speak with the professionals currently working with you, they are aware of your participation and have been asked to provide you an opportunity to meet and access support in regards to your participation. If you would like us to arrange this, please do make us aware as soon as possible. This will be discussed at the end of your interview to ensure you have had the opportunity to check in with the professionals working with you.

- Mental Health Hub- 0800 448 0828, this line is available to anyone residing in Northamptonshire and is available 24/7 and free to call.
- Text 'SHOUT' to 85258 – free, confidential 24/7 support service for anyone in the UK struggling to cope.
- Samaritans- 116 123
- Northamptonshire Healthcare NHS Foundation Trust Crisis cafes: https://www.nhft.nhs.uk/crisis-cafe. There may be crisis cafes in your local NHS trust, please ask your practitioner.
- MIND- 0300 123 3393 or visit mind.org.uk

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Contact details for Researcher, Olivia Hopkins- Young:

[email address]

Contact details for Supervisor, Dr Artur Brzozowski:

Assistant Professor in Forensic Psychology

[address and telephone number].

Appendix N- Ethical considerations

There were important ethical considerations within this research due to the nature of the research area. The consent form (Appendix I) was used to obtain fully informed consent from participants. The information sheet and consent form outlined the right to withdraw from the project during the interview and up to two weeks following participation. This was detailed clearly in the debrief form (Appendix L). Participants were informed that there were no consequences for withdrawing from the study and that their data would be removed and discarded. Noting informed consent and process to withdraw is particularly crucial where it was acknowledged that participants would be engaged with an MHTR, a community order as sentenced by the criminal justice system. Thus, it was ensured that participants were aware that participation did not hold any weight to their order and that it was clear they did not need to participate. Similarly, it was ensured that participants knew that withdrawing from the study would not affect their order.

Confidentiality and storing of data were pertinent. Interviews were confidential unless any information pertaining to risk was shared, in which case it would need to be fed back to the practitioner working with them to facilitate risk management. Participants were made aware of this upon signing the consent form, however, no information was shared during this research that necessitated information sharing. As outlined in the consent form, participants were given a three-digit ID to anonymise data held, including their demographic data. This allowed identification of the data in the case of withdrawal or loss of capacity. This information and the interviews, that were recorded on an encrypted Dictaphone, were stored safely in a secure research data store at the University of Birmingham. Once transcribed and anonymised, they were deleted. This ensured the protection of the confidentiality of participants, again particularly important given potential media interest around individuals with offences.

Due to the nature of the research, ethical considerations for protecting participants were necessary due to raising potentially distressing topics with them. Thus, support services and

support from professionals working with the participant were available and encouraged. This was detailed in the participant information sheet, consent form, and debrief form. Appendix M presented a risk protocol; part of this was to manage potential risk posed to the researcher. For the safety of both the researcher and participant, in the instance of face-to-face interviews, MHTR practitioners remained nearby during completion of the interviews.

Appendix O- Distress Protocol

Appendix P- Table of GETs

Table **15**

GET 1: Stuck in feelings of shame

Chris	Colin	James
Stuck and avoidance. Getting stuck in shame and subsequent negative self- talk- p17. "if I sit down and wallow in my shame then it's just going to progress into more and more negative outcomes and it's going to make me, even if I'm subliminally talking about myself in a bad way it's just going to make me view myself as that" Avoidance of feelings such as shame as get stuck in it- p9. "I'm trying to see the positive in it all really, not dwell on them emotions because I am quite in tune with them so if I start going down a rabbit hole with sad, fear and shame I start in it for ages" Impact of avoidance- p1. "you'll have deeper psychological issues if you start doing that, yeah to bury it"	**Shame as long lasting** Long term effects- p5/ p6 "even after, after I was on probation it (feeling shame) still went on for months, you know after the court hearing still continued" "I don't know if it's (shame) affected us now because I've become more of a recluse" Understanding and dealing with shame for months- p7 "now I would say I understand it and I look back on it, I'm a lot more comfortable in myself at the moment now, it was a big thing I had to deal with for months to forgive myself"	**Shame as an all-consuming feeling.** Constant feelings of shame Shame is there everyday- p4. "all the time, everyday... look back and think, that wasn't the sort of person I was, I don't know what made me get to that point" Feelings of shame will always be there- p17 and p15. "understand a bit more why I feel like this, (doing that, has that changed some of the shame you've felt?), no [laugh], no, I'll always have, It'll always be there" "I don't think its (shame) changed it, it's always going to be there" Shame will never go- p13. "it (shame) will never change, that shame will never go... it will be there, probably for life, because you know if, you know like you're really sorry about whatever happened that will be there for life you know you won't forget it" feeling shame preventing continuing with usual life- p16. "i was quite a good footballer, urm and i just didn't want to pursue it anymore, because of that (shame)... just didn't want to leave the house, sort of get out of

			bed or, meet anyone, urm yeah, I don't know if people out and things, as well" Feeling shame prevented thoughts of future goals- p16. "i used to have a lot of dreams back in the day, i used to do a lot of snooker and pool" Being unable to do everyday things- p6. "isolation [pause] from people, urm not seeing my mates anymore [pause], urm not even talking to my family anymore, urm loosing my jobs over it, yeah just affected everyday life really"

GET 2: Experience of opening up

Table 16
GET 2.1: Recognising a need to open up

Jenny	James	Chris	Jane
Need to be open in MHTR appointments-p22 **"**Because if you're not honest because the only person you're lying to is yourself and you're not going to get the right support" Feels good to acknowledge feelings of shame and someone listen- p16	**Talking as helpful** Talking to a stranger lets it all out- p2. "talk about how you feel all the time and or even talk to a stranger would be better than talking to someone you know, that might be yeah... a better way of coping with it, so it let's it all out"	**Opening up** The value in just being honest and facing what you have done- p10. "it's just like, it's just bite the head of the snake, if someone doesn't want to hear it even if it's not, just get it out there and tell it straight and you'll feel everything	**Opening up to a stranger** The value of going to therapy, someone separate and not feel shame in front of that person p.7 "I just wish everybody would see therapy and urm not feel shame at all in front of someone who is not your close friend, or you know, make it easier for

“I think it’s good to be able to acknowledge it (shame) and have someone listen to you” The value of acknowledging shame- p6. “some people choose not to acknowledge it (feeling shame) which in itself is sad” The impact of systemic issues causing delays and people not being able to talk about their shame- p7 “The system is so overwhelmed which [pause] if something could be done to fix it people would learn to acknowledge shame and talk about it which I think is really important” Delay in sentencing impacting the need to talk about it p6 “I mean there was a delay in me being sentenced and everything like that through various different reasons but yeah it was just prolonged I didn’t	MHTR as a space to “let his feelings out” - p11 “I can see that it’s helping... starting to help... letting your feelings out, urm speaking to people”	just start to relax a little bit and it’s like” Increase in feeling shame when talking about the events but need to “face it” - p20. “probably would increase a little bit of shame going through it all, but I suppose unless you really face it if you keep running away from it you’re never going to tackle it so, I think” Feeling shame when starting to open up- p15. “yeah when i first started opening up and talking about what I had done, sure, it get’s a bit like oooft, you do feel shame again” The negative impact of “bottling it up” - p24. “it’s like for me if i bottled all this up and felt bad about it it would probably lead me to lash out and not control things because it would overtake your life a little bit if you keep worrying about it and	people to speak about their shame” Talking to a professional helped p.5 “What helped was possibly urm speaking to someone who wasn’t, urm, personally involved in my life, I was able to go, you know, this is me” Talking to a stranger helps to open up p.2 “You can get stuck in that feeling but if you’ve got somebody that’s not a friend or family or anything like that being able to, to talk to, yeah to open up” Easier to open up to someone separate p.6 “They have helped me a lot because it’s easier to open up to someone who is not urm immediate family or friends” Value in opening up p.9 “I would say open up, you won’t lose anything”

have the opportunity to talk it out loud"	worrying about it will ruin you" Journey of openness and taking accountability– p18. "once you've told that and you realise no one will judge you any different it's like oh ok I've been bottling that up and sitting on it for all this time and I've not needed too, so yeah, in my case, just getting it out, be like, taking it, not trying to deflect it or justify your actions, or whatever, just say I've done it" Acknowledging the things I have done- p1. "I have had to look myself in the mirror, the things I have done so that's where the shame comes in" **Helpful talking to a "neutral perspective"** **"**getting it all out" to a professional- p24/ p19 "I would say seek help, seek help or yeah yeah I would	Opening up is key, not just about shame but other worries p.6 "most definitely, most definitely. Yeah cause I can discuss anything, like urm, my worries…" Feeling bonded with practitioner marked by being able to talk about anything p.5 "What helped was… that I was able to bond with my practitioner and be able to, to talk about anything" Being accepted by others -p.1 "When you do open up it makes it easier, when you feel that embarrassment or shame in life, you just need someone to say, urm, you're ok" Accepting it herself has allowed her to be more open- p.6 "I've come to terms with things and I have been able too, like I say, open up a little bit more, and just go, I don't need to be ashamed of the things I have done

		say seek help cause I think you can't talk to certain people about some things because that's where the guilt or shame come from so I'd say seek professional help from a neutral perspective and get it all out and you'll see how quickly improves you" "it helped to get it out to a neutral perspective... it's nice having someone to chat to about it"	anymore, I just don't, and urm what happened, has happened now, so I can just you know move on"

Table 17
GET 2.2: "It's a hard thing to talk about"

James	Jane	Colin
Shame is a hard thing to talk about- p1. "you just don't want to talk about, talk about it (shame) to anyone, it's a hard, it's a hard thing to talk about" " Difficult to talk at the start of MHTR- P14. "Just not used to it, just not used to being in this situation... it's like alien to me, so it's hard to speak about it, haven't really done it my whole life either, I've bottled everything up, and	**It's difficult to talk about** Finding it difficult to say how I feel p.2 "It was so difficult obviously seeing somebody new and say, oh this is how I feel to a complete stranger, it's hard" Shame creates difficulties opening up p.1 "Shame is urm, errr, the feeling of being embarrassed to open up, to say how you feel"	**Talking about feeling shame and shameful thing** Difficulty saying it out loud to a stranger for MHTR- p15. "it's going to be difficult you know you have to talk about things you don't want too you have to open up and say things you hoped people would never hear" Important for others to know he admitted it – p4. "urm I admitted it straight away, straight away, no point trying to deny it I said yes I did it was me, there was two

that's probably, that didn't help either"	People struggle to talk about the things they feel shameful for p.2. "People go into themselves and then just, or keep things to themselves and then don't want to because of the shame of it all" The understanding we all make mistakes but still difficult to say p.2 urm sometimes, we all mistakes, we all do some weird and shady things and sometimes it's so hard to say…. sometimes it's hard to open up to things, oh no you're a thief aren't you, you know, you're a bad person" Shame not viewed as something to talk about p.9 "I think probably sometimes people don't feel, don't feel they should talk about that bit of how they are feeling" Other things take priority in sessions p.9 "I never thought about speaking about the shame, it was the other feelings that have made me not feel the shame" Need to discuss in future sessions p.9 "I've got more sessions and that would be quite	separate things, do you know what I mean, I was fully admitting what I did... but then trying to hide afterwards, the shame set in"

	interesting to discuss really (shame)		

GET 3: Moving Through Shame

Table 18
GET 3.1: Finding ways to look at it all differently

James	Chris	Jenny	Colin
Looking at the situation differently Recognising I am not the only one and people go on MHTRs for different reasons- p12. "I felt more shame, then, but now I'm not the only person, I don't think, so that's kind of made me, alright I shouldn't be on an MHTR anyway but I'm not the only person so that's kind of pushed me a bit... like a lot of people go on them, for all different reasons" Not me- Separating self from what happened- p4. "Look back and think, that wasn't the sort of person I was, I don't know what	Feeling you have to go through shame to know and accept yourself- p11. "I feel like you have to go through rough stages and shame, experience it all before you can just be at one with yourself because it's like you don't really know yourself until you have been in that deepest, darkest bit of shame" What happened was a "blessing"- p15. "obviously I do feel shame, but I also I think it was a bit of a blessing to get me a final kick up the arse to say come on mate what are you doing" Grateful it happened as it led to other	Help others and be an advocate – does it improve feeling about self- p16. "because if it can help anyone else if it can give anyone advice or guidance I've got something out of it" "I have always been very good at being an advocate for other people" Feeling shame and turning that feeling into a positive outcome p12. "it's predominantly a negative word but you can probably feel shame for something but have made a positive outcome out of it"	**Needing to give back** Paying back changed feelings of shame- p11 "I'm just guessing and that but with doing the community service and the like making do you know I mean it feels like I'm paying something back that I've done something good" "it's not as bad because I feel I've given something back"

made me get to that point” Important to learn from shameful experience and carry on- p3. “if you feel that much shame, you won’t do it again [pause], urm yeah you learn from your mistakes and you live through them. You’ve got to live through them... learn from them and carry on with how you have to be, it’s your life at the end of the day” Time helps shame- p8. (what helped change that shame) “it’s just time, you can’t live like that for the rest of your life because you’re just not going to get nowhere” Importance of not giving up and carrying on- p20. “don’t give up, pursue it, urm always think that, no ones in your life really, like no ones in your head, it has to be, you and you only in your	difficulties being dealt with- p6. “i am actually grateful it all happened, you know fucked up, urm I got my diagnosis, I’m on medication... I’m kind of grateful for it, it’s given me a big change of perspective”	Seeing what happened as an opportunity- p12 “just a little moment in time that just almost like that sliding doors type of thing, where it’s kind of like you can go either way” “Getting the support I need now”- p20 “I mean I'm very lucky that in my instance no one got hurt so I think that’s one of things that I in a weird way take as a positive which is a positive, so i think thats just one of the key things i take from this whole process I'm getting the support i need now” Learning opportunity- p5. “I’ll never be able to get rid of that particular day in my head so but it’s also I think it’s also a learning curve for you to learn through how it feels and I think everyone at some stage in their life must feel shame”

body so you need to look, carry on with life as much as you can and just, everyone finds shame, just try and work through it, yeah, if that makes, yeah I would say so, yeah work through it, try not to hide away because it will make you feel better”	Changing perspective – p15, p21 “Sometimes these sorts of things do add to the shame because it’s like I caused it but then I try and put the spin on it ok well I can’t change it” “someone else is always having a worse day than you... I think it’s always about context... yes challenging your perspectives and then also understanding why” Seeing it as making you the person you are today- p5. “I don’t like to say I regret things because I believe regret is you wish you’d never done it but it makes you into who you are today” Hopeful that feeling shame is something that can be worked through- p2. “I have said several times I don’t want to be ashamed of myself anymore so I can’t change me feeling guilty but I think shame is something that you can develop

		you can adapt, not adapt it, but you can kind of like work your way through your skills and your coping mechanisms and things like that to be like ok I didn't do the right thing but I'm working on coping with the decision I made" Changing feelings of shame takes time and you have to keep trying- p22. "it's about keep trying... put it down to when we were trying to ride a bike when we were little... try, try, try again"

Table 19
GET 3.2: Acceptance

Jenny	Colin	Jane
Accepting the decisions I made to cope – p2. "Be like ok I didn't do the right thing but I'm working on coping with the decision I made" Feeling the need to accept what happened- p7.	**Needing to forgive myself** To feel better, needed to forgive himself- p1. "I mean I've worked with my practitioner, I've done my community service and helping out in the community, I've worked on myself to forgive myself"	Acknowledging the need for help and being herself – p.5 "Me willing to get that help I think and then I was like you know, you're going to take me or leave me, but this is it" "I was able to go, you know, this is me, shameful me, this is me"

“it happened however many months ago... and I’m learning to accept it” Not see the point in beating yourself up over the same things- p13. “if I'm going off on a little downward spiral i can always try and pick myself up by saying but you’ve already visited this before there’s no point in beating yourself up any more about it”	Helping others to forgive self- p15. “Take your time, don’t try and deal with it all straight away and look at ways you can go back and forgive yourself... I was looking at trying to help the homeless like to you know like to help out and help with the charities and stuff” Probation and time needed to forgive self- p7. “It (feeling shame) was a big thing I had to deal with for months to forgive myself (How?) time, probation, time and probation, probation is a negative thing I used it as a positive.” “I think that times a healer isn’t it”	

Appendix Q- Reflective Diary

As a previous MHTR practitioner, keeping a reflective diary was particularly helpful in keeping in mind the challenges surrounding neutrality. Within my analysis, I was able to draw out potential biases and reflect on them. Below is a summary of the reflections made:

Participants in this research spoke about how it is easier to talk to professionals. Previous clients I have worked with in MHTR services have shared the same experience. They also talked about being grateful to be given an opportunity to talk to a professional, someone outside of their inner circle. Clients I worked with directly linked this to reducing feelings of shame, not experiencing a fear of being judged or letting down their family and friends by talking honestly about how they feel. When participants spoke about this in their interviews, I understood this through this experience, which felt helpful.

In James' interview, he spoke about people being on MHTRs for many reasons, which seemed comforting. I recognised this as a common reasoning for many clients which directly challenges feeling bad about themselves. Clients I have worked with have previously spoken about being bad or seeing themselves differently as criminals for being on an MHTR, so it evoked the same response for me when James spoke about this. It prompted me to think about this as a coping mechanism, which I previously considered it to be. However, I was mindful that James had not labelled it as this, but it was a possible interpretation.

Similarly, participants in this research spoke about seeing their offence as an opportunity, which has been shared by previous MHTR clients of mine and always felt another way of coping with what has happened. For me, this has always evoked quite an emotive response in me. I have seen the desperation clients have felt at having not received help before despite desperately wanting it. This has always made me feel more passionate about the MHTR. I noted that this passion for the service could potentially bias my view of participants' accounts, so I was mindful of this throughout my analysis. When Jenny spoke about the service delays and their impact on her, it again made me think about how desperately many MHTR clients want support and, thus, the importance of getting MHTR services right.

In thinking about the client's views of being bad or a 'criminal', I was mindful of conveying choice as much as possible in the meeting before and during the interview. I reflected on how conscious I felt that, in my experience, MHTR clients can be very agreeable due to worries of how they will be perceived and trying to repair both their views and those of others. I think it was helpful for me to have this knowledge to ensure the research was done most safely.

A significant reflection for me during the analysis was that I had expected more difficult views of shame and engaging with an MHTR. Again, I recognised this biased view, as some clients have previously spoken about how difficult it was to be open and attend MHTR appointments, particularly at the start. This prompted the thought of a potential limitation of this research where a select group are likely participating, those able to talk so openly and want to for the purpose of the research.