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SHAME:
ASSOCIATIONS WITH
CHILDHOOD MALTREATMENT
AND MENTAL HEALTH

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Thesis Abstract

Research consistently reports a relationship between childhood maltreatment and the experience of psychological distress in adulthood. More recently, researchers have sought to identify the emotional consequences of these experiences. The current literature review focuses on the experience of shame. In particular, research is presented which demonstrates how childhood maltreatment, especially psychological abuse, has been associated with the experience of internalised shame. Furthermore, research is presented demonstrating an association between internalised shame the experience of psychological distress in adulthood. A burgeoning evidence base illustrates how shame partially mediates the relationship between childhood maltreatment and the experience of psychological distress in adulthood, although the review concludes that this research remains limited, and the models presented require further investigation to broaden the understanding of the role of shame in the relationship between childhood maltreatment and psychopathology.

The empirical paper explores the associations between childhood maltreatment and internalised shame in a sample of participants with a diagnosis of bipolar disorder (BD; $n = 35$), compared with a control group of participants with no psychiatric diagnoses ($n = 35$). Participants completed measures of maltreatment, internalised shame, and resource loss and gain. Participants in the BD group reported significantly higher levels of internalised shame, resource loss, and most sub-types of childhood maltreatment, compared with participants in the control

group. Internalised shame was significantly correlated with childhood emotional abuse and neglect, even when controlled for the effect of low mood and mania. The theoretical and clinical implications are discussed, and directions for further investigation are indicated.

TABLE OF CONTENTS

List of Tables	xi
List of Figures	xii
Acknowledgements	xiii

LITERATURE REVIEW:

Internalised shame and its association with childhood maltreatment and psychopathology: a review of the literature.

Abstract	2
1. Introduction	3
<i>1.1 Self-conscious emotions</i>	<i>3</i>
<i>1.2 Shame and guilt</i>	<i>4</i>
<i>1.2.1 Shame.</i>	<i>6</i>
<i>1.2.2 Guilt.</i>	<i>7</i>
<i>1.3 Overview</i>	<i>8</i>
2. State Shame and Internalised Shame	10
<i>2.1 State shame</i>	<i>11</i>
<i>2.2 Internalised shame</i>	<i>12</i>
3. Childhood Experiences and Internalised Shame	13
<i>3.1 Negative cognitive style</i>	<i>14</i>

3.2 Shame and childhood maltreatment	16
3.2.1 Sexual abuse and shame.	17
3.2.2 Emotional abuse and shame.	19
3.2.3 Emotional neglect and shame.	21
3.2.4 Physical maltreatment and shame.	22
3.3 Summary	23
4. Maltreatment, Shame and Psychopathology	24
4.1 Maltreatment and psychopathology	24
4.2 Internalised shame and psychopathology	27
4.3 Relationship between childhood maltreatment, shame and psychopathology	28
4.4 Shame as a mediator between childhood maltreatment and psychopathology	29
4.5 Models of childhood maltreatment, shame and psychopathology	31
4.6 Summary	35
5. Other factors mediating between childhood maltreatment and adult adjustment	36
5.1 Reactions to disclosures of childhood abuse	37
5.2 Social support and coping strategies	38
5.3 Abuse-related characteristics	39
6. Conclusions	41
References	44

EMPIRICAL PAPER:
An Exploratory Study Investigating the Associations Between
Maltreatment, Internalised Shame, and Resource Loss in a Sample of
Individuals with a Diagnosis of Bipolar Disorder

Abstract	65
1. Introduction	67
<i>1.1 Bipolar disorder</i>	67
<i>1.1.1 The aetiology of BD.</i>	69
<i>1.2 Childhood maltreatment and psychopathology</i>	70
<i>1.3 Childhood maltreatment in community samples.</i>	73
<i>1.3.1 Gender differences in the experience of childhood maltreatment.</i>	73
<i>1.4 Childhood Maltreatment in BD</i>	74
<i>1.5 Experiences of maltreatment in adulthood and psychopathology</i>	76
<i>1.6 Internalised shame, maltreatment, and psychopathology</i>	77
<i>1.7 Resource loss in BD</i>	79
<i>1.8 Summary</i>	81
<i>1.9 Research questions</i>	81
2. Method	82
<i>2.1 Design</i>	82
<i>2.1.1 Group differences.</i>	82
<i>2.1.2 Relationships between variables.</i>	83

2.2 Participants	83
2.2.1 <i>BD Group.</i>	83
2.2.2 <i>Control Group.</i>	84
2.2.3 <i>Recruitment procedure.</i>	85
2.2.4 <i>Justification of sample size.</i>	86
2.3 Measures	86
2.3.1 <i>Internal State Scale (Bauer et al., 1991).</i>	87
2.3.2 <i>Hospital Anxiety and Depression Scale (HADS; Snaith & Zigmond, 1994).</i>	88
2.3.3 <i>Childhood Trauma Questionnaire (CTQ).</i>	89
2.3.4 <i>Internalized Shame Scale (Cook, 1994).</i>	90
2.3.5 <i>Childhood Trauma Questionnaire–Revised (CTQ–Revised).</i>	91
2.3.6 <i>Conservation of Resources – Evaluation (COR–Evaluation; Hobfoll, Lilly, & Jackson, 1991).</i>	92
2.4 Ethical approval	93
2.5 Procedure of data collection	93
3. Results	94
3.1 Preliminary Analyses	94
3.1.1 <i>Normal distribution.</i>	94
3.1.2 <i>Transformations.</i>	95
3.1.3 <i>Mood state.</i>	95
3.1.4 <i>Internal consistency.</i>	96
3.2 Research question 1(a) and 1(b): group and gender differences	97

3.2.1 <i>BD group compared with control group.</i>	97
3.2.2 <i>Gender differences in the BD group.</i>	100
3.2.3 <i>Gender differences in the control group.</i>	100
3.3 <i>Research question 2: Level of childhood maltreatment, internalised shame, and resource loss and gain</i>	102
3.3.1 <i>Levels of childhood maltreatment.</i>	102
3.3.1.1 <i>Experiences of maltreatment in adulthood</i>	105
3.3.2 <i>Levels of internalised shame.</i>	105
3.3.3 <i>Levels of resource loss and gain.</i>	106
3.4 <i>Research question 3: associations between maltreatment, internalised shame, and resource loss and gain in BD</i>	106
3.5 <i>Research question 4: influence of mood state on the associations between childhood maltreatment, internalised shame, and resource loss and gain in BD</i>	108
3.6 <i>Correlations between variables in the control group</i>	109
4. Discussion	110
4.1 <i>Results summary</i>	110
4.2 <i>Supporting literature</i>	111
4.2.1 <i>Experiences of maltreatment in childhood.</i>	111
4.2.1.1 <i>Gender differences in childhood maltreatment.</i>	113
4.2.2 <i>Experiences of maltreatment in adulthood.</i>	114
4.2.3 <i>Internalised shame.</i>	114
4.2.4 <i>Resource loss and gain.</i>	115
4.3 <i>Clinical implications of the findings</i>	116

<i>4.4 Limitations of the study</i>	117
<i>4.4.1 Sample size.</i>	117
<i>4.4.2 Screening of participants.</i>	118
<i>4.4.3 Psychiatric comparison.</i>	119
<i>4.4.4 Validity of the CTQ-Revised.</i>	119
<i>4.4.5 Controlling for extraneous variables.</i>	120
<i>4.4.6 Research design.</i>	121
<i>4.4.7 Retrospective self-reports of childhood maltreatment.</i>	122
<i>4.5 Ideas for future research</i>	123
5. Conclusions	124
References	126
List of Appendixes	151

LIST OF TABLES

Literature Review

Table 1.	<i>Descriptions of sub-types of childhood maltreatment, taken from Cawson, Wattam, Brooker and Kelly (2000), and Webb, Heisler, Call, Chickering, and Colburn (2007).</i>	18
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Empirical Paper

Table 2.	<i>Mean scores on the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998)) reported in previous studies investigating the prevalence of subtypes of childhood trauma in participants from psychiatric, community, and undergraduate student samples.</i>	72
Table 3.	<i>Comparison of demographic information from participants in the bipolar disorder (BD) group (n = 35) and the control group (n = 35).</i>	85
Table 4.	<i>Mann Whitney U-test results identifying group differences between participants in the bipolar disorder (BD) group (n = 35) and the control group (n = 35).</i>	99
Table 5.	<i>Mann Whitney U-test results identifying group differences between male (n = 13) and female (n = 22) participants within the bipolar disorder (BD) group (n = 35).</i>	101
Table 6.	<i>Classification of Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998) scores for participants in the bipolar disorder (BD) group (n = 35) and control group (n = 35) using the guidelines presented by its authors.</i>	104
Table 7.	<i>Pearson Product Moment Correlation matrix of the rating scale scores of participants in the bipolar disorder (BD) group (n = 35).</i>	107

LIST OF FIGURES**Literature Review**

Figure 1. Model predicting psychological maladjustment as a function of childhood sexual abuse, shame, and cognitive attribution (Feiring, Taska, & Lewis, 1996). 33

Figure 2. Model predicting behaviour problems as a function of childhood maltreatment, shame and anger (Bennett, Sullivan, & Lewis, 2005). 33

Empirical Paper

Figure 3. The percentage of participants in the BD group ($n = 27$) and the control group ($n = 22$) reporting multiple forms of maltreatment using the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998). 103

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INTERNALISED SHAME AND ITS
ASSOCIATION WITH
CHILDHOOD MALTREATMENT AND
PSYCHOPATHOLOGY:
A REVIEW OF THE LITERATURE

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Internalised shame and its association with childhood maltreatment and psychopathology: a review of the literature.

Abstract

Shame is a hugely debilitating self-conscious emotion that leads an individual to perceive him or herself to be fundamentally flawed. Considering these negative self-evaluations, it has been shown that shame has a greater association with psychopathology compared with other affective states such as guilt. Whilst shame can be experienced as a transient emotion that can help to moderate behaviour, it can also be an internalised trait with profound consequences, whereby the individual retains an irrational sense of defectiveness that acts as a filter through which all experiences are perceived. This internalised shame predominantly stems from a range of sexually abusive or emotionally invalidating incidents experienced during childhood, which result in the development of underlying shameful beliefs that the self is unwanted or unlovable. Consequently, the shamed individual is left vulnerable to the development of psychological distress. Studies have identified shame to be a significant factor associated with the experience of childhood maltreatment, and individuals with a range of psychopathological symptoms typically report high levels of internalised shame. A small evidence base demonstrates how shame might act as a mediator between childhood abuse and adult psychopathology. However, further research is required to firmly establish the role of shame within these associations.

Keywords: Internalised shame; sexual abuse; emotional abuse; neglect; mental illness.

Internalised shame and its association with childhood maltreatment and psychopathology: a review of the literature.

1. Introduction

1.1 Self-conscious emotions

It is commonly understood that babies develop a set of basic emotions over the first nine months of life. Such primary emotions include happiness, sadness, and fear (Campos, Barrett, Lamb, Goldsmith, & Stenberg, 1983). These initial feelings are followed in the second and third year of life by the development of more complex self-conscious emotions. These self-evaluating feelings include pride and empathy along with guilt, embarrassment, and shame (Stipek, 1995).

Lewis, Wolan Sullivan, Stanger, and Weiss (1989) suggest that these self-conscious emotions develop later because children must first come to understand that particular rules determine socially appropriate behaviour, and that their own behaviour will be evaluated by others according to these standards.

Tracy and Robins (2004) propose that self-conscious emotions differ from basic emotions because they require a capacity for self-awareness and the formation of stable self-representations. A sense of self includes an ongoing sense of self-awareness (the “I” self) and the capacity for complex self-representations (the “me” self); these self-processes make it possible for self-evaluations, and therefore self-conscious emotions, to occur. Thus, the primary distinctive characteristic of self-conscious emotions is that their elicitation requires the ability to form stable self-representations (“me”), to focus attention on those representations, and to put it all together to generate

a self-evaluation. External evaluations (e.g., “Mummy gets mad when I spill milk”) can be internalised when the child develops the capacity for self-awareness, and then transformed into the stable self-evaluations (e.g., “I am bad when I spill milk”), which is essential for the development of self-conscious emotions.

As a result of the developing understanding of external evaluations, people tend to experience self-conscious emotions such as pride and shame only when they become aware that they have lived up to, or failed to live up to, some actual or ideal self-representation (Tracy & Robins, 2004). As such, self-conscious emotions play a central role in motivating and regulating people’s thoughts, feeling and behaviours (Fischer & Tangney, 1995). Indeed, they drive people to work hard in achievement and task domains, as well as behave in moral, socially appropriate ways in their interpersonal interactions and intimate relationships (Baumeister, Stillwell, & Heatherton, 1994). In particular, with the threat of losing social status in the eyes of others, our social behaviour is influenced by the slightest chance of public shame, guilt or loss of face (Goffman, 1955).

1.2 Shame and guilt

Shame has historically been considered to be synonymous with other negative self-conscious emotions such as guilt. In particular, amongst the literature reporting on the similarities and differences between the self-conscious emotions, it would appear that shame and guilt have garnered the greatest attention from researchers. Indeed, early writings typically failed to distinguish between shame and guilt (Burney & Irwin,

2000; Tangney, 1996), and previously, guilt was used to refer to both emotions, with subsequent researchers using the terms interchangeably (Tangney, 1995).

In personality theory, both guilt and shame fall within the personality trait of Neuroticism, which is a central construct in the Five-Factor ('Big Five'; Costa & McCrae, 1992) and Three-Factor ('Giant Three'; Eysenck, 1991) models of personality. In both models, Neuroticism represents the tendency to experience a variety of negative emotions including fear, anger, sadness, embarrassment, and disgust, as well as shame and guilt. Indeed, Neuroticism has been labelled 'negative affectivity' (Watson & Clark, 1992). However, whilst shame and guilt are both facets of Neuroticism, and thus seemingly similar experiences of negative affect, it is important to recognise and distinguish between the two emotions.

Shame is an overpowering and incapacitating emotion. According to Cook (1987), it is one of the most basic and central of human affects. Shame is a universal emotion that is an intense and immediate affective reaction following exposure and disapproval of some significant impropriety or personal shortcoming (Gross & Hansen, 2000). It is equated with feelings of disgrace, dishonour and humiliation, and may be accompanied by sensations of apprehension, disgust, nausea and dread (Will, 1987). In its most negative context, shame reflects feelings about a defect of the self (Morrison, 1983), and can be a tormenting sense of inferiority, brought about by the sudden annihilation of personal integrity, revealing social inadequacy and moral degeneracy (Berke, 1987).

As with shame, guilt also involves a significant degree of negative affect, and has been defined as an agitation-based emotion in which the person experiences fear,

worry, anxiety and tension in response to behaviours perceived as violating internal moral standards (Ferguson, Stegge, Miller, & Olsen, 1999). Ausubel (1995) defines guilt as “a special kind of negative evaluation which occurs when an individual acknowledges that this behaviour is at variance with a given moral value to which he feels obligated to conform” (p. 378).

Early psychodynamic theories focused primarily on the differences between the private-public and internal-external dimensions of shame and guilt. However, these have received little empirical support and have largely been abandoned in favour of more complex conceptualizations of shame and guilt, in which the two affects are differentiated in terms of the role of the self or in terms of cognition and attribution (Tangney, 1990).

1.2.1 *Shame.*

There is a general consensus within the literature that with a shame reaction, the whole self, rather than some correctable action or behaviour, is experienced as flawed or intolerable. Consequently, the individual rejects himself or herself with a statement such as “I am bad”, and the self is considered fundamentally defective. The negative self-attributions that are associated with shame are typically global, affecting the entire self, and can be enduring (Miller & Tangney, 1994), and typically result in the desire to hide away from the world (Tangney, Burggraf, & Wagner, 1995; Tangney, Miller, Flicker, & Barlow, 1996; Wicker, Payne, & Morgan, 1983). In particular, the shamed individual feels an uncomfortable sense of exposure, and it is this discomfort and sense of smallness, inadequacy, and worthlessness that motivates the shamed

individual to escape interpersonal situations that may have elicited this emotional experience and remain unseen by others (Lewis, 1971).

Given these incapacitating feelings of worthlessness and defectiveness, it is unsurprising that researchers have identified shame as being closely associated with various forms of psychopathology¹ and psychological distress, particularly when compared with other self-conscious emotions such as guilt (Gilbert, Pehl, & Allan, 1994; Sanftner, Barlow, Marschall, & Tangney, 1995; Tangney, 1990, 1991; Tangney & Dearing, 2002; Tangney, Wagner, Fletcher, & Gramzow, 1992; Thompson & Berenbaum, 2006; Webb, Heisler, Call, Chickering, & Colburn, 2007).

1.2.2 *Guilt.*

Whereas shame is considered to be a hugely debilitating affect, with a global focus in which the entire self is rejected (Tangney, 1992), in guilt, the negative affect focuses on the specific act, or failure to act, that violates internal standards. Tangney reports that with the experience of guilt, there is a feeling of remorse or regret over the 'bad thing' that was done, and the subsequent tension often serves to motivate reparative action. Indeed, guilt has been seen to facilitate prosocial, adaptive functioning, and can be regarded as an emotion that serves to repair social relationships

¹ It is recognised that clinical psychologists are moving away from diagnoses and the language that typically accompanies the medical model. Although, the term 'psychopathology' is acknowledged to be a medical expression used to describe individuals diagnosed with a mental illness, for ease of use, this phrase will be used in this paper to describe individuals who have received a psychiatric diagnosis.

and foster healthy interpersonal interactions (Baumeister et al., 1994; Tangney, 1995) as well as promoting empathy, altruism and care-giving (Tangney & Dearing, 2002).

As stated, shame has been more closely associated with a range of psychopathological symptoms, particularly when compared with guilt. Indeed, the role of guilt in psychopathology is more controversial (Ferguson et al., 1999), and at present, the research findings regarding the degree to which guilt is implicated in the experience of psychological distress is conflicting at best (Harder, Cutler, & Rockhart, 1992; Tangney, Wagner, & Gramzow, 1992).

1.3 Overview

Shame is a hugely incapacitating and enduring self-conscious emotion. As such, given how it has been reported to be more closely associated with psychological distress compared with other similar emotions, shame remains the focus throughout the current article. In particular, the paper focuses on the intense experience of shame which can develop in childhood and is akin to a personality trait through which all subsequent experiences are filtered. The literature indicates that experiences of maltreatment during childhood are hugely influential in the experience of pathological levels of shame, and research is presented which details how emotional abuse and neglect are considered to be particularly damaging to a child's feelings of self-worth and their self-concept.

Research is also presented detailing how shame has been identified as a significant factor in the presentation of a range of mental health difficulties. The article finally draws together these elements of shame, childhood maltreatment, and

psychological distress by presenting the findings of a small evidence base supporting a model whereby shame is hypothesised to mediate the relationship between mental illness and childhood maltreatment.

It is important to recognise that there are a number of issues implicated in the investigation of the consequences of childhood maltreatment. The majority of studies are cross-sectional, in which participants are recruited in adulthood, and childhood experiences are reported retrospectively. However, these studies are limited in terms of drawing causal conclusions as a result of their single-time point assessments. As such, a longitudinal research design is being increasingly employed in the child abuse literature, whereby children are recruited at birth and followed over the course of their development. However, very few of these studies report on the experience of shame in their participants. Furthermore, most of these longitudinal studies are currently reporting findings with regards to the childhood and adolescent experiences of their cohorts. However, the focus of the current review is on the impact of shame in adults, and consequently there are few longitudinal studies reporting such findings.

An alternative design involves cross-sectional designs in which young people are recruited from child protection agencies or other similar sources, in which maltreatment has been officially reported. However, as the participants in these studies are children or adolescents, it is not possible to draw conclusions regarding the impact of their experience in adulthood, which is the aim of the current paper.

Each of these methodologies has significant strengths and limitations, and it is beyond the scope of this paper to consider these in detail. As such, to avoid any unintentional bias, the findings of studies utilising a range of these designs are included

in the current review of literature, and the designs are described as necessary. The search strategy for this review was restricted to papers published in journals, peer-reviewed e-journals, and books^{2,3}.

2. State Shame and Internalised Shame

As described, shame is a normal emotional response to a transgression of some social ideal. Most people experience shame at various points in life, and moderate levels of shame are likely to serve adaptive functions in the healthy individual. However, some situations may lead to a more intense shameful response.

It has been indicated in this paper that shame has a greater association with psychological maladjustment, and might indeed be one of the most distressing of emotions. However, given the universality of shame, it is unlikely that the ‘normal’ experience of shame leads to psychological distress. The following section considers how shame can be experienced in two distinct ways, initially as a transient emotional

² The terms ‘shame’, ‘internalised shame’ ‘internalized shame’, ‘guilt’, ‘self concept’, ‘mental disorders’, ‘child abuse’, ‘physical abuse’, ‘child neglect’, ‘emotional trauma’, and ‘sexual abuse’ were entered into the PsychLit, PsychINFO including PsycARTICLES 1806- present, Ovid MEDLINE 1950 – 2008, Embase 1980 – 2008, and Web of Knowledge databases. These terms were also used to search the Internet using Google Scholar, and included (where appropriate) e-journals.

³ Although the papers presented are taken from peer-reviewed journal, the article does reference one study not published in a peer reviewed journal but instead was sourced from the National Society for the Prevention of Cruelty to Children (NSPCC) website.

event with a potentially adaptive function, but also as a personality trait, with associated negative self-evaluations and underlying feelings of defectiveness and worthlessness.

2.1 State shame

When one experiences shame as an acute and transitory 'in the moment' emotion, one is experiencing state shame (Tangney & Dearing, 2002). This brief, albeit intense experience can be potentially adaptive, by protecting social bonds, defining borders for privacy, and preventing us from losing ourselves in ideas of our own grandiosity (Skårderud, 2007). Indeed, we associate certain positive values with shame, including modesty, morality, respect, moderation, honour, pride and inhibition. However, certain negative values are also associated with shame, including immorality, disrepute, shamelessness, censure, vice, and contempt (Anastasopoulos, 1997).

As an adaptive function, shame can be viewed as an extension of anxiety, which embraces cultural prescriptions of desired and undesired behaviour, and has been seen to be associated with shyness and embarrassment (Harder et al., 1992; Mills, 2005; Schott, 1979; Tangney et al., 1996). The transient pain of state shame might motivate productive soul-searching and revisions to one's priorities and values (Tangney, 2003). These experiences result in the learned behaviour that shame can be reduced by avoiding the acts that provoke it, and by accepting the prohibitions as correct (Will, 1987).

In evolutionary terms, shame might have served an adaptive function of communicating submission, protecting the individual against being hurt when confronted with violations in relationships, thus affirming relative rank in the

dominance hierarchy of early humans (Gilbert, 1998). This perspective emphasises the role of shame as a means of communicating one's acknowledgement of wrongdoing, thus diffusing anger and aggression. As such, the motivation to withdraw and hide away may be a useful response, interrupting potentially threatening social interactions until the shamed individual has a chance to regroup or the situation has blown over (Tangney, 2003).

2.2 Internalised shame

Whilst theorists have proposed that shame can be experienced as a transient emotion with some, albeit limited, adaptive functions, it is also possible to experience shame at a more characterological level. When one experiences shame in such a pervasive internalised manner, one possesses *trait* shame, or internalised shame (Goss, Gilbert, & Allan, 1994). Contrary to state shame, the potential consequence of internalised shame can be shattering. Indeed, within the context of internalised shame, Cook (1987) states, "too much shame can be emotionally crippling" (p. 197).

This notion of internalised shame depicts an extreme and intense sense of shame as a core aspect of identity, as distinct from the emotion of state shame, which although sometimes intense, is transitory. Internalised shame permeates a person's life as a filter through which all of their experiences are perceived, and leads the person into believing himself or herself to be bad, dirty, worthless, and hopeless (Claesson & Sohlberg, 2002). Erikson (1963) says of the intensely shamed person, "he would like to destroy the eyes of the world" (pp. 252-253).

With internalised shame, the individual is pervaded by feelings of worthlessness and inadequacy, and is often in a state of emotional distress, unable to function well in everyday life because of difficulty speaking, thinking and interacting with others (Lewis, 1971). The shamed individual feels a fundamental sense of incompetence and inferiority, and is typically prone to misread social cues and communication, expecting the worst in all situations, and perceiving benign or positive social exchanges to be injurious or insulting (Balcom, Call, & Pearlman, 2000). Thus, the experience of internalised shame becomes a concept distinct from situational state shame, the latter of which can be experienced by anyone in a typically embarrassing situation (Claesson & Sohlberg, 2002). For clarity, references to shame from hereon in refer to internalised shame, unless otherwise specified.

3. Childhood Experiences and Internalised Shame

As stated, a primary aim of the current paper is to consider the factors currently reported in the literature as leading to the experience of internalised shame, and in particular, how shame moves from the affective state (state shame) to a personality-like trait (internalised shame). It has been suggested that is likely that early experiences have a profound impact on the development of self-concept, and in particular, our sense of shame (Alessandri & Lewis, 1996). Specifically, negative incidents experienced during the period when self-conscious emotions are developing might result in an increased vulnerability to internalised shame. Cook (1987) describes how internalised shame results from early experiences that regularly evoke experiences of enduring,

intolerable and intense levels of state shame. These enduring levels of shame are believed to result from experiences of abandonment and rejection (Claesson & Sohlberg, 2002), or sexual abuse (Murray & Waller, 2002). Indeed, Loader (1998) suggests that child abuse may be “all about shame” (p. 53). As an example of this, Alessandri and Lewis found that maltreated children generally demonstrated greater levels of shame when failing a task, and displayed fewer experiences of pride following successfully completed tasks when compared with non-abused children. It would seem that negative childhood experiences are as yet the only factors that have been identified in the development of pathological levels of shame. Consequently, the following section reviews these experiences, and the potential mechanisms which might result in the experience of internalised shame.

3.1 Negative cognitive style

As stated, the negative self-attributions that are associated with shame are typically global, affecting the entire self, and can be enduring (Miller & Tangney, 1994). Attribution processes concern causal influences or the perceived reason an event has occurred. Individuals may use three dimensions to explain the causes of good and bad events

- (1) internality (the self is the cause) versus externality (someone or something outside of the self is the cause);
- (2) stability (the reason will remain the same) versus instability (the reason may change); and

(3) globality (the reason affects my entire self or everything that happens to me) versus specificity (the reason applies to a particular event or aspect of the self).

Attributions about negative events that are internal, stable and global are typically labelled as a negative cognitive style (e.g., Gibb, 2002). There is a body of evidence that suggests that the occurrence of negative life events in childhood contributes towards the development of a negative cognitive style (e.g., Garber & Flynn, 2001; Nolen-Hoeksema, Girgus, & Seligman, 1991). Maltreatment is likely to be one of the most distressing of negative life events, and as such, it is understandable that researchers have sought to identify the relationships between childhood maltreatment and the development of a negative cognitive style. Rose and Abramson (1992) suggest that when maltreatment occurs, children seek to understand the causes of the event, in order to develop strategies to prevent recurrences, thus maintaining the child's sense of hopefulness. A single occurrence of maltreatment might be explained as "They were just in a bad mood today," (an external, unstable, and specific attribution), thus maintaining the hopefulness that the maltreatment will not re-occur. Chronic maltreatment can result in repeated disconfirmation of the child's hopefulness-inducing attributions. When this happens, the child may begin to explain the occurrence of the abuse by thinking "there must be something wrong with me that keeps them doing this to me," (an internal, stable, and global attributional explanation). This serves to increase the child's hopelessness about avoiding future maltreatment, and the more frequently the child employs internal, stable, and global attributional explanations for

their abuse, the more likely they are to form a negative cognitive style, and the more likely they are to be rigidly applied to all negative events (Gibb, 2002).

3.2 Shame and childhood maltreatment

Feiring, Taska, and Lewis (1996) acknowledge the importance of an individual's attributions about abuse, and how these attributions might mediate the influence of the abuse on subsequent feelings of shame. Consequently, with regard to the experience of childhood maltreatment, attributions for negative events that are internal, stable and global (e.g., "This happened because I am a bad person, and this is how things will always be") are the most likely to lead to shame (Lewis, 1992). Indeed, Janoff-Bulman (1979) reported that shame ought to be viewed as an affective state stemming from internal, global, uncontrollable, and presumably stable attributions.

As stated, the experience of shame occurs when the individual senses that they have failed to live up to some actual or ideal self-representation. As such, shame is not seemingly an obvious consequence of being a survivor of abuse, as the shamed individual has not deliberately transgressed any social boundary. Given that shame is the product of self-reflection and negative self-evaluation, it appears that the experience of maltreatment results in some internalisation of the events as a negative evaluation of themselves. In support of this hypothesis, researchers have suggested that individuals who have experienced abuse as a child tend to experience extreme levels of shame because of feelings of not being valued as a person (Steele, 1980), and of the violation of personal boundaries (Fossum & Mason, 1986).

Further to the use of the term 'maltreatment' as an expression encompassing a range of abusive and neglectful experiences, researchers have presented findings related to specific experiences of maltreatment, namely physical, sexual and emotional assault, as well as physical and emotional neglect. Table 1 presents examples of behaviours and experiences characteristic of each sub-type of childhood maltreatment.

In many cases, sub-types of abuse do not occur in isolation, and researchers have frequently noted that participants report a range of abusive experiences. Indeed, according to Mullen, Martin, Anderson, Romans, and Herbison (1996), children who are victims of one form of abuse are more likely to experience other forms of maltreatment. For example, Cawson, Wattam, Brooker, and Kelly (2000) suggest that childhood sexual abuse (CSA) frequently involves a level of physical abuse, and all forms of abuse involve an element of emotional abuse. As such, studies focussing on a single type of abuse may suffer because they assume the absence of other forms of maltreatment amongst their participants (Edwards, Holden, Felitti, & Anda, 2003).

3.2.1 Sexual abuse and shame.

Research has consistently identified shame as a frequently reported consequence of CSA (e.g., Feiring et al., 1996; Finkelhor & Browne, 1986; Kessler & Bieschke, 1999). Feiring and Taska (2005) reported the findings of the longitudinal follow-up of 118 young people who were reported to have been sexually abused, either by specific medical findings, confession by the offender, abuse validated by an expert such as child protective services, or a conviction of the offender. These young people were assessed within eight weeks of the abuse being reported, and then one year later.

Final assessments were conducted six years after the abuse discovery. It was found that abuse-related shame that was high at discovery and after one year was likely to remain high across a number of years, thus demonstrates the enduring nature of internalised shame following the experience of CSA.

Table 1.

Descriptions of sub-types of childhood maltreatment, taken from Cawson, Wattam, Brooker, and Kelly (2000), and Webb, Heisler, Call, Chickering, and Colburn (2007)

Type of maltreatment	Behaviours
Sexual Abuse	<p>Sexual acts occurring against the child's wishes</p> <ol style="list-style-type: none"> 1. Physical contact: intercourse, oral sex, touching and fondling, sexual hugging or kissing. 2. Non-contact abuse: using the child to make pornographic photographs or videos, showing the child pornography, forcing or encouraging the child to watch live sexual acts, or exposing sex organs to excite themselves or shock the child.
Physical Abuse	<p>Physical acts with two levels</p> <ol style="list-style-type: none"> 1. Violent treatment: being hit with implements such as sticks, punched, kicked, knocked down, shaken, deliberately burned or scalded, throttled, or threatened with a knife. 2. Physical treatment/discipline: slaps smacks, and pinches.
Physical Neglect	<p>Poor quality of physical care, such as going to school in dirty clothes, not being taken to the doctor when ill, being abandoned or deserted, living in dangerous physical conditions.</p>
Emotional abuse	<p>Emotionally abusive acts with two levels</p> <ol style="list-style-type: none"> 1. Direct acts: psychological control and domination, terrorizing, humiliation and degradation. 2. Proxy attacks: harming someone or something the child loves or values.
Emotional neglect	<p>Parental figures or childhood caregivers detached/uninvolved, demonstrate little affection.</p>

It has been suggested that CSA interferes with mastering childhood developmental tasks, including independences and competence, and this results in a chronically shame-based personality (Lebowitz, Harvey, & Herman, 1993; Zupancic & Kreidler, 1998). Because the experience of CSA is one that the child cannot prevent or control, and one from which they cannot escape, the victim learns that they are helpless and their actions have little power to change their environment. The secretive context in which CSA takes place, condemnation of the victim by the perpetrator, and explicit threats to keep silent are all key factors which facilitate and perpetuate feelings of shame (Herman, 1992). Shame can be heightened further when the abuse is discovered by family members and social services. When these criminal and taboo sexual acts become public, children are vulnerable to feeling ashamed for being involved in behaviours viewed as wrong and dirty (Feiring, Taska, & Lewis, 2002; Lewis, 1992).

3.2.2 Emotional abuse and shame.

Further to the impact of CSA, there is a growing body of evidence demonstrating an association between the experience of childhood emotional abuse and the development of shame. Indeed, Claussen and Crittenden (1991) suggest that emotional abuse may be more damaging in some respects than other forms of maltreatment. Hoglund and Nicholas (1995) reported greater exposure to emotional abuse was related to higher shame, compared with physical abuse. They propose that this is because an individual's self-concept is a core component of both shame (experiencing the self as inferior, defective, and helpless) and emotional abuse, which directly attacks a person's self-worth by continual criticism and invalidation.

Childhood emotional abuse incites in the developing child a sense of 'badness' not simply about certain behavioural choices or courses of action, but about the totality of the self; the child perceives their abusive experiences to be occurring in response not simply to their behaviour, but because of themselves as a person. This sense of 'badness' might eventually permeate the self-schema of the adult and subsequently demonstrate a tendency towards shaming, negative self-appraisal in their understanding of everyday events (Webb et al., 2007). Bennett, Wolan Sullivan, and Lewis (2005) suggest that because of ongoing punitive and invalidating experiences, the self-conscious emotions of maltreated children may differ in quantity to those of non-maltreated children. For example, if children are severely punished, criticised, or ignored by the primary caregiver, they are likely to develop a belief that they are unwanted and unlovable. The use of harsh parenting may give children the message that they are 'bad', and the secretiveness that often accompanies maltreatment may perpetuate the experience of shame.

It is suggested that a single instance of emotional abuse or neglect is unlikely to be directly harmful in the same way that a single physical attack might lead to injury. Instead, it appears that the harm of emotional abuse results from the cumulative effect of repeated occurrences (Claussen & Crittenden, 1991).

Praise and criticism from parents are likely to be important factors in the development of pride and shame, since these evaluations focus the child on the reasons for their success or failure. In support of this, cross-sectional studies of adult participants have demonstrated how a vulnerability to shame in adulthood has been positively correlated with retrospective recall of criticism from parental figures in

childhood (Gilbert, Allan, & Goss, 1996; Hoglund & Nicholas, 1995), as well as disgust, withdrawal of love and disciplinary messages focused on the rejection of the child's self (Tangney & Dearing, 2002). Similarly, in support of the findings of these cross-sectional studies, a prospective longitudinal study by Koestner, Zuroff, and Powers (1991) found that parents' behaviours that exhibit excessive restrictiveness and rejection were shown to be associated with the development of self-criticism, which is a factor that is frequently cited as a key component of shame (Lewis, 1992).

Cross-sectional research with samples of maltreated children has supported this association between emotional abuse and the experience of shame. In particular, studies have identified that neglectful mothers are generally more critical, negative and controlling, and give less praise to their child during play sessions (Aragona & Eyberg, 1981; Burgess & Conger, 1978).

3.2.3 Emotional neglect and shame.

Further to the reported significant role of emotional abuse in the development of shame, Claesson and Sohlberg (2002) suggest an even greater association between emotional *neglect* and the experience of shame. Comparing scores on the Internalized Shame Scale (ISS; Cook, 1994) and the Structural Analysis of Social Behaviour Intrex (Benjamin, 1974), they found that retrospective memories of an 'ignoring', abandoning mother, that is, an emotionally neglectful mother, were more highly associated with internalised shame than the negative behaviours of 'blame' (emotionally abusive behaviours) and 'attack' (physically abusive behaviours). This is not to say that physical and emotional abuse have no role to play in the experience of internalised

shame. Indeed, both had substantial correlations with shame. However, the authors propose that these behaviours do at least provide some kind of involvement, albeit negative, between mother and child. With emotional neglect, it is the lack of interaction, indifference, abandonment and rejection that might contribute to the heightened experience of invalidation and shame.

3.2.4 Physical maltreatment and shame.

As stated, Hoglund and Nicholas (1995) observed that retrospective memories of childhood emotional abuse were related to higher levels of shame. Interestingly, the researchers report a lack of an association between shame and reported experiences of physical abusiveness. Unlike emotional abuse and CSA, physical abuse appears to be infrequently reported in isolation in studies of childhood maltreatment and shame, and instead tends to be grouped with other abusive experiences (e.g., Andrews, 1995; Andrews & Hunter, 1997). Indeed, it has been seen that physical abuse does not contribute to the development of shame when controlled for the effects of other abuse sub-types (Gross & Keller, 1992).

These findings indicate that physical abuse might not be a direct attack against the individual's self-esteem in the way that emotional abuse or CSA appears to be. Instead, it may be perceived as punishment for actual or imagined transgressions. The child is more likely to feel bad for what they have 'done', rather than for what they 'are', and as such the guilt response rather than shame is likely to be triggered.

3.3 *Summary*

The research presented in this segment of the article has shown how CSA has been associated with the subsequent experience of internalised shame. However, a burgeoning research base demonstrates how emotionally abusive and neglectful experiences, including lack of praise, criticism, and invalidation from parents, might be more significant in the subsequent experience of internalised shame. It is possible that internalised shame follows on from these experiences because the person feels devalued, with violated personal boundaries and subsequently they regard themselves as defective and vulnerable to further attack.

The current literature largely indicates the impact of childhood maltreatment on the development of internalised shame. In the absence of studies reporting the pre-molestation psychological functioning of children (Briere, 1992), it is not possible to determine if there are, for example, personality factors underlying the development of internalised shame which might also expose the child's vulnerability to abuse. As such, it is not possible to confirm that maltreatment is the sole factor implicated in the experience of pathological levels of shame. Furthermore, given the largely cross-sectional nature of the studies presented here, it is not possible to attribute the experience of shame directly to abusive experiences. Nevertheless, given that the findings of a large number of cross-sectional studies using adult survivors of childhood maltreatment are supported by the findings of longitudinal projects as well as studies recruiting maltreated children, it would seem that incidents of childhood maltreatment are significant in the experience of internalised shame.

4. Maltreatment, Shame and Psychopathology

It is recognised that victims of childhood abuse and neglect are at risk for deleterious physical and psychological consequences throughout their formative years (McGee, Wolfe, & Wilson, 1997). Such difficulties include a range of externalising behaviours, such as aggressiveness, delinquency, and conduct problems, as well as negative internalising behaviours, such as withdrawal, anxiety and depression (e.g., Ammerman, Cassisi, Hersen, & van Hasselt, 1986; Cicchetti & Carlson, 1989; Cicchetti & Toth, 1995; Macfie, Cicchetti, & Toth, 2001; Starr & Wolfe, 1991). Further to such consequences during childhood, there is a wealth of literature that suggests a link between childhood maltreatment and a range of negative psychological consequences in adulthood. The following section describes some of these research findings and identifies some of the processes involved in the association between childhood maltreatment and maladjustment in adulthood. Furthermore, the association between these factors and the potentially mediating function of internalised shame is considered.

4.1 Maltreatment and psychopathology

Clinicians and researchers alike concur that individuals in psychiatric services typically report a high prevalence of childhood abuse. Herman (1992) writes

Many or even most psychiatric patients are survivors of child abuse. The data on this point are beyond contention. On careful questioning, 50-60% of psychiatric inpatients and 40-60% of outpatients report childhood histories of physical or sexual abuse or both. (p.122)

The suggestion by Herman (1992) regarding the high prevalence of abusive histories in psychiatric populations has been consistently reaffirmed in the research literature, with figures ranging from 48% to 92% in inpatient samples, and 35% to 52% in outpatient samples (Bebbington et al., 2004; Bryer, Nelson, Baker Miller, & Kroll, 1987; Read, 1997, 1998; Read, van Os, Morrison, & Ross, 2005).

Childhood maltreatment is not unique to psychiatric populations, although unsurprisingly, the prevalence rates are higher than those in the general population, with estimated prevalence rates of abuse amongst community samples varying between 2% and 21% (Baker & Duncan, 1985; Edwards et al., 2003; Gorey & Leslie, 1997; Mullen et al., 1996; Silverman, Reinherz, & Giacopis, 1996; Stein et al., 1996).

In both clinical and non-clinical populations, the estimated prevalence rates clearly vary widely, and it is likely that methodological differences between these studies, as well as diverse definitions of what constitutes abuse partially account for such variation. Nevertheless, it can be seen that within psychiatric populations, incidents of childhood maltreatment are frequently-reported experiences.

From their review of the literature, Browne and Finkelhor (1986) found that when studied in adulthood, CSA survivors demonstrated approximately twice as much psychological impairment than their non-maltreated counterparts. They suggest that these individuals often feel isolated and may gravitate towards various stigmatised groups in society. As such, they may get involved in drug or alcohol abuse, criminality, or prostitution. Finkelhor and Browne (1985) propose that stigmatisation is frequently experienced as a result of CSA, and is characterised by feelings of disgust directed at

the self, low self-esteem⁴ and shame, which might lead to extreme forms of self-destructive behaviour, substance misuse and suicide attempts. These behaviours can result in a maintenance cycle of negative self-evaluations, leading to additional maladaptive behaviours indicative of psychological distress associated with their experiences.

Further to the relationship between CSA and the development of self-destructive behaviours, research has demonstrated how childhood emotional abuse has also been associated with specific psychiatric disorders. In particular, depression has been correlated with emotional abuse (Gross & Keller, 1992). Zelikovsky and Lynn (2002) support this relationship, although they also found an even greater association between the combined experience of emotional and physical abuse and depression.

⁴ Shame and low self-esteem are seemingly very similar constructs. Nevertheless, they are not synonymous with the same experience, and as such, for purposes of clarity, it is important to differentiate between the two. Tangney (1995) describes how global self-esteem is a stable trait involving one's general evaluation of the self, largely independent of specific situations. Essentially, it is a self-evaluative construct. In contrast, shame is an emotion, an affective state. As such, the negative affect reported by individuals with low self-esteem may more specifically reflect feelings of shame (Tracy & Robins, 2004). Brown and Marshall (2001) found that most of the shared variance between self-esteem and affect is accounted for by self-conscious emotions, specifically shame and pride; when one is high in self-esteem, one experiences pride; low self-esteem results in the affective state of shame. Furthermore, Tangney (1996) argues that low self-esteem is a pre-existing factor which can be a precursor to shame. As such, she recommends that the two should not become confused, and nor should shame be confused with post-shame affect. For example, after an experience of shame and feeling devalued, people might become depressed, withdrawn and irritable (Gilbert, 1998).

4.2. Internalised shame and psychopathology

The sustained experience of shame has been seen to be associated with poor psychological maladjustment in adulthood, and has also been seen to be linked with various personality traits, such as narcissism (Gramzow & Tangney, 1992) and neuroticism (Johnson et al., 1987). Furthermore, high levels of shame have been reported by individuals with a number of specific psychiatric difficulties and maladaptive behaviours including anger (Hoglund & Nicholas, 1995; Tangney, Wagner, Fletcher, et al., 1992), depression (Hoblitelle, 1987; Lewis, 1971), social anxiety (Gilbert, 2000), and disordered eating (Skårderud, 2007).

Even in non-clinical samples, researchers have observed that depressive symptoms are consistently correlated with shame (Ferguson et al., 1999; Tangney, Wagner, & Gramzow, 1992). It is proposed that the strength of this correlation is the result of shared characteristics and behaviours of shame and depression, including schemas of the self as inadequate and flawed, feelings of subordination, and the urge to escape interpersonal interaction. Because shame responses typically lead to withdrawal from other people, a set of maladaptive cognitive-affective spirals is triggered that can lead to depressive episodes. Indeed, the self-deprecating thoughts that are characteristic of shame, such as "I am a failure", are also examples of depressive thinking (Thompson & Berenbaum, 2006). Furthermore, following the earlier suggestion that shame is an affective state consistent with a negative cognitive style (Janoff-Bulman, 1979), Gibb (2002) suggests that individuals who tend to attribute the occurrence of negative events to internal, stable and global causes (a negative cognitive style) are more likely to develop helplessness and depression as a response to negative life events, compared

with individuals who tend to attribute negative events to external, unstable and specific causes.

Tangney, Wagner, and Gramzow (1992) suggest that there are several potential explanations for the correlations between shame and psychopathology. Firstly, they suggest that individuals who are vulnerable to the experience of shame may also be more vulnerable to a range of psychological disorders because of repeated disruptions in self-functioning caused by the devastating nature of shame. Secondly, they suggest that these individuals might also be prone to feelings of hopelessness, which may be proximal causes of depression and other forms of psychological distress. Thirdly, they propose that the relationship between shame and psychological distress can often be cyclical. As well as underlying psychological distress, shame might also maintain emotional difficulties; the recognition and experience of psychological symptoms may place people at higher risk for further episodes of shame, and as such, people may feel ashamed of the psychological symptoms themselves. In support of this latter suggestion, Skårderud (2007) found that in a qualitative study of shame in clients with disordered eating, some respondents reported feeling ashamed of the feeling of shame due to their perceived worthlessness: "I think that perhaps I am ashamed... but I don't think I have the right to feel ashamed. I am not worth it" (p. 86).

4.3. Associations between childhood maltreatment, shame and psychopathology

It has been reported that internalised shame is associated with a range of psychopathological symptoms in both clinical and non-clinical samples. It has also been shown that internalised shame is associated with experiences of childhood

maltreatment, and in particular, emotional abuse, emotional neglect and CSA. In view of the significant nature of the associations between these factors, it is unsurprising that researchers have attempted to establish the nature of these links.

Some researchers have reported a significant association between the experience of abuse, shame, and psychological maladjustment. For example, Webb et al. (2007) found that emotional abuse was positively correlated with shame and symptoms of depression. Furthermore, in dissociative disorders, Lewis (1992) proposes that the dissociation is a defence against shame, which is an emotional consequence of CSA. Andrews and Hunter (1997) demonstrated that behavioural shame (shame regarding one's behaviour), characterological shame (shame regarding one's character), and bodily shame (shame regarding one's body, or parts of it), were all related to a chronic or recurrent course of depression, although bodily shame had the strongest relationship with early physical abuse and CSA. As such, it appears that bodily shame in particular is involved in the interaction between CSA and the manifestation of depression in adulthood. This specific pattern of results is relatively unsurprising, given that researchers have typically shown CSA to have a specific relationship to bodily shame (Andrews, 1995; Finkelhor & Browne, 1986; Tripp & Petrie, 2001). Nevertheless, this research provides strong support for the association between shame, abuse and the onset of adult depression.

4.4 Shame as a mediator between childhood maltreatment and psychopathology

Further to the observed bivariate relationships between childhood maltreatment, shame and psychological distress (Andrews and Hunter, 1997; Hoglund

& Nicholas, 1995; Lewis, 1992), there is a small body of research to suggest that following childhood maltreatment, shame might in fact be a salient predictor of later psychological maladjustment. For example, Andrews (1995) explored the relationship between retrospective reports of childhood abusive experiences, depression and shame in a female community sample. It was found that childhood abuse was a significant predictor of chronic or recurrent depression. However, when experiences of bodily shame and childhood abuse were entered simultaneously into a logistic regression, bodily shame was the only predictor of chronic or recurrent depression. Experience of abuse was no longer significant, thus demonstrating the mediating role of bodily shame in this study.

Andrews (1997) observed very similar results regarding the mediating role of bodily shame in the relationship between childhood abuse and bulimia nervosa. In their female community sample, bodily shame and childhood abuse were both significantly related to a diagnosis of bulimia nervosa. However, the effect of child abuse was no longer apparent when entered simultaneously with shame.

Murray and Waller (2002) observed a similar mediating influence of shame in the experience of bulimia using a sample of female undergraduate students. Further to the significant relationship between CSA and scores on the ISS, a stepwise multiple regression revealed that internalised shame acted as a partial mediator in the relationship between a reported history of CSA and bulimic attitudes.

It ought to be acknowledged that despite the interesting findings concerning the potentially mediating function of shame presented by these studies, none have been conducted using a clinical sample, and all their data regarding maltreatment was

recorded retrospectively using a cross-sectional design. As such, it is not possible to draw accurate conclusions from these studies regarding the causal effect of abuse on the experience of shame, and consequently, these studies remain largely exploratory concerning the true nature of shame in the experience of psychopathology. As stated, longitudinal studies are yet to report the findings of the experience of shame in adult samples following childhood maltreatment, and as such, the research literature is still uncertain regarding the relationship between abuse and shame. Nevertheless, these findings regarding the mediating role of shame between the experience of childhood and maltreatment and subsequent psychological maladjustment in adulthood present a fascinating preliminary understanding.

4.5 Models of childhood maltreatment, shame and psychopathology

The studies presented here indicate that in community samples, shame might mediate the relationship between a history of childhood maltreatment and depression (Andrews, 1995), as well as bulimia (Andrews, 1997; Murray & Waller, 2002). Further to this literature, researchers have formulated models to demonstrate the significant role of shame.

A key model involving social cognition that relates to CSA and shame is the Traumagenic Dynamics Model (Finkelhor and Browne, 1985). This model presents four 'traumagenic' dynamics to explain the impacts of CSA: traumatic sexualisation, stigmatisation, betrayal, and powerlessness. These dynamics "alter children's cognitive and emotional orientation to the world, and create trauma by distorting children's self-concept, world view, and affective capacities" (p. 531). The factor identified as relating

to shame is stigmatisation, which occurs when the perpetrator and others threaten and blame the child for the maltreatment, and as a result the child grows up with persistent feelings of shame, believing that he or she is defective or damaged, somehow deserving of the maltreatment. The child might continue to feel stigmatised by people close to them even after the abuse has been disclosed, as these individuals now attribute further negative characteristics to the victim because of the molestation, such as loose morals, or being “spoiled goods” (p. 184).

There is little empirical support for this model, although a study by Coffey, Leitenberg, Henning, Turner, and Bennett (1996) found that perceptions of stigma and self-blame mediated the relationship between CSA and the presentation of psychopathological symptoms as measured by the Brief Symptom Inventory (Derogatis & Spencer, 1982). They conclude that the sense of feeling ashamed, tainted and blameworthy about the abuse may impact adjustment by affecting the individual's core beliefs about their worth as a person, and subsequently, adult adjustment is affected.

Based on the work by Finkelhor and Browne (1985, 1986), Feiring et al. (1996) developed a model specific to the traumagenic dynamic of stigmatisation to describe how the experience of CSA results in shame in the victim (see Figure 1). In particular, the model provides a specific set of emotional and cognitive processes to explain and predict response to CSA.

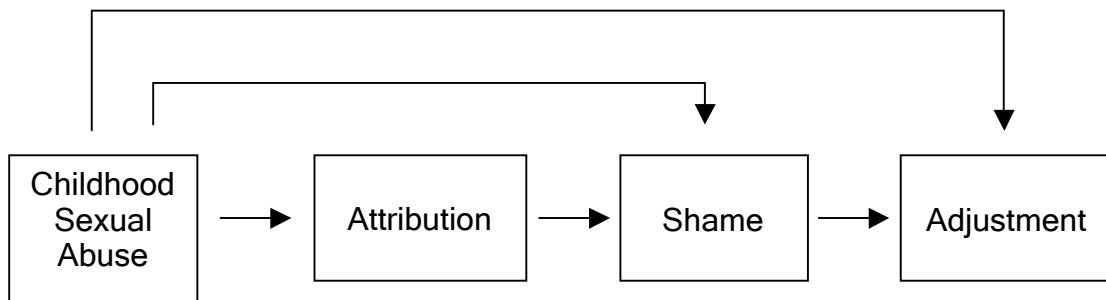


Figure 1. Model predicting psychological maladjustment as a function of childhood sexual abuse, shame, and cognitive attribution (Feiring, Taska, & Lewis, 1996).

Bennett et al. (2005) developed a similar model in which they suggest that shame mediates the hypothesized relationship between maltreatment and behavioural adjustment (see Figure 2). Their model differs from its predecessor by broadening the predisposing experience of abuse beyond CSA to include alternative forms of maltreatment. In addition, the revised model was applied to young children, whereas the original draft related only to adolescent experiences.

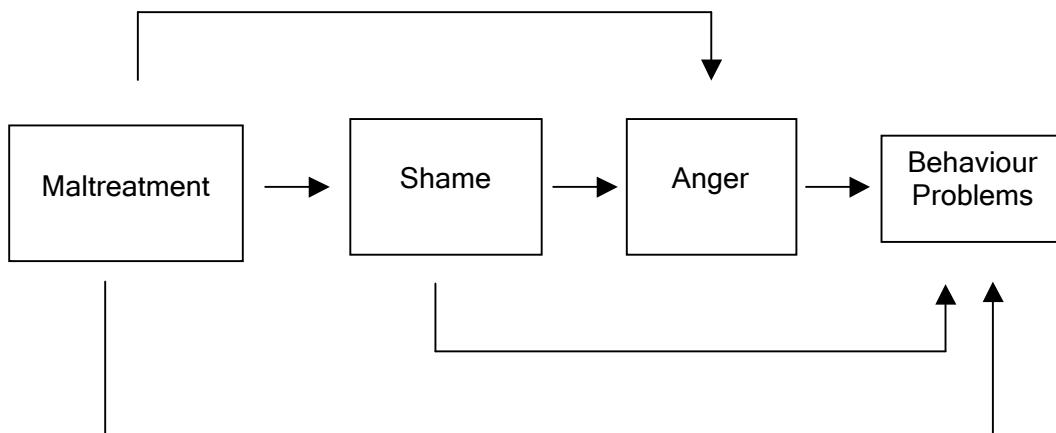


Figure 2. Model predicting behaviour problems as a function of childhood maltreatment, shame and anger (Bennett, Wolan Sullivan, & Lewis, 2005).

The models of Bennett et al. (2005) and Feiring et al. (1996) both function in similar ways. Each model proposes that the experienced of abuse leads to behavioural and psychological maladjustment through the mediation of shame and cognitive attributions about the abuse. Both models also demonstrate how shame might only act as a partial mediator, wherein some individuals experience behavioural and psychological maladjustment following maltreatment without the influence of shame, which is consistent with research findings (e.g., Murray & Waller, 2002).

Crucially, despite the recognition that shame is not always a consequence of childhood maltreatment, and potentially only partially mediates the relationship between abuse and maladjustment, both models neglect to reference or acknowledge the significance of potential factors which might increase or protect against vulnerability to psychological distress, such as social support, coping strategies, or the reactions of others to disclosures of childhood abuse. These are significant omissions from both models that ought to be recognised when appraising these explanations of the interaction between childhood abuse, shame and psychopathology.

There is little supporting evidence for either model, although Bennett et al. (2005) provide some empirical support for their theory. Further to observations that allegations of physical abuse were related to shame, and shame to anger in a sample of young children, a trend was found for shame to mediate the indirect effect between abuse and anger. In turn, children's anger was related to more total behaviour problems. They conclude that their results provide support for their model for physical abuse, anger and the mediating role of shame.

Interestingly, the study by Bennett et al. (2005) presents results describing the mediating role of shame as an emotional response to physical abuse. It has been stated previously that there is little evidence supporting an association between physical abuse and shame, and theorists have proposed that physical abuse does not strike at a person's self-concept in the same way as CSA or emotional abuse. Furthermore, in this study, a history of maltreatment was formed using allegations of physical abuse retrieved from social service records. This is a potentially flawed method of data collection, given the potential biases and inaccuracies in recording adverse events. Consequently, one must be cautious in interpreting these data, and thus the empirical support for the model presented by Bennett et al. remains uncertain.

4.6 Summary

It has been seen that there are significant relationships between childhood maltreatment and the development of internalised shame. This final section of the paper has drawn together these relationships and has presented the small evidence base suggesting how shame mediates the experiences of childhood abuse and depression and bulimia nervosa. Furthermore, three theoretical models have been presented as formulations of this mediating effect. The models presented by Feiring et al. (1996) and Bennett et al. (2005) are both derivatives of the overall Traumagenic Dynamics Model of CSA developed by Finkelhor and Browne (1985). All three appear to adequately explain the cognitive processes involved in the development of shame following childhood abuse, although there is very little empirical research evidence to support the validity of these models. Indeed, the research of Bennett et al. provides uncertain

support for their model, and only in relation to the predisposing factor of physical abuse. Nonetheless, despite the very limited supporting evidence available, these models present an understanding of the function of shame as a mediator of the relationship between childhood experiences of physical abuse and CSA, and the development of anger and psychopathological symptoms.

5. Other factors influencing adult adjustment following childhood maltreatment

As stated, the proposed mediation models of shame do not account for the potential influence of factors other than shame in the relationship between childhood maltreatment and psychopathology. However, it has been recognised that childhood abuse does not inevitably lead to psychological distress in childhood or adulthood. Indeed, Kendall-Tackett, Meyer-Williams, and Finkelhor (1993) reported that there is a subgroup of CSA survivors that appear to be symptom-free, and Finklehor and Browne (1986) suggest in their review of the CSA literature that only one-fifth of victims report significant psychological distress in adulthood. Caffaro-Rouget, Lang, and van Santen (1989) found that approximately half of their sample of 219 girls and 21 boys did not exhibit adjustment difficulties, measured using self-report questionnaires, as well as social worker and policemen records. Furthermore, Conte and Shuerman (1987) reported that 21% of their sample of CSA survivors aged between 4 and 17 years did not show any behavioural symptoms as evaluated by questionnaires by the social worker and by the non-abusive parent.

Although these studies uniquely report on the experience of survivors of CSA, it can be seen that extreme long-term effects of childhood maltreatment are not necessary inevitable. Even as a conservative estimate, it would seem therefore that a large majority of victims are able to adequately manage their experiences without developing psychological distress as adults.

Given that a substantial proportion of victims of childhood traumatisation do not go on to report significant psychological distress, it would seem that there may be some protective factors that help to maintain the psychological integrity of victims of childhood maltreatment. Whilst it is beyond the remit of this paper to discuss these protective factors in any significant detail, it is prudent to acknowledge that some interest has been shown towards identifying what might prevent a victim of childhood maltreatment from subsequently becoming psychologically maladjusted.

5.1 Reactions to disclosures of childhood abuse

Researchers have demonstrated that the way in which disclosures of abuse are received has a significant impact on an individual's functioning. In particular, a response by a significant caregiver that is perceived by the victim as being negative or adverse is associated with greater levels of psychopathology in adulthood (Everill & Waller, 1995; Testa, Miller, Downs, & Panek, 1992; Ullman, 2003).

Roesler (1994) found that in those participants who disclosed a history of CSA during childhood, the reaction to disclosure had a mediating effect between childhood abuse and adult symptoms. In particular, those experiencing a bad reaction from the first person told had poorer scores on general trauma symptoms, symptoms of post-

traumatic stress disorder, and dissociation. Conversely, individuals who receive a positive reaction in terms of the provision of support present significantly fewer psychopathological symptoms (Gries et al., 2000).

5.2 Social support and coping strategies

In addition to the research by Gries et al. (2000), Runtz and Schallow (1997) identified factors including parental warmth, social support, and support and belief from the non-offending parent as being important determinants of the long-term impact of CSA. Indeed, further to CSA, it has been seen that in children who have been physically abused or neglected, the presence of a supportive adult during childhood seems to serve as a protective factor (Werner & Smith, 1982). Similarly, Tremblay, Hébert, and Piché (1999) found that behavioural difficulties were less intense when the maltreated child felt supported by parents. Thus, a warm and comforting relationship with a significant parental figure appears to have a positive effect on adjustment following CSA.

Further to their model of CSA, stigmatisation and shame, Feiring et al. (1996) emphasise the importance of social support, which they found moderated the effects of negative events. For example, emotional support provided by parents, siblings and peers has been seen to mitigate the effects of negative events and promote good adjustment. A person's support network can serve to mitigate the negative effects of stressful events and also may operate to enhance the individual's sense of competence and self-worth. As such, social support can operate to buffer against the negative events of CSA and maladjustment (Brownell & Shumaker, 1984). There is some empirical

support for this. For example, Conte and Berliner (1988) found that in a sample of survivors of childhood abuse, a supportive relationship with an adult or a sibling was associated with fewer negative symptoms. Feiring et al. suggest that the reason social support helps to prevent the development of shame and psychological distress is that it helps to moderate the victim's attributions about the abuse such that victims with more social support will be less likely to hold internal, global, stable attributions about why the abuse happened.

Further to the potential protective function of social support following maltreatment, there are many studies that consistently report an association between avoidant coping strategies following abuse and subsequent behavioural and psychological difficulties throughout childhood. For example, Tremblay et al. (1999) found that the more a child employs avoidant strategies, the more prevalent are the behaviour difficulties. These findings are echoed in a number of other studies whereby maltreated children who use more avoidant strategies present with an increase in psychological maladjustment. For example, Johnson and Kenkel (1991) found that adolescent girls who relied more frequently on wishful thinking were found to experience more distress following CSA. Similarly, Chaffin, Wherry, and Dykman (1997) found that children who relied more frequently on internalised and aggressive strategies presented more adjustment problems.

5.3 Abuse-related characteristics

Further to the impact of factors subsequent to maltreatment, researchers have considered the significance of specific characteristics of CSA, and the impact that these

factors have on long-term adjustment. In particular, research suggests that greater psychological impairment is associated with factors such as the duration of the abuse, the relationship between the perpetrator and the child, or if coercion and force are used (e.g., Browne & Finkelhor, 1986; Conte & Schuerman, 1987).

Tremblay et al. (1999) found that the relationship between victim and perpetrator was the only abuse-related characteristic that was found to have an influence on internalizing behaviour problems. As such, children who were abused by a close adult tended to manifest more anxiety, depression, somatic complaints and withdrawal symptoms compared to victims assaulted by a more distant perpetrator. The severity of the abuse, its duration, and the relationship with the perpetrator were not contributing variables to explain externalizing behaviour problems. Instead, they propose that parental reactions to disclosures may better explain the presence of these behavioural problems.

In a similar way to Tremblay et al. (1999), Steel, Sanna, Hammond, Whipple, and Cross (2004) tested a model incorporating abuse-related characteristics and coping strategies in the experience of psychological distress. They found that there were several characteristics of CSA which influenced the degree of negative impact of the abuse, and they suggest that these characteristics might account for the individual differences in responding to the abuse. In particular, they found that the number of offenders and the duration of the abuse were directly related to long-term psychological distress. All other characteristics measured, (i.e., familiarity with the offender, the degree of force used during the abuse, resistance, age of onset of abuse, participation,

and frequency of abuse) were mediated by variables measuring coping or attributional style (e.g., confrontative coping, accepting responsibility, internalization of CSA).

It is important to recognise that these studies present findings unique to CSA, and as a consequence, cannot be generalised to alternative forms of maltreatment. It would be interesting to compare these findings against the coping strategies employed by children following emotionally abusive and neglectful incidents, as well as the specific characteristics of these forms of maltreatment. Nevertheless, regardless of the nature of the relationship, independently, the two seem to be implicated in increasing the likelihood of, or protecting against, childhood and adult maladjustment following the experience of CSA.

6. Conclusions

This paper has presented some of the literature concerning internalised shame, and how it has been associated with psychological distress and maladjustment in adulthood. The literature has also shown how shame can be experienced in two different ways, either as a brief, transient emotional experience that serves to protect our social bonds and manage our desired (and undesired) behaviour, or as an extreme and intense emotional trait that is a core aspect of identity, whereby an individual views themselves as bad, dirty and worthless. This latter, internalised experience of shame has been significantly associated with psychopathological symptoms.

In terms of the development of internalised shame, the literature consistently reports the significance of early negative experiences. In particular, because of their

experiences, survivors of childhood maltreatment have been seen to be vulnerable to developing a highly negative self-concept, with common themes of worthlessness, defectiveness, and inadequacy. In specific, recent research findings have highlighted the significance of emotional abuse and neglect in the development of internalised shame and subsequent psychological distress.

Further to these negative early experiences, there are no research findings reporting on any pre-molestation personality characteristics which might increase an individual's vulnerability to the experience of shame. As such, it is not yet possible to attribute the experience of shame solely to incidents of childhood maltreatment. Nevertheless, the consistent findings of a large volume of research, both cross-sectional and longitudinal, support the association between childhood maltreatment and internalised shame.

Further to the research findings reporting high levels of shame in both survivors of childhood maltreatment and in those individuals with a range of mental health difficulties, more recent research findings have suggested that shame may mediate the relationship between childhood maltreatment and the experience of psychological distress in adulthood. This body of research is still in its infancy and at present has identified a potentially mediating function of shame in the subsequent development of symptoms of depression and bulimia nervosa amongst community samples using cross-sectional studies. It is evident that further investigation with a wider range of clinical groups is required to establish the true nature of the predictive nature of shame, and in particular, whether there are differences in strength of the mediating role of shame depending on the sub-type of abuse and the psychiatric

population. Furthermore, it is important to recognise that shame is not the sole contributory factor in the experience of psychological distress, and nor is it an inevitable consequence of childhood maltreatment. As such, further research is required to establish the variance explained by shame compared with a number of other negative emotions and other factors involved in the experience of mental illness in adulthood.

Nevertheless, the findings in the current review are striking, and it would be helpful to draw further upon the models presented by Finkelhor and Browne (1986), Feiring et al. (1996) and Bennett et al. (2005) and apply them to a wider range of psychiatric populations. These models have been seen to illustrate the mediating effect of shame, although only for CSA and physical abuse as predisposing factors to anger and general psychological maladjustment. Presently, there is very little supporting evidence available, and consequently they are not yet robust explanations for the clinical observations and research findings. Furthermore, additional factors such as coping strategies and abuse-related characteristics ought to be considered when reflecting on the relationship between maltreatment, shame and psychological distress,

Given the significance of childhood emotional abuse, further studies using clinical samples are required to establish the role of shame following these invalidating experiences. Furthermore, whilst similar, there are some fundamental differences between the models and it is hoped that by expanding on the research, it may be possible to reach some consensus concerning the interactions between childhood experiences of abuse, internalised shame, and psychological distress.

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AN EXPLORATORY STUDY
INVESTIGATING THE ASSOCIATIONS
BETWEEN MALTREATMENT,
INTERNALISED SHAME, AND RESOURCE
LOSS IN A SAMPLE OF INDIVIDUALS
WITH A DIAGNOSIS OF BIPOLAR
DISORDER

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**An Exploratory Study Investigating the Associations Between
Maltreatment, Internalised Shame and Resource Loss in a Sample of Individuals
with a Diagnosis of Bipolar Disorder**

Abstract

Background: Relatively little is understood regarding the aetiology of bipolar disorder (BD) other than for the influence of a large genetic component and the impact of stressful life events. However, research consistently reports a relationship between childhood maltreatment and other psychiatric conditions, and these abusive experiences are frequently linked with high levels of internalised shame.

Methods: A sample of 35 participants with a diagnosis of BD, and 35 participants with no psychiatric diagnoses completed measures of maltreatment, internalised shame and resource loss and gain.

Results: Participants in the BD group reported significantly higher levels of most subtypes of childhood abuse compared with the control group. In particular, moderate levels of emotional abuse and neglect were reported by participants in the BD group. Levels of internalised shame and resource loss were also significantly higher in the BD group. Significant correlations were observed between internalised shame, childhood maltreatment and resource loss.

Limitations: The relatively small sample means that these results ought to be regarded as exploratory, and are not indicative of overall prevalence rates within the BD population. Results were not controlled for the influence of potentially confounding extraneous variables, including number of hospital admissions. Data regarding relationship and employment status were not recorded.

Conclusions: The high levels of childhood maltreatment and internalised shame indicate that these are particularly salient issues in the experience of BD. Consequently, these factors identify important clinical implications, particularly towards explicitly assessing for abusive histories, and being vigilant towards the potential for significant levels of shame.

Keywords: Bipolar disorder; internalised shame; child abuse; emotional abuse; emotional neglect; resource loss.

**An Exploratory Study Investigating the Associations Between
Maltreatment, Internalised Shame and Resource Loss in a Sample of Individuals
with a Diagnosis of Bipolar Disorder**

1. Introduction

1.1 *Bipolar disorder*

Bipolar disorder (BD) is a severe and enduring mental health problem that is associated with recurring episodes of repeated hospitalisations and significant risk of self-harm and suicide (Dittmann et al., 2002). The onset of BD tends to occur around 19-21 years of age, and in most cases, the pattern of illness remains chronic (Joyce, 1984; Judd et al., 2003). In the UK, the estimated annual incidence is seven per 100,000, with an estimated lifetime prevalence of 4-16 per 1,000 in the general adult population (National Institute for Health & Clinical Excellence, 2006).

The spectrum of bipolar disorders ranges from sub-syndromal presentations to severe psychosis including delusions and hallucinations (Dupue et al., 1981), and all share a common pathological disturbance in affect involving abnormal mood swings, including mania, hypomania, mixed states, and major depressive episodes (Hirschfeld & Vornik, 2004). The illness is generally episodic in nature, typically with a return to a more euthymic condition in between episodes, although as the illness becomes more chronic, clients experience greater difficulty stabilizing to this euthymic state (Craddock & Jones, 1999; Perugi et al., 1998). Indeed, Ahmed and Morriss (1997) refer to the 'kindling effect', whereby affective relapses become progressively more easily triggered

by the same circumstances, until eventually no triggers are required, and hypomanic or depressive relapses occur spontaneously.

Mania is a persistent elevation of mood with accompanying severe psychosocial impairment; hypomania is similar to mania, but less severe. The diagnostic criteria described by the International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10; World Health Organisation [WHO], 1993) and the Diagnostic and Statistical Manual of Mental Disorders 4th Edition (DSM-IV; American Psychiatric Association, [APA], 1994), report similar symptoms of a manic episode. These include increased energy, activity and restlessness, as well as euphoric mood, extreme irritability, racing thoughts, poor concentration, aggressive behaviour, and an unrealistic belief in one's abilities and power. According to the ICD-10, these phases of the illness can last for between two weeks and four to five months.

Depressive phases of the illness are dramatic contrasts to manic episodes; symptoms include a lasting sad, empty mood, along with feelings of hopelessness, pessimism, worthlessness or helplessness, and thoughts of death or suicide (National Institute of Mental Health, 2007). Depressive phases of BD have many similarities with unipolar depression, such as altered sleep and eating patterns, low mood, lack of energy and feelings of inadequacy (Depue & Monroe, 1978). However, there are also critical differences, including a younger age of onset, a shorter duration, an increased likelihood of psychotic experiences and a wider range of symptomatic and mood variability (Goodwin & Jamison, 1990). Compared with the duration of episodes of mania,

depressive phases of the illness tend to last longer, with a median length of approximately six months (WHO, 1993).

1.1.1 The aetiology of BD.

At present, our understanding of the factors involved in the development of BD is less well understood compared with other psychiatric diagnoses. There is a general acceptance that genes make an important contribution to the pathogenesis of the disorder (McGuffin et al., 2003), and family studies have demonstrated that the presence of BD is higher amongst relatives of individuals with a diagnosis of BD than among relatives of individuals with no psychiatric illness (Alda, 1997). The approximate lifetime risk of developing BD in relatives of an individual with the disorder is estimated at between 40-70% in a monozygotic co-twin, 5-10% in a first-degree relative, and 0.5-1.5% in an unrelated person (Craddock & Jones, 1999). Cadoret (1978) presents marginally lower figures, estimating concordance rates for BD of 57% for monozygotic twins, and 14% for dizygotic twins. A genetic theory is further supported by findings that indicate that concordance rates of BD amongst identical twins are similar regardless of whether the twins are raised together or separately (Alda, 1997; Taylor, Faraone, & Tsuang, 2002).

Irrespective of these inconsistencies, all estimates suggest a concordance rate less than 100%, and it is recognised that genetic and biological processes are unable to fully account for the onset, course and expression of BD. Consequently, this suggests additional aetiological factors (Alda, 1997).

Further to the proposed genetic contribution, current opinion supports the likelihood that BD is triggered by an interaction of genetic, medical, environmental and social factors (Rush, 2003). Indeed, the ICD-10 describes how both manic and depressive episodes often follow stressful life events or trauma, and there is substantial evidence suggesting that such events might predict the timing and severity of both manic and depressive symptoms (Johnson, 2005; Kennedy, Thompson, Stancer, Roy, & Persad, 1983).

1.2 Childhood maltreatment and psychopathology

The impact of stressful life events has not been restricted to BD. For example, it is estimated that clients with major depression report up to three times as many life events before the onset of a depressive episode compared with individuals with no mental health difficulties (e.g., Brown & Harris, 1978; Paykel et al., 1969).

Further to the impact of stressful life events, clients with a range of psychiatric difficulties consistently report negative early experiences, and in particular, incidents of childhood abuse and neglect. Indeed, it is estimated that the prevalence of abusive histories lies between 48% to 92% in inpatient samples, and 35% to 52% in outpatient samples (Bryer, Nelson, Baker Miller, & Kroll, 1987; Read, 1997, 1998; Read, van Os, Morrison, & Ross, 2005).

Abuse can be subdivided into a number of specific subtypes, including childhood sexual abuse (CSA), physical abuse, and emotional abuse and neglect. Research has identified that adult survivors of CSA typically report a greater range of mental health difficulties compared with non-abused adults (Spataro, Mullen, Burgess,

Wells, & Moss, 2004), and it is estimated that between 34% and 53% of clients with a severe mental illness have a history of CSA (Greenfield, Strakowski, Tohen, Batson, & Kolbrener, 1994; Morrison, Frame, & Larkin, 2003; Ross, Anderson, & Clark, 1994; Wurr & Partridge, 1996).

In addition to the high levels of CSA, Mueser et al. (1998) also found that between 16% and 18% of participants in their sample reported being physically abused as children. Table 2 presents the findings of a number of studies exploring the levels of various forms of childhood maltreatment in a range of psychiatric population. All the studies presented used the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998) as their measure of childhood maltreatment. The CTQ is a well-validated and reliable retrospective rating scale that measures various forms of childhood maltreatment: emotional, sexual and physical abuse, and emotional and physical neglect (see Section 2.3.3).

Due to the wide variation in the sample sizes reported in these studies, comparisons of the findings of the studies in Table 2 ought to be done so with caution. Nevertheless, it can be seen that across a range psychiatric populations, samples of participants consistently report emotional abuse and neglect as being the more prevalent form of maltreatment experienced in childhood.

PUT IN TABLE 2 HERE

1.3 Childhood maltreatment in community samples

The experience of maltreatment is not exclusive to those with mental health difficulties. Large epidemiological studies, investigating the experiences of thousands of participants from community samples, have estimated prevalence rates of CSA between 10% and 40% (Baker & Duncan, 1985; Briere & Elliott, 2003; Finkelhor, Hotaling, Lewis, & Smith, 1990; Silverman, Rienherz, & Giaconia, 1996); estimated rates of physical abuse in the general population lie between 2.7% and 40% (Mulder, Beautrais, Joyce, & Fergusson, 1998; Silverman et al.).

There are wide variations in the estimated levels of maltreatment, and it is possible that these are partially due to variations in abuse definitions, and how experiences are recorded. Indeed, the general lack of consensus as to what constitutes abuse is a general criticism of the childhood maltreatment literature, particularly with regards to physical and emotional abuse (Trickett, Noll, Reiffman, & Putnam, 2001). As such, the use of a standardised measure is helpful in providing a consistent definition of maltreatment and facilitates comparisons between studies, although one must still be mindful of variations in sample sizes across these studies. Further to the findings amongst psychiatric samples in studies using the CTQ, emotional abuse and neglect have been seen to also be the most frequently reported experiences of childhood maltreatment in non-psychiatric samples.

1.3.1 Gender differences in the experience of childhood maltreatment.

Research indicates that the relationship between CSA and adult mental health difficulties tends to be stronger for women than for men (MacMillan et al., 2001).

Indeed, 35.5% and 39% of male patients from inpatient and outpatient psychiatric populations respectively report a history of CSA, compared with 52% of female participants (Mueser et al., 1998; Wurr & Partidge, 1996). This gender divide is mirrored in the general population, although the difference is potentially less remarkable. In particular, between 7% and 36% of females report experiences of CSA, compared with between 3% and 29% of males (Baker & Duncan, 1985; Briere and Elliott, 2003, Finkelhor, 1997; Gorey & Leslie, 1997; MacMillan et al., 2001).

With the experience of physical abuse, the gender difference is somewhat less distinct than with CSA, with levels estimated between 22% and 29% for males, and 19% and 21% for females (Briere and Elliott, 2003; MacMillan et al., 2001). As yet, there is little available evidence documenting any gender differences between the experience of emotional abuse and neglect in psychiatric and non-psychiatric samples, although in the studies presented in Table 2, the gender differences in the general population would appear to be unremarkable.

1.4 Childhood maltreatment in BD

The literature regarding the experience of childhood maltreatment in BD tends to report similar levels to those of other psychiatric populations. For example, Gorno, Goldberg, Ramirez, and Ritzler (2005) recorded a history of childhood abuse in approximately half of their participants with a diagnosis of BD, with at least one-third of participants reporting multiple forms of abuse. Similarly, using a semi-structured clinical interview, Hyun, Friedman, and Dunner (2000) found a significantly higher level of CSA amongst their BD sample, compared with participants with major

depressive disorder. Conversely, they found no significant difference between the two diagnostic groups on rates of physical abuse. Neria, Bromet, Carlson, and Naz (2005) found that approximately 28% of a sample of inpatients with a diagnosis of BD with psychotic features reported childhood physical abuse or CSA. Furthermore, they found that histories of childhood assault were more frequently reported by female participants (34.5%) compared with male participants (19.6%).

Contrary to these findings, indicating levels of childhood abuse in BD that are similar to other psychiatric samples, Hammersley et al. (2003) found that 16% of their sample reported a history of CSA. In their study, therapists recorded spontaneous disclosures of childhood abuse during six months of cognitive-behavioural therapy (CBT). Although no control group was used to compare these findings, the authors conclude that given that the majority of participants made no direct reference to a history of CSA, clients with BD are unlikely to be any more traumatised than other groups. However, it is possible that the levels of CSA are underestimations, partially due to the methodology, given how researchers relied upon spontaneous disclosures of abusive incidents. It has been reported that many clients do not disclose these kinds of experiences unprompted due to their anticipation of a negative response, such as being labelled or judged by their therapist (Harder, 1990; Macdonald & Morley, 2001; Williams, 1994). As such, it might be concluded that the results of Hammersley and colleagues are not so robust as to refute the findings of studies report a higher level of childhood maltreatment in individuals with a diagnosis of BD.

Despite the findings of these studies in relation to the experiences of childhood maltreatment reported by individuals with a diagnosis of BD, none comment on the

levels of childhood emotional abuse or emotional neglect. Given the literature demonstrating the significance of psychological abuse, and in particular, the findings presented in Table 2 indicating these forms of maltreatment to be the most frequently reported amongst participants from psychiatric and non-psychiatric populations alike, this is an extremely important omission in the BD literature.

1.5 Experiences of maltreatment in adulthood and psychopathology

Chronic mental illness has been identified as being significantly associated with experiences of intimate partner abuse (Coker et al., 2002). Furthermore, several inquiries have revealed that clients with chronic and severe mental health difficulties who live in supported accommodation or hostels may live in conditions where they are neglected by the people who are responsible for their well-being and care (e.g., Camden and Islington Community Services NHS Trust, 1991; Jones, 1993).

Further to negative childhood experiences, these findings would appear to indicate an association between mental health difficulties and adult experiences of maltreatment. Indeed, Mueser et al. (1998) report that in a sample of participants from an adult psychiatric population, over 46% of participants reported experiences of sexual assault in adulthood, and between 37% and 42% reported adult experiences of physical assault. Similarly, Goodman et al. (1999) found that in a sample of chronically mentally unwell outpatients, the level of adult physical abuse in female participants was 90%, and 71% for males; the rate of adult sexual abuse was 79% for female participants, and 19% for males.

Further to these reports, research has also identified that CSA survivors are more likely to be re-victimised in adulthood (Russell, 1986). Indeed, experiences of rape, battery or assault are more frequently observed in women who have been sexually abused in childhood compared with those who suffer no such abuse (Fromuth, 1986).

1.6 Internalised shame, maltreatment and psychopathology

The experience of childhood abuse is often dominated by feelings of shame (Cook, 1987; Draucker, 1993; Negrao, Bonanno, Noll, Putnam, & Trickett, 2005). Shame is a dejection-based emotion involving feelings of helplessness, incompetence, and a desire to escape or avoid contact with others. It can be experienced in two ways. *State* shame is the shame-response experienced as a transient feeling in certain situations, and is a universal emotion that is experienced by most people at some point in their lives. However, when one experiences shame in a more intense and pervasive manner, one possesses trait shame, or *internalised* shame (Goss, Gilbert, & Allan, 1994). In this case, one feels a fundamental sense of incompetence and inferiority that results from enduring and intense levels of shame during development (Claesson & Sohlberg, 2002). In this latter experience of shame, the person is concerned with being rejected and exposing the entire self as defective (Ferguson, Stegge, Miller, & Olsen, 1999; Lewis, 1971; Tangney, Burggraf, & Wagner, 1995).

The experience of shame is typically associated with perceptions of being criticised, devalued and disapproved of by others for actions or attributes of self that others find undesirable or unattractive (Gilbert, 1998; Tangney, 1996), and it is

associated with self-perceptions of unfavourable social comparison, such as being inferior or less attractive than others (Gilbert, Allan & Goss, 1996; Goss et al., 1994).

Tangney (1996) argues that the experience of shame should not be confused with pre-existing factors, such as low self-esteem, that can be precursors of shame. Nor should shame be confused with post-shame affect. For example, after an experience of shame and feeling devalued people might become depressed, withdrawn, and irritable (Gilbert, 1998).

Internalised shame has been consistently associated with experiences of CSA (Feiring, Taska, & Lewis 1996; Finkelhor & Browne, 1986; Kessler & Bieschke, 1999) and psychological abuse (Hoglund & Nicholas, 1995; Webb, Heisler, Call, Chickering, & Colburn, 2007). In particular, it is suggested that individuals who have a history of childhood abuse tend to experience unhealthy levels of shame because of feelings of not being valued as a person (Steele, 1980), or as the result of the violation of personal boundaries (Fossum & Mason, 1986). In addition, it is suggested that shame may develop following the child's interpretation of the abuse as a personal attack on the self, leaving the individual feeling deeply defective, damaged and defeated, somehow deserving of the maltreatment (Feinauer, Hilton, & Callahan, 2003; Feiring & Taska, 2005; Finkelhor & Browne, 1986).

It has been proposed that emotional abuse may be more damaging than other forms of maltreatment due to repeated experiences of criticism, invalidation and rejection (Bennett, Wolan Sullivan, & Lewis, 2005; Claussen & Crittenden, 1991; Gilbert, 1998; Tangney, 1995; Webb et al., 2007).

As a result of this research identifying an association between childhood maltreatment and the experience of internalised shame, it is perhaps unsurprising that studies have demonstrated a further significant association between shame and a range of psychiatric diagnoses, including depression (Andrews & Hunter, 1997; Harder, Cutler, & Rockhart, 1992; Hoblitzelle, 1987; Thompson & Berenbaum, 2006), social anxiety (Gilbert, 2000), and eating disorders (Skårderud, 2007).

Further to these diagnoses, there is a small body of literature detailing the experience of shame in BD. Specifically, it has been suggested that individuals with a diagnosis of BD may experience shame following their behaviour during past manic episodes (Mansell, Colom, & Scott, 2005; Wolfersdorf, Lehle, & Adler, 2005), as well as a result of the psychosocial consequences of these manic behaviours, such as the breakdown of relationships (Goodwin & Jamison, 1990). Subsequently, researchers and clinicians have identified shame as a key target for intervention in the treatment of BD (Brondolo & Mas, 2001).

1.7 Resource loss in BD

Research has demonstrated how individuals with a diagnosis of BD are vulnerable to experiencing a range of concrete and abstract losses. For example, Prien and Potter (1990) estimate that any adult who develops BD in their mid-20s effectively loses up to nine years of their total life, 12 years of 'normal' health, and 14 years of work activity.

BD affects many aspects of an individual's life and, in particular, it greatly interferes with a person's ability to find and maintain employment. For example,

Targum, Dibble, Davenport, and Gershon (1981) found that financial and employment problems were reported as the most frequent long-term difficulties associated with BD by approximately 70% of patients and their partners. Specific to these employment difficulties, Harrow, Goldberg, Grossman, and Meltzer (1990) reported that of their sample of 73 participants with a diagnosis of BD, 23% were continuously unemployed, and 36% showed a clear decline from their premorbid level of functioning at work. Job-related difficulties are common, and individuals with a diagnosis of BD tend to have higher rates of absenteeism from work compared with working individuals without BD (Bowden, 2005). Further to employment difficulties, individuals with a diagnosis of BD tend to experience significant difficulties maintaining interpersonal relationships. For example, Brodie and Leff (1971) report a divorce-rate of 57% in their sample following an initial manic episode.

The experience of loss has inevitable emotional implications. For example, a person's perceived lack of control over his or her own life may subsequently undermine any belief in self-efficacy and may then lead to demoralisation (Kahn, 1990). Furthermore, Freedy, Shaw, Jarrell, and Master (1992) consider resource loss to be a risk factor for the development of clinically significant psychological distress. Further to the shame associated with their behaviour during manic episodes, individuals with BD may also experience shame owing to the psychosocial consequences of their illness, particularly unemployment and relationship breakdown (Goodwin & Jamison, 1990; Mansell et al., 2005).

1.8 Summary

At present, our understanding of the developmental factors involved in BD is incomplete. The available literature regarding the levels of childhood maltreatment in clients with a diagnosis of BD is varied, and there is a noticeable absence of research regarding the level of emotional abuse in BD. This is an important omission, considering the literature identifying emotional abuse as a significant factor in other mental health difficulties, and might relate to the experience of internalised shame to a greater degree compared with other forms of abuse.

Despite the emphasis on directing CBT interventions at the experience of shame in BD, our understanding of the shame experience in this population is currently insufficient. The present study aims to address some of these inequalities by providing a preliminary understanding of the association between internalised shame and reported histories of childhood and adult maltreatment in BD based upon the findings of a small sample of individuals with a diagnosis of BD. Of particular interest is the level of childhood emotional abuse and neglect in the sample, and associations between maltreatment, internalised shame, and resource loss are investigated.

1.9 Research questions

The current study presents four research questions

1. (a) Are there differences in the levels of childhood and adult maltreatment, internalised shame, and resource loss and gain in a sample of participants with a diagnosis of BD compared with participants with no psychiatric diagnoses?

(b) Are there any differences between male and female participants' reporting of levels of childhood and adult maltreatment, internalised shame, and resource loss and gain?

2. What levels of childhood maltreatment, internalised shame, and resource loss and gain are reported by a sample of participants with a diagnosis of BD?
3. Are self-reported levels of childhood maltreatment associated with internalised shame and resource loss and gain in a sample of participants with a diagnosis of BD?
4. Does current mood state account for these associations?

2. Method

2.1 Design

The current research was a cross-sectional study, and there were two separate designs based on the research questions.

2.1.1 Group differences.

To identify group and gender differences, a between-subjects design was applied, for which the independent variables (IVs) are the participant group and gender. The dependent variables (DVs) are reported levels of internalised shame, maltreatment, and resource loss and gain.

2.1.2 Relationships between variables.

To identify associations between internalised shame, maltreatment, and resource loss and gain, a correlative design was applied.

2.2 Participants

2.2.1 BD group.

One of the two groups in the current study consisted of 35 adult outpatients who had previously been given a diagnosis of BD by a consultant psychiatrist using the diagnostic criteria of the ICD-10 (see Appendix C). All participants were currently, or previously had been, NHS patients being managed in secondary care by their consultant psychiatrist.

Information regarding the original diagnoses of 31 participants was available, which revealed that the mean age at which participants were originally diagnosed was 32.55 years ($SD = 8.76$ years), and the mean duration of illness was 11.79 years ($SD = 8.93$ years). Medical records provided evidence of hospital admissions for 20 participants in the BD group. For these participants, the number of admissions ranged between one and nine ($m = 2.50$, $SD = 2.01$), and the mean length of each admission was 51.78 days ($SD = 70.24$); the overall mean number of days spent in hospital was 130.60 ($SD = 210.62$).

All participants in the BD group except for one were currently taking medication as management of their illness. Participants were prescribed at least one type of mood stabilising medication, as well as some form of anti-depressant medication and/or an anti-psychotic drug. Two participants had received electroconvulsive therapy

(ECT) in the treatment of their illness; sixteen participants reported having experienced some form of psychological intervention, with CBT being the most frequently cited therapeutic experience.

2.2.2 *Control group.*

A second group of participants consisted of 35 control participants who reported no history of psychiatric difficulties. Participants in the control group were screened at first contact for any history of mental health difficulties, being asked “Have you ever been diagnosed with or received treatment for any mental illness?”; potential participants were excluded if they reported a positive response.

Control participants were matched to participants in the BD group based on age and years of education. Analyses of the matching criteria demonstrate no significant differences, indicating that the groups were equally matched in terms of age and years of education (see Table 3). In both groups, there were 22 female participants and 13 male participants. Exclusion criteria for both groups were an identified learning disability, history of head injury, current substance misuse, and those participants whose first language was not English⁵.

⁵ Participants whose first language was not English were excluded because the measures had only been standardised in English, and it was not possible to use translators due to constraints on financial resources. This was deemed to be a sufficiently appropriate rationale by the University of Southampton School of Psychology Ethics Committee and the National Research Ethics Service Southampton and South West Hampshire Research Ethics Committee A, and was not considered to be unnecessarily prejudicial.

Table 3.

Comparison of demographic information from participants in the bipolar disorder (BD) group (n = 35) and the control group (n = 35).

Demographic variable	BD		Control		U-test	p
	<i>m</i>	<i>SD</i>	<i>m</i>	<i>SD</i>		
Age (years)	45.57	9.89	46.20	12.78	598.0	.87
Education (years)	14.03	3.14	13.86	3.27	584.5	.74

2.2.3 Recruitment procedure.

Participants in the BD group were recruited from two sources: NHS outpatient mental health services within Hampshire Partnership NHS Trust (HPT), and the Southampton branch of MDF The Bipolar Organisation (formerly the Manic-Depression Fellowship [MDF]).

Participants recruited from HPT were accessed through two community mental health teams (CMHTs) in Southampton, as well as the Mood Disorders Service, a specialist tertiary service for mood disorders in Hampshire. Potential participants were given information about the study by their care co-ordinators or consultant psychiatrist (see Appendixes D & E). Information was only passed on to those clients who had previously been diagnosed with BD by their psychiatrist. Clients who were interested in participating returned their contact details to the researcher (see Appendix F) which was used to arrange appointments with participants to conduct the study.

Participants recruited from the MDF The Bipolar Organisation volunteered following an informal presentation made at one of their monthly meetings, during which the study was described and copies of the Information Sheet were distributed, along

with a cover letter (see Appendix G). Members who were interested in participating provided the researcher with contact information as described above. All members of the MDF who participated in the study had previously been given a diagnosis of BD by a consultant psychiatrist.

Control participants were recruited from the University of Southampton, and also by placing advertisements at local organisations using contacts of the researcher (see Appendix H). Potential control participants who expressed an interest in participating were provided with further information regarding the study (see Appendix I). All participants' GPs were informed of their participation (see Appendix J).

2.2.4 Justification of sample size.

Sample size was determined a priori based on effect sizes and power of a previous study by Gilbert (2000), who compared participants with a diagnosis of depression with a control group on a measure of shame and found a highly significant difference between the two groups⁶. A Cohen's D effect size of .60 (power = .96) was found. For this study, power of .8 is sufficient. A power calculation using G*Power version 3.0.10 for Windows (Faul, Erdfelder, Lang, & Buchner, 2006) revealed that a sample size of 36 per group is sufficient to find similar group differences.

2.3 Measures

Six questionnaires were used to address the research questions and were presented in the following order

⁶ Depressed group: $n = 50$, $m = 51.42$, $SD = 9.87$. Control group: $n = 109$ $m = 45.81$, $SD = 9.06$

2.3.1 Internal State Scale (Bauer et al., 1991).

The Internal State Scale is a 15-item self-report scale that is unique among self-report measures in that it allows for the simultaneous assessment of both manic and depressive symptoms in BD (Sherwood Brown, Bauer, Suppes, Khan, & Carmody, 2000). Each item consists of a statement above a 100mm line, anchored at 0 (*Not at all, Rarely*) and 100 (*Very much so, Much of the time*). Participants are required to mark a ‘**×**’ at the point on the line that best describes their mood over the past 24 hours. The distance from the 0 anchor to the participant’s mark is measured in millimetres to produce a score. The scale has four subscales: Activation, Perceived Conflict, Depression, and Well-Being. Scores on these subscales are used in combination to categorise four mood states in BD: ‘depression’, ‘euthymia’, ‘mixed state’ and ‘(hypo)mania’.

Bauer et al. (1991) report how the Activation and Depression subscales correlate highly with clinician ratings of mania ($r = .60$ with the Young Mania Rating Scale; Young, Biggs, Ziegler, & Meyer, 1978), and depression ($r = .84$ with the Hamilton Rating Scale for Depression; Hedlung, & Vieweg, 1979) respectively. These findings have been consistently found in both inpatient and outpatient samples of participants with BD (Bauer et al.), and also those with a rapid cycling course of illness (Cooke, Krüger, & Shugar, 1996).

The Internal State Scale has only been validated as a measure of current mood with participants who have a diagnosis of BD. Consequently, the measure was only completed by participants in the BD group as a measure of their current mood state.

2.3.2 Hospital Anxiety and Depression Scale (HADS; Snaith & Zigmond, 1994).

The HADS is a well-validated and reliable 14-item self-report instrument for assessing anxiety and depressive states in both somatic, psychiatric, and primary care patients, as well as in the general population (Snaith & Zigmond, 1994). Each item begins with a statement and respondents are instructed to select one of four options to indicate how they have been feeling over the preceding seven days. Individual items are summed to provide a total anxiety score (HADS-A) and a total depression score (HADS-D). Higher scores indicate a greater number of symptoms and a greater severity of the emotional state; scores over 15 indicate particularly severe symptoms. Bjelland, Dahl, Haug, and Neckelmann (2002), conducted a review of the validity of the HADS, examining 747 identified papers that included the scale in the procedure. Their review revealed that the HADS compared favourably to other questionnaires for anxiety and depression in common use including the Beck Depression Inventory (BDI; Beck, Ward, & Mendelson, 1961), the State-Trait Anxiety Inventory (STAI; Spielberger, 1983), the Clinical Anxiety Scale (Westhuis & Thyer, 1989), and the anxiety and depression subscales of the Symptom Checklist (SCL-90; Derogatis, Lipman, & Covi, 1973). Similarly, Löwe et al. (2004) reported that the HADS is a reliable tool comparing favourably with the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I; First, Spitzer, Gibbon, & Williams, 1995), and the Patient Health Questionnaire (PHQ; Spitzer, Kroenke, & Williams, 1999).

2.3.3 *Childhood Trauma Questionnaire (CTQ)*.

The 28-item CTQ is a brief retrospective self-report inventory that reliably assesses five types of traumatic experiences that took place before the age of 18: emotional, sexual and physical abuse, and emotional and physical neglect. *Emotional abuse* refers to verbal assaults on a child's sense of worth, or any humiliating, demeaning, or threatening behavior directed toward a child by an older person. *Physical abuse* refers to bodily assaults on a child by an older person that pose a risk of, or result in, injury. *Sexual abuse* refers to sexual contact or conduct between a child and an older person, including explicit coercion. *Emotional neglect* refers to the failure of caretakers to provide basic psychological and emotional needs, such as love, encouragement, belonging and support. *Physical neglect* refers to a failure to provide basic physical needs including food, shelter, and safety.

The instrument is comprised of 25 items that load on to the five factors of childhood maltreatment; three items of minimization/denial control for underreporting of maltreatment. Items on the CTQ are rated on a Likert scale from 1 (*never true*) to 5 (*very often true*), and scores range from 5 to 25 for each subscale; the recommended guidelines for classifying the severity of scores on each subscale are presented in Appendix K.

The CTQ has demonstrated excellent content validity for each of the five subscales. Correlations between interview-based ratings of abuse and corresponding CTQ subscales among adult participants ranged from .42 for both the emotional abuse and physical neglect subscales, to .58 for the sexual abuse subscale (Bernstein & Fink, 1998). Correlations between therapist ratings of abuse and the CTQ subscales among

adolescent psychiatric inpatients ranged from .42 for the physical neglect subscale to .72 for the sexual abuse subscale (Bernstein, Ahluvalia, Pogge, & Handelsman, 1997). Scores on the CTQ have been seen to be stable over time, both pre- and post- therapy, and are consistent with reports from corroborative sources (Bernstein et al., 1994; Fink, Bernsetin, Handelsman, Foote, & Lovejoy, 1995; Paivio, 2001; Walker et al., 1999).

2.3.4 Internalized Shame Scale (Cook, 1994).

The Internalized Shame Scale is a 30-item self-report scale, accurately measuring trait shame, in which high-shame individuals are conceptualised as frequently or continuously experiencing generalised or global shame, rather than state shame, which is specific to certain situations or events (Tangney, Stuewig, & Mashek, 2007). Twenty-four items incorporate phenomenological descriptions of internalised shame, providing a total shame score; the six remaining items constitute a subscale of self-esteem⁷. Participants respond on a Likert scale ranging from 0 (*never*) to 4 (*almost always*). The total shame score is obtained by excluding the self-esteem items and summing the remaining items giving a score range of 0 to 96; scores over 50 indicate clinical levels of internalised shame, with scores of 60 indicating extreme levels.

⁷ The items used to constitute the self-esteem subscale of the Internalized Shame Scale are taken from the Rosenberg Self-Esteem Scale (Rosenberg, 1965). This subscale is not designed to be an independent measure of self-esteem. Instead, the author suggests that these items can be used as a cursory indication of positive self-esteem. As such, whilst the current study includes the self-esteem subscale of the Internalized Shame Scale in the analyses, the interpretation of these findings is done with caution.

Reliability tests with a clinical sample demonstrate Cronbach's Alpha scores of .95 and .96 for shame and self-esteem respectively, and test-retest correlations of .84 and .69 for shame and self-esteem respectively over a seven-week interval, based on mixed, non-clinical and clinical samples (Cook, 1994, 2001). In addition, Rosario and White (2006) found that both the internalised shame and self-esteem subscales demonstrated a high level of stability across a 14 week test-retest period.

Rosario and White (2006) illustrate how the items of the Internalized Shame Scale encompass multiple factors of internalised shame, consistent with Nathanson (1992), who proposed that the experience of trait shame is accompanied by multiple categories of cognitions. Their analysis revealed a dominant factor of Inferiority, which is a fundamental theme underlying the experience of trait shame (Cook, 1994, 2001). Two other factors were identified, labelled Fragile/Exposed and Empty/Lonely, which respectively are consistent with Nathanson's proposed shame cognitions of "Issues of seeing and being seen", and "Wishes and fears about closeness", in which one thinks they are unlovable and condemned to being alone. As such, they conclude that the scale's sensitivity to the multiple factors of trait shame proposed by Nathanson reveal it to be an accurate and reliable measure of internalised shame.

2.3.5 Childhood Trauma Questionnaire-Revised (CTQ-Revised).

The original version of the CTQ was re-worded for participants in this study to rate their experiences of trauma in adulthood (see Appendix L). The original rubric "When I was growing up..." was changed to "Now that I am an adult...", and the tense

of some items was changed. As the CTQ-Revised was developed specifically for this study, no validity data is available.

2.3.6 Conservation of Resources – Evaluation (COR-Evaluation; Hobfoll, Lilly, & Jackson, 1991).

The COR-Evaluation is a 74-item measure of resource loss and gain. Items are initially scored by participants in relation to the degree of actual or threatened resource loss on a scale of 0 (*not at all / not applicable*) to 4 (*to a great degree*). The items are then scored again using the same scale in relation to the degree of resource gain. To reduce respondent burden, threatened loss was not scored in the current study.

Participants in the BD group were asked to score each item in relation to the period since they were initially given a diagnosis of BD. Participants in the control group were asked to respond with reference to their experiences over the preceding five years.

The COR-Evaluation has demonstrated excellent concurrent, divergent, and predictive validity in community-based and trauma-based samples (Hobfoll & Lilly, 1993; Ironson et al., 1997) with internal reliability being .86 and .85 at two different administration time points nine months apart (Hobfoll, Johnson, Ennis, & Jackson, 2003). The test-retest for recent loss and gain ranged from .55 to .64 and for the loss and gain during the past year measures ranged from .64 to .67. These figures are consistent with findings for recent life event measures and further suggest that reporting of loss and gain is not random or overly influenced by mood. Hobfoll and Lilly conclude that these findings suggest that the COR-Evaluation is a reasonable research instrument and is as reliable and valid as the commonly used life event measures.

2.4 Ethical approval

The study was initially reviewed and approved by an independent and impartial researcher within the School of Psychology at the University of Southampton (see Appendix M). Ethical approval was granted by the University of Southampton School of Psychology Ethics Committee (see Appendix N), and National Research Ethics Service approval was granted by the Southampton and South West Hampshire Research Ethics Committee A (see Appendix O). Research and Development approval was granted by HPT (see Appendix P), and sponsorship and professional indemnity was provided by the University of Southampton (see Appendix Q). A detailed consideration of the ethical issues highlighted by the current study is presented in Appendix R.

2.5 Procedure of data collection

All participants had individual meetings with the researcher at their GP surgery or at a local CMHT base. Signed consent was obtained from participants (see Appendixes S & T), and the procedure was explained, after which participants were given the opportunity to ask questions and clarify any uncertainties. To facilitate engagement with the participant, the researcher spoke with each participant in the BD group for approximately 30 minutes about his or her experience of having a diagnosis of BD (see Appendix U). The researcher held a more general conversation with participants in the control group as a method of developing a rapport. The results of these interviews are not presented here.

Demographic information was collected (see Appendixes V and W) and participants were presented with each of the measures in the order described above. The researcher was present throughout the procedure if participants required any support or assistance, or if they had any questions or concerns, or wished to withdraw. Following the completion of the questionnaires, participants were verbally debriefed and given a copy of the debriefing statement (see Appendixes X and Y), and finally thanked for their participation in the study.

The procedure of explaining the study, gaining consent, building rapport, completing the measures, and debriefing lasted approximately 90 minutes for participants in the BD group, and 60 minutes for participants in the control group.

3. Results

All data were analysed using Statistical Package for the Social Sciences (SPSS) version 15.0 for Windows.

3.1 Preliminary analyses

3.1.1 Normal distribution.

A one-sample Kolmogorov-Smirnov test was used to identify the distribution of the variables. Scores on the HADS-D, all subscales of the CTQ and CTQ-Revised and the COR-Evaluation were not normally distributed (see Table Z1 in Appendix Z). Consequently, the appropriate non-parametric tests were used where possible.

3.1.2 Transformations.

As stated, the raw data of many of the variables in the present study were identified as being not normally distributed; as such, the appropriate non-parametric analyses were selected for use. However, the use of some parametric analyses was unavoidable, such as the use of Pearson Product Moment Correlations in the partial correlational analyses (see Section 3.5). As such, the data was transformed using the appropriate function on SPSS. Transforming the data in this manner is consistent with the recommendations of researchers who suggest that nonparametric analyses, or parametric analyses using transformed data, both show superior power to parametric analyses of raw data that is not normally distributed (Rasmussen & Dunlap, 1991). As such, when nonparametric analyses were not available or appropriate, parametric analyses of the transformed data were used.

3.1.3 Mood state.

The Internal State Scale was included in the protocol as a measure of current mood state for participants in the BD group. This revealed that participants in the BD group were in different mood states: ‘depression’ ($n = 8$), ‘euthymia’ ($n = 14$), ‘mixed state’ ($n = 4$), and ‘(hypo)mania’ ($n = 9$). A Kruskal-Wallis test⁸ revealed that there were no significant differences between participants in different internal mood states on

⁸ Data for participants classified by the Internal State Scale as being in the ‘depression’, ‘euthymia’, and ‘(hypo)mania’ mood states were included in the Kruskal-Wallis analyses. The data of the four participants categorised as being in a ‘mixed state’ were excluded from the analysis because groups with fewer than five participants are inappropriate for inclusion in this type of analysis.

most of the variables⁹. The results of these analyses are presented in Table Z2 in Appendix Z.

Although no significant differences were reported between the three mood-state groups on HADS-D, this score is only marginally outside of the level of significance. The mean HADS-D score for the participants in the 'depressed' group was higher than the other two mood state groups (see Table Z3 in Appendix Z). As such, it is likely that an increased sample size would yield a significant difference, with HADS-D scores being higher in the 'depressed' group.

3.1.4 Internal consistency.

A revised version of the CTQ was used to assess adult experiences of maltreatment. It is unusual to use the same questionnaire twice in a single study session, and because there are no statistics to support the use of the CTQ as a measure of adult maltreatment, the internal consistency was checked. The Cronbach's Alpha coefficient scores for both the original format are presented in Table Z4 in Appendix Z, and demonstrate that the internal validity of the CTQ-Revised is acceptable.

⁹ G*Power version 3.0.10 was also used to determine the effect size of the differences between HADS-A and HADS-D, CTQ, Internalized Shame Scale, CTQ-Revised, and COR-Evaluation, between the 'depression', 'euthymia', and 'hypomania' groups, as categorised using the Internal State Scale. These analyses revealed that on these measures, Cohen's D effect sizes ranged between 0.4 and 18.83. Power ranged between .83 and 1.0. The required sample size ranged between 6 and 48. These analyses revealed that for the majority of the subscales, the study was sufficiently powered.

3.2 Research question 1(a) and 1(b): group and gender differences

3.2.1 BD group compared with control group.

A Mann Whitney *U* analysis was used to determine any differences between the BD group and the control group (see Table 4). It can be seen that significant differences were found between the two groups on most of the subscales. For each of the non-significant differences, the *p* values indicate a trend towards significance, and it is likely that a greater sample size would yield a significant difference between the two groups on these variables¹⁰.

¹⁰ The Kolmogorov-Smirnov analyses revealed that the self-esteem and shame subscales of the Internalized Shame Scale were normally distributed, and therefore appropriate for analysis using parametric analyses. However, they were included in the non-parametric analyses for the clarity and readability of the document. Nonetheless, separate *t*-tests, as the appropriate parametric analyses, were calculated to determine group differences. These analyses demonstrated a significant difference between the BD group and the control group on the shame subscale of the Internalized Shame Scale ($t = -4.588$, $df = 55.190$, two-tailed $p < .001$). These analyses also revealed a significant difference between the two groups on the self-esteem subscale of the Internalized Shame Scale ($t = 2.020$, $df = 68$, two-tailed $p = .047$). However, considering that the self-esteem subscale is not an independent measure of self-esteem, but rather it is a cursory indication of positive self-esteem, and given the marginal difference between the results of the *t*-test and the Mann Whitney *U* test, it was not considered necessary to report a separate analysis in the main document.

On all of the key variables of childhood and adult maltreatment, internalised shame, and resource loss and gain, scores were significantly greater for participants in the BD group compared with the control group¹¹.

Using the recommended method for categorising CTQ scores, it can be seen that all of the control group's CTQ subscale scores fall within the *low* category. Scores in the BD group range from the *low* category (physical neglect) to *severe* (CSA).

Analyses of scores on the minimization/denial subscale of both versions of the CTQ revealed that there was no significant difference between the two groups. The mean scores were less than 1 for both groups on both measures, indicating that participants were not minimising or denying their experiences when responding to items on the CTQ.

¹¹ Using the means, standard deviations and sample size from the current sample, a new power calculation was conducted using G*Power version 3.0.10 (Faul et al., 2006) to determine the effect size of the study with the mean score of the internalised shame subscale of the Internalized Shame Scale as the main variable. A Cohen's D effect size of 1.1 (power = .99) was found. This reveals that a sample size of 30 would have been required to find the significant results reported here. Consequently, the sample size of 35 was sufficient. BD group: $n = 35$, $m = 46.34$, $SD = 24.61$. Control group: $n = 35$, $m = 24.17$, $SD = 14.55$.

A similar calculation was conducted to determine the effect size of the study with total CTQ as the main variable. A Cohen's D effect size of 0.97 (power = .87) was found. This reveals that a sample size of 34 would have been required to find the significant results reported here. Consequently, the sample size of 35 was sufficient. BD group: $n = 35$, $m = 50.06$, $SD = 21.61$. Control group: $n = 35$, $m = 33.57$, $SD = 10.51$.

INSERT TABLE 4 HERE

3.2.2 Gender differences in the BD group.

In the current study, 90.9% of female participants in the BD group reported a history of childhood maltreatment, compared with 53.8% of male participants. A chi-square test demonstrated that this was significant $\chi^2 (1, 35) = 6.37, p < .05$.

The data presented in Table 5 indicates that female participants in the BD group reported higher levels across most of the variables compared with male participants, particularly on the levels of internalised shame, and emotional abuse and neglect. No significant differences were observed between male and female participants' scores on the Activation and Depression subscales of the Internal State Scale, indicating that there were no gender differences on levels of low mood and mania.

3.2.3 Gender differences in the control group.

In the control group, 72.7% of female participants reported a history of childhood maltreatment, compared with 46.2% of male participants. A chi-square test revealed that this difference was not significant $\chi^2 (1, 35) = 2.47, p = .116$. Mann Whitney *U* analyses were conducted to explore the differences between male and female participants in the control group (see Table Z5 in Appendix Z).

INSERT TABLE 5 HERE

No significant differences were observed on any of the variables, although a similar pattern of results was observed as seen in the BD group, whereby scores across the key variables of internalised shame, and childhood and adult maltreatment were higher for female participants compared with male participants. As participants in the control group did not complete the Internal State Scale, it was not possible to investigate potential gender differences for mania and low mood.

3.3 Research question 2: Level of childhood maltreatment, internalised shame, and resource loss and gain

3.3.1 Levels of childhood maltreatment.

In the current study, 77.14% of participants in the BD group reported at least one form of childhood abuse, compared with 62.86% of participants in the control group. A chi-square test revealed that this difference was not significant, $\chi^2 (1, 70) = 1.70, p = .192$. This is perhaps contrary to what might be expected, as one might predict that more participants in the BD group would report a history of childhood maltreatment compared with participants in the control group. It is possible that this result is due to the low threshold of the CTQ, whereby low levels of parental punishment for example might be classified as abuse. As such, given the widespread experience of maltreatment across both groups, it is perhaps more meaningful to look at the level of maltreatment rather than the frequency using the recommended guidelines. As stated, the mean scores on four of the five subscales of the CTQ, as well as the total trauma score, were significantly higher for participants in the BD group compared with the control group. Consequently, whilst there may be no significant difference between the BD group and

the control group in the number of participants reporting a history of childhood maltreatment, there is a highly significant difference in the severity of these experiences between the two groups.

Further observations of the data identified that there were also differences in the number of maltreatment subtypes experienced by participants in the BD group compared with the control group. This information is presented in Figure 3.

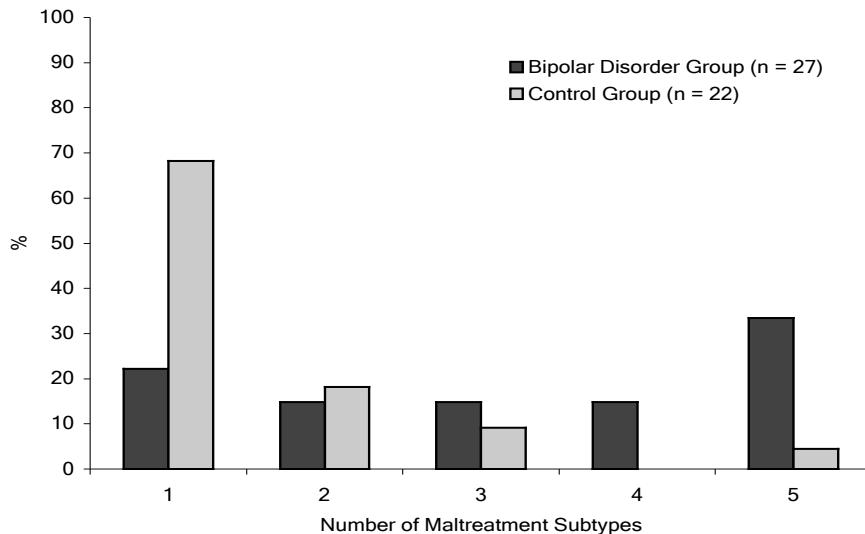


Figure 3. The percentage of participants in the bipolar disorder (BD) group ($n = 27$) and the control group ($n = 22$) reporting multiple forms of maltreatment using the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998).

Note: Participants reporting no maltreatment are excluded.

It can be seen that of those participants in the control group reporting a history of maltreatment, the majority reported only one of the five maltreatment subtypes. In comparison, in the BD group, a large majority of participants reported experiencing multiple forms of maltreatment, with approximately one-third of participants reporting a

history of all five subtypes. These data indicate that for both groups, scores for maltreatment subtypes were not mutually exclusive, and many participants, particularly those in the BD group, were likely to have experienced a number of different forms of maltreatment.

Table 6 presents the data from both the control group and the BD group, detailing the number of participants reporting each subtype of maltreatment. The levels of severity are also presented, using the original classification guidelines (Bernstein & Fink, 1998). It can be seen that, of those participants who reported a history of childhood maltreatment, emotional abuse and emotional neglect were the most frequently reported subtypes in both the control and the BD group.

Table 6.

Classification of Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998) scores for participants in the bipolar disorder (BD) group (n = 35) and control group (n = 35) using the guidelines presented by its authors.

CTQ Subscale	Categories of maltreatment severity								Total	
	None (or minimal)		Low (to Moderate)		Moderate (to Severe)		Severe (to Extreme)		reporting trauma ^{a, b}	
	BD	Control	BD	Control	BD	Control	BD	Control	BD	Control
Emotional abuse	12	25	7	8	7	1	9	1	23	10
Physical abuse	22	33	3	1	5	0	5	1	13	2
Sexual abuse	23	32	2	1	2	1	8	1	12	3
Emotional neglect	12	23	9	10	5	2	9	0	19	12
Physical neglect	21	28	3	4	5	1	6	2	14	7

^a Calculated by summing the number of participants reporting a history of trauma, excluding those whose scores fall within the *none (or minimal)* category.

^b Because of participants' reported experience of multiple forms of maltreatment, the total scores are not mutually-exclusive

Analyses of the differences between the subtypes of maltreatment using the CTQ demonstrated there was a highly significant difference between scores on the five subscales, $\chi^2 (4, 70) = 110.82, p < 0.001$. Results of the Wilcoxon signed-rank test, which was a post hoc analysis for significant items on the Friedman analysis of variance, are presented in Tables Z6 and Z7 in Appendix Z. These indicate that across the entire sample, scores of childhood emotional abuse and neglect were significantly higher than other abuse subtypes. The same analyses were computed for both the BD group and the control group independently, and similar results were obtained.

3.3.1.1 Experiences of maltreatment in adulthood

The Mann Whitney *U* analyses identified higher levels across all subscales of the CTQ-Revised in participants in the BD group compared with participants in the control group. As stated, the scale was specifically modified for use in this study as a measure of adult maltreatment. Consequently there are no recognised guidelines for the classification of the subscale scores, and as such, it was not possible to classify the severity of adult abuse.

3.3.2 *Levels of internalised shame.*

As stated, there was a highly significant difference between the level of internalised shame reported by participants in the BD group and the control group, with participants in the BD group reporting significantly higher levels. The analyses also indicated a significant difference between male and female participants' scores on the measure of internalised shame, with the mean level reported by female participants

falling above the threshold for clinical levels of internalised shame using the recommended classification guidelines (Cook, 1994).

3.3.3 Levels of resource loss and gain.

Analyses of the COR–Evaluation scores revealed that participants in the BD group reported significantly higher levels of resource loss and gain compared with participants in the control group. There are no recommended guidelines to classify the severity of resource loss. Consequently, it is not possible to comment on whether the levels of resource loss and gain reported by the participants in the BD group in the current study were comparable to those observed in alternative clinical populations.

3.4 Research question 3: associations between maltreatment, internalised shame, and resource loss and gain in BD

To explore the potential associations between the variables measured in the BD group in the current study, a Pearson Product Moment Correlation analysis was conducted^{12,13}. The results of these correlations are presented in the matrix in Table 7.

¹² Correlations were calculated for the two groups separately to facilitate more meaningful interpretations.

¹³ The correlations presented throughout this paper are Pearson Product Moment correlations, as SPSS uses parametric correlations in the calculation of partial correlations. However, because the raw data are largely non-parametric, the correlations presented here use the transformed data.

INSERT TABLE 7 HERE

These correlational analyses identified many significant associations between the variables within the BD group. In particular, significant correlations were observed between internalised shame and all subscales of the CTQ, except for CSA. Similar correlations were observed across most of the subscales of the CTQ-Revised, except for physical abuse and CSA. Further to the positive correlations observed between internalised shame and most of the subscales of the CTQ and CTQ-Revised, the total score on both measures also significantly positively correlated with internalised shame. Furthermore, a highly significant correlation was found between internalised shame and resource loss. Notably, none of the variables correlated significantly with resource gain.

Further to the correlations observed between the different variables, these analyses also indicated that there were significant positive inter-correlations between the subscales of the CTQ, as well as between the subscales of the CTQ-Revised. Furthermore, some of the subscales of the original version of the CTQ correlated significantly with the subscales of the CTQ-Revised, indicating that childhood maltreatment was not independent of adult abuse in the current study.

3.5 Research question 4: influence of mood state on the associations between childhood maltreatment, internalised shame, and resource loss and gain in BD

As stated, there were no significant differences between participants classified as being in the ‘depression’, ‘euthymia’ or ‘(hypo)mania’ mood states on any of the variables investigated in the current study. To support this finding, and to explore the possibility of the effect of low mood and mania on some of the associations within the BD group, partial correlational analyses were calculated using the Depression and

Activation subscales of the Internal State Scale. The results of these partial correlations are presented in Table Z8 and Z9 in Appendix Z.

The results of these analyses demonstrate that although some of the correlations were no longer significant when controlled for the effect of low mood and mania, many of the correlations were confirmed, and in particular, the correlations between internalised shame and the CTQ subscales of emotional abuse and neglect remain highly significant. Similarly, the significant correlations between internalised shame and adult experiences of maltreatment, and internalised shame and resource loss, also held. Furthermore, the highly significant inter-correlations within the subscales of both the CTQ and the CTQ-Revised were held, although the correlations between the two measures were no longer significant when controlled for the effect of low mood and mania.

3.6 Correlations between variables in the control group

Correlational analyses were also conducted to explore the relationships between the variables within the control group (see Table Z10 in Appendix Z). From these analyses, it can be seen that there are few significant correlations between the variables in the control group. Notably, there are no significant correlations between internalised shame and the subscales of the original version of the CTQ, although internalised shame significantly correlated with some of the CTQ-Revised subscales. No significant correlation was observed between internalised shame and resource loss in the control group. Significant inter-correlations are demonstrated within the subscales

of both versions of the CTQ, and there are some correlations between the subscales, although there are fewer than observed in the BD group¹⁴.

4. Discussion

4.1 Results summary

The primary aim of the current study was to explore the levels of internalised shame, childhood and adult maltreatment, and resource loss and gain in a sample of outpatient participants with a diagnosis of BD, comparing the results against a control group of individuals with no psychiatric diagnoses. A second aim of the study was to investigate the associations between these variables within the BD sample.

Interestingly, preliminary analyses of the data revealed no significant difference between the total number of participants in the BD group reporting a history of childhood maltreatment compared with the number in the control group. However, further analyses identified that there were highly significant differences between the two groups in terms of the level of maltreatment. Participants in the BD group reported higher levels of childhood and adult maltreatment compared with the participants in the

¹⁴ The Internal State Scale was not completed by participants in the control group. As such, it was not possible to conduct partial correlations as with the BD group analyses, controlling for the effect of low mood and mania using the Depression and Activation subscales of the Internal State Scale respectively. However, the associations between variables amongst the BD group were of greatest relevance in the current study. Furthermore, the original correlations for the control group demonstrate few significant correlations, and as such, it was not necessary to explore the potential impact of mood state on these associations.

control group. In particular, the mean scores of most of the CTQ subscales fall within the *moderate* level of severity, compared with the scores of the control group, which fall within the *none (or minimal)* category.

Levels of internalised shame and resource loss were also significantly greater in the BD group compared with the control group. Significant gender differences were observed within the BD group, with female participants reporting significantly higher scores on the majority of variables compared with male participants.

Correlations within the BD group revealed that there were many significant associations between the variables. Internalised shame significantly correlated with most of the subscales of the CTQ and CTQ-Revised, as well as resource loss, even when controlled for the effect of current low mood and mania.

4.2 Supporting literature

4.2.1 Experiences of maltreatment in childhood.

The results of the current study support the general observation that the experience of childhood maltreatment is particularly prevalent amongst adults with mental health difficulties, and that individuals with a psychiatric diagnosis report significantly higher levels of childhood maltreatment compared with those in the general population (e.g., Bryer et al., 1987; Read, 1997, 1998; Read et al., 2005; Spataro et al., 2004).

The current findings also support previous studies using the CTQ to measure experiences of maltreatment. There is a shared finding whereby participants both from

psychiatric and non-psychiatric populations report higher levels of emotional abuse and emotional neglect compared with the other subtypes of maltreatment.

The present research also supports previous studies reporting high levels of childhood maltreatment within samples of individuals with a diagnosis of BD (e.g., Garno et al., 2005; Hyun et al., 2000). The levels of childhood maltreatment in the current study are higher than those reported by Neria et al. (2005), although their study neglected to investigate childhood experiences of psychological maltreatment. Consequently, these observed differences in the levels of maltreatment may be partially accounted for by the additional reporting of emotional abuse and neglect in the current study, thus increasing the level of reported maltreatment by participants in the current sample. Methodological differences between these studies may also have influenced the differences, as well as diversity in defining maltreatment.

The current study demonstrated that the majority of the participants in the BD group reported multiple forms of childhood maltreatment. As such, these findings support those of Garno et al. (2005) who found that approximately one-third of their participants with a diagnosis if BD reported multiple forms of maltreatment.

Further to all of these shared findings, the current study has added to current understanding by demonstrating that participants in the BD group reported experiences of childhood emotional abuse and neglect significantly more frequently compared with other forms of maltreatment, and the levels of severity were significantly higher than other maltreatment subtypes. As stated, previous studies reporting on the levels of childhood maltreatment in BD have neglected to investigate the levels of childhood emotional abuse in their samples. Consequently, the current exploratory findings are

particularly important, expanding on the current understanding of the experience of childhood maltreatment in a sample of participants with a diagnosis of BD. Indeed, these findings are particularly interesting as they mirror previous studies in which childhood emotional abuse and neglect were seen to be particularly prevalent in other psychiatric samples (e.g., Allison et al., 2007; Bernet & Stein, 1999; Lochner et al., 2002; Sarchiapone et al., 2007) and community samples (e.g., Paivio & Cramer, 2004; Scher et al., 2001).

4.2.1.1 Gender differences in childhood maltreatment.

The finding that female participants consistently reported higher levels of childhood maltreatment compared with male participants are consistent with gender differences reported in previous studies with BD samples (Hyun et al., 2000; Neria et al., 2005), as well as samples of participants from general psychiatric populations (Read et al., 2005; Wurr & Partridge, 1996), and non-clinical populations (Briere & Elliott, 2003; Gorey & Leslie, 1997; Silverman et al., 1996).

The current study offers preliminary findings regarding the differences in the levels of childhood psychological maltreatment reported by male and female participants within the BD group. In particular, it was seen that female participants consistently reported higher levels of emotional abuse and neglect compared with male participants. These findings are consistent with previous studies using participants from different psychiatric groups (e.g., Didie et al., 2006), as well as the general populations (e.g., Paivio & Cramer, 2004; Scher et al., 2001).

4.2.2 Experiences of maltreatment in adulthood.

The current study offers support, albeit cautious, for studies investigating the experience of maltreatment in adulthood in samples with mental health difficulties. In particular, the high levels of adult maltreatment are consistent with the findings of Mueser et al. (1998) and Read et al. (2005) who report that participants from psychiatric populations report high levels of sexual and physical assault in adulthood. Furthermore, given the highly significant correlation between both child and adult experiences of maltreatment reported in the current study, provisional support is provided to the previous findings demonstrating the levels of adult re-victimisation following CSA (Fromuth, 1986; Russell, 1986).

The current findings contribute tentatively towards the understanding of the impact of adult experiences of maltreatment, and in particular, it appears that there is a significant association between internalised shame and adult experiences of psychological maltreatment.

There is a lack of research reporting on the experience of emotional abuse and neglect in adulthood. As a consequence, these findings demonstrate an interesting area for further research development. However, given the concerns regarding the method of recording adult experience of maltreatment (see Section 4.4.4.), these conclusions are offered tentatively.

4.2.3 Internalised shame.

Further to experiences of maltreatment, the current study supports previous findings suggesting that shame is frequently experienced by individuals with mental

health difficulties (Gilbert, 2000; Hoblitzelle, 1987; Skårderud, 2007). Interestingly, however, no significant correlation was observed between internalised shame and CSA. This is perhaps contrary to what might be expected, given that previous researchers have reported a link between CSA and shame (Feinauer et al., 2003; Feiring & Taska, 2005; Finkelhor & Browne, 1986). However, the association in the current study was only marginally non-significant, and it is likely that a larger sample size would have yielded a more significant relationship.

Considering the correlations between internalised shame and childhood emotional abuse and neglect were highly significant, even when the effects of low mood and mania were controlled for, the results of the current study would appear to support previous researchers who suggest that psychological maltreatment may be more damaging than other forms of abuse (Bennett et al., 2005; Claussen & Crittenden, 1991; Gilbert & Proctor, 2006). However, due to the small sample size, the current results cannot be regarded as being confirmation of these previous findings. Nevertheless, they do suggest an interesting profile of the nature of emotional abuse and neglect and internalised shame in BD that warrants further investigation.

4.2.4 Resource loss and gain.

The high level of resource loss reported by participants in the current study is reminiscent of previous studies demonstrating how individuals with a diagnosis of BD typically experience significant difficulties with maintaining interpersonal relationships and employment throughout the course of their illness (Brodie & Leff, 1971; Harrow et al., 1990; Targum et al., 1981). Furthermore, the high levels of resource gain reported

by participants in the BD group compared with the control group is consistent with typical behaviors that are characteristic of manic episodes of BD, particularly excessive spending, resulting in the acquisition of superfluous resources (Hirschfield & Vornik, 2004; Miklowitz & Johnson, 2006).

4.3 Clinical implications of the findings

The findings of the present study have demonstrated the importance of psychosocial factors in the experience of BD. In particular, it is important to note that when working clinically with a client who has a diagnosis of BD, one ought to carefully assess for childhood experiences of abuse and ask explicit questions, as clients are likely to be reluctant to volunteer information regarding traumatic histories (Goodwin, Attias, McCarty, Chandler, & Romanik, 1988; Jacobson, Koehler, & Jones-Brown, 1987; Wurr & Partridge, 1996). This reticence to make spontaneous disclosures of abuse is understandable, considering the findings of studies in which clients voiced concern regarding a negative response following disclosure (Harder, 1990; Macdonald and Morley, 2001; Williams, 1994). By failing to be explicit in one's assessment, the clinician is at risk of overlooking some valuable information, which is likely to lead to an incomplete understanding of the client's difficulties and an inaccurate formulation.

The significant association between experiences of childhood maltreatment and internalised shame indicates that clinicians working with individuals who report histories of childhood maltreatment might also be alerted to the potential for these clients to be experiencing high levels of internalised shame. Indeed, individuals with traumatic histories and current feelings of shame are likely to be suitable candidates for

compassionate mind training, which has been seen to be effective in increasing self-soothing abilities and decreasing feelings of shame and self-criticism (Gilbert & Proctor, 2006).

The exploratory results presented here also indicate that it is important to assess for experiences of maltreatment in adulthood. Re-victimization is likely to be a significant maintaining factor in a client's presentation and may result in further psychological distress. Furthermore, there may be implications concerning engagement and attendance, and the clinician must consider the welfare of the client and thus may need to liaise with appropriate services and authorities to maintain the safety of the client and any other individuals placed at risk.

4.4 Limitations of the study

4.4.1 Sample size.

The current study had a relatively small sample size. Consequently, it is reiterated that although subsequent power analyses indicated that the sample size was sufficient for many of the analyses, the results presented here cannot be generalised to the wider BD population. For more conclusive findings regarding the levels of childhood maltreatment, one ought to look at studies with larger sample sizes, such as that of Edwards, Holden, Felitti, and Anda (2003) who report findings based on the investigation of 8,667 participants randomly selected from the general population. However, there remains a lack of research regarding the level of childhood maltreatment specific to the BD population using a sufficiently large sample and rigorous methodology. As such, despite the sample size, the current study provides

interesting exploratory findings regarding the relationships between childhood maltreatment, internalised shame and resource loss and gain in a small sample of participants with a diagnosis of BD.

4.4.2 Screening of participants.

It is recognised that the current study did not include a standardised screening interview, which would have been beneficial in supporting participants' diagnosis of BD. However, the clinicians who made the original diagnoses were all highly experienced consultant psychiatrists working in the NHS with extensive knowledge and experience regarding the application of the ICD-10 diagnostic criteria in the diagnosis of BD. Consequently, despite the lack of the use of a screening interview in the current protocol, the diagnoses of participants were considered to be robust. This confidence was further supported by the details regarding the duration of participants' illnesses, and their repeated contact with mental health services with no change in diagnosis.

It is also recognised that participants in the control group were not screened using a standardised screening measure prior to their participation in the study. However, they were informally screened during their first contact with the researcher, although this might not have been sufficient to identify previous mental health difficulties. Nevertheless, it is unlikely that participants would deliberately mislead the researcher and conceal a history of mental health difficulties, given the lack of an incentive such as payment for participating in the study.

If the control group did indeed comprise of participants with no history of mental health difficulties, then it is important to acknowledge that they may not have

been completely representative of the general population because of their lack of mental health difficulties. It has been estimated that in the UK, the prevalence of the most common mental illnesses, (i.e., depression and anxiety), is approximately 15% in the general population (Singleton, Lee, & Meltzer, 2002). As such, it ought to be considered that the significant differences identified between participants in the control group and the BD group may be somewhat exaggerated. Whilst it is likely that these differences would remain significant, using a 'true' sample taken from the general population might yield marginally different results.

4.4.3 Psychiatric comparison.

Whilst the inclusion of the control group consisting of participants reporting no history of mental health difficulties was useful as a baseline measure against which the results of the BD sample could be compared, it is important to acknowledge that there was no psychiatric control group. As such, it is not possible to draw any disorder-specific conclusions from the data. Nevertheless, the study provides interesting data which supports previous literature regarding the differences in the levels of childhood emotional abuse, and the association between childhood maltreatment and the experience of internalised shame in a psychiatric sample compared with a non-psychiatric control group.

4.4.4 Validity of the CTQ-Revised.

As stated, the results concerning the levels of adult maltreatment ought to be interpreted with some degree of caution, given that these experiences were measured

using an unstandardized questionnaire. Indeed, the measure was a revision of an established tool for retrospectively assessing childhood experiences of maltreatment. As such, this revised version might not be an accurate assessment of adult experiences of maltreatment. Although high internal consistency was recorded across all scales, further validity checks correlating scores of the CTQ-Revised with clinician ratings of maltreatment might yield more robust results regarding the specificity of the items in relation to measuring adult experiences of trauma.

Some items on the CTQ-Revised may not appear to be particularly relevant to adult experiences of maltreatment, particularly those measuring experiences of physical neglect. However, this was carefully considered in the development of the protocol, and items were retained to capture those experiences of adults who experience physical neglect by abusive partners and others, as indicated in previous studies and hospital inquest reports (e.g., Camden and Islington Community Services NHS Trust, 1991; Coker et al., 2002; Jones, 1993). As such, although these experiences may not have been universal across the samples investigated in the current study, the measure was still important to retain as an indication of adult maltreatment.

4.4.5 Controlling for extraneous variables.

Some information was not gathered as part of the research protocol, yet might be important to consider in terms of monitoring any potential extraneous variables. In particular, participants' current relationship status and perceived social support, both of which have been identified as having potential modifying effects in the experience of

shame (Feiring et al., 1996) might have had an effect on the results presented here.

However, these variables were not recorded as a part of the current protocol.

The employment status of participants in the study might have implications concerning how representative the current sample was of the BD population as a whole. Participants were invited to attend appointments at GP surgeries and CMHT bases between 9am and 5pm. As such, it is recognised that other than for a minority of participants who worked shifts, the sample presented in this study was potentially biased toward those who either were unemployed or worked on a part-time basis.

4.4.6 Research design.

The current study presents some interesting findings. However, it is important to recognise that the cross-sectional design of the study and the correlational analyses mean that it is not possible to comment on any causal relationships. As such, it cannot be concluded that the high levels of internalised shame reported by participants in the BD group result from experiences of childhood maltreatment, nor can it be concluded that resource loss results in high levels of internalised shame. Indeed, as other researchers have emphasised, it may not be the history of abuse itself that leads to greater vulnerability for psychiatric illness, but rather confounding social and familial factors associated with both the experience of child abuse and greater risk of disorders (MacMillan et al., 2001; Fergusson, Lynskey, & Horwood, 1996; Mullen et al., 1996).

The optimum research design for examining childhood maltreatment and its effects might involve a longitudinal design whereby the participants and their families are randomly selected and evaluated prior to any maltreatment, so that pre-molestation

conditions and psychological functioning can be determined. Following reports of maltreatment, both abused and non-abused participants ought to then be repeatedly and regularly studied over time, with within- and between-groups analyses performed to investigate the development of abuse-specific psychological effects. Such a methodology has significant limitations, most notably being that it is intensely time-consuming and expensive, and is vulnerable to high attrition rates. Furthermore, the investigation of the consequences of childhood maltreatment using a longitudinal design has significant ethical concerns, particularly regarding the measurement of distress without offering intervention. Similarly, identification of maltreatment would mean reporting cases to child protection agencies, and subsequent intervention is likely to have an impact on a child's adjustment, resulting in the data becoming contaminated. Consequently, the untainted longitudinal experience of maltreatment remains unclear. As a result of these limitations, the use of cross-sectional designs is not unusual in the child abuse literature (Briere, 1992).

4.4.7 Retrospective self-reports of childhood maltreatment.

Further to the difficulties regarding the use of a cross-sectional design, it is recognised that the current study employed a methodology requiring the retrospective recall of experiences of childhood maltreatment. Consequently, it is recognised that such recall might be considered to be unreliable, and mood state might be seen as having a significant impact on the recollection of autobiographical information. However, in a review of studies examining the accuracy of retrospective recall in individuals with mental health difficulties, Brewin, Andrews, and Gotlib (1993) found

that in participants with a diagnosis of depression, the ability to recall early experiences shows no evidence of systematic distortion and appears to be stable across variations in mood. Furthermore, Read et al. (2005) report that the assumed unreliability of disclosures of child abuse made by psychiatric patients is not evidence-based and is incorrect. A number of studies have demonstrated the reliability of reports of abuse of psychiatric patients, including those diagnosed with psychosis (Goodman et al., 1999; Meyer, Muenzenmaier, Cancienne, & Struening, 1996). Indeed, high levels of reliability have been found, with corroborating evidence, for reports of CSA by psychiatric patients being found for between 74% and 82% of cases (Herman & Schatzow, 1987; Read, Agar, Argyle, & Aderhold, 2003).

Considering all of these factors, as well as the reliability of the CTQ in the retrospective measurement of childhood maltreatment, and the results of the partial correlations presented here controlling for the influence of low mood and mania, the accuracy of the recall of participants in the current study were considered to be relatively robust.

4.5 Ideas for future research

This is the first study of its kind investigating the association between childhood maltreatment and shame in a sample of participants with a diagnosis of BD. As such, it is necessary to replicate the study, particularly with a larger sample, to support the current findings. In addition, further to a longitudinal exploration of the experience of shame in BD, some potential areas for further investigation have been indicated by the current findings. In particular, although some interesting findings

regarding adult experiences of trauma were observed, these were not examined in detail, largely because of the degree of caution regarding the validity of the CTQ-Revised. However, these patterns are particularly important, as these ongoing experiences of abuse might potentially maintain participants' experience of internalised shame. It would be interesting, therefore, to examine this relationship more closely, and in particular, the relationships between childhood and adult maltreatment in BD. Furthermore, the development of an appropriate scale would be valuable for future research and clinical application. Finally, it would be interesting to consider the role of shame alongside other factors, such as coping strategies and social support, in the association between childhood maltreatment and psychological distress in adulthood.

5. Conclusions

The current study has added some important and valuable exploratory findings towards the understanding of some of the psychosocial factors involved in the experience of BD. From these results, it is suggested that individuals with a diagnosis of BD are likely to experience greater levels of childhood and adult maltreatment, internalised shame and resource loss and gain compared with individuals with no psychiatric diagnoses. In particular, the study demonstrated the prominence of emotional abuse and neglect amongst the BD sample, with participants reporting significantly greater levels compared with other maltreatment subtypes. Furthermore, internalised shame significantly correlated with emotional abuse and neglect.

These findings do not intend to infer that shame is the only factor deserving of consideration in the relationship, as one must also consider the significance of factors such as coping strategies, which might serve to protect the individual from the development of psychological distress. Nevertheless, the findings of the current study demonstrate the importance of assessing for incidents of childhood maltreatment, particularly emotional abuse, as well as the experience of internalised shame in those individuals presenting with psychological distress and mental health difficulties.

Several limitations of the study have been identified, although the findings are sufficiently robust to provide a satisfactory framework from which future avenues of study can be generated in the advancement of clinical and research understandings of the function of internalised shame in the presentation of BD.

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LIST OF APPENDIXES

	Appendix Title	
A	Notes to contributors - <i>Clinical Psychology Review</i>	153
B	Notes to contributors - <i>The Journal of Affective Disorders</i>	157
C	Diagnostic criteria for Bipolar Disorder taken from the International Statistical Classification of Diseases and Related Health Problems, 10 th Revision (ICD-10; World Health Organisation, 1993)	164
D	Letter to Consultant Psychiatrists	180
E	Invitation Letter and Information Sheet (Bipolar Disorder Group)	183
F	Expression of Interest form (Bipolar Disorder Group)	190
G	Letter for members of the Southampton branch of MDF The Bipolar Organisation	192
H	Poster advertisement to recruit control participants	195
I	Invitation Letter and Information Sheet (Control Group)	197
J	Letter to GPs	202
K	Guidelines for the classification of Childhood Trauma Questionnaire scale scores (Bernstein & Fink, 1998).	204
L	Childhood Trauma Questionnaire – Revised (CTQ-Revised)	206
M	Feedback from an impartial researcher in the University of Southampton School of Psychology	208
N	University of Southampton School of Psychology Ethics Committee Application Form, Risk Assessment, and correspondence	213
O	National Research Ethics Service Southampton and South West Hampshire Research Ethics Committee A Application Form, submission documents, and correspondence	224

P	Hampshire Partnership Trust Research & Development Approval & Data Protection Agreement	293
Q	University of Southampton Sponsorship and Professional Indemnity Agreement documents	296
R	Document detailing the ethical issues involved in the current study	300
S	Consent Form (Bipolar Disorder Group)	333
T	Consent Form (Control Group)	335
U	Interview Schedule (Bipolar Disorder Group)	337
V	Background Information Sheet (Bipolar Disorder Group)	339
W	Background Information Sheet (Control Group)	341
X	Debriefing Statement (Bipolar Disorder Group)	343
Y	Debriefing Statement (Control Group)	345
Z	Results Tables	348

APPENDIX A

Notes to contributors –

Clinical Psychology Review



CLINICAL PSYCHOLOGY REVIEW

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APPENDIX B

Notes to contributors –

Journal of Affective Disorders



JOURNAL OF AFFECTIVE DISORDERS

Official Journal of the International Society for Affective Disorders

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APPENDIX C

Diagnostic criteria for Bipolar Disorder taken from the
International Statistical Classification of Diseases and
Related Health Problems, 10th Revision
(ICD-10; World Health Organisation, 1993)

F31 Bipolar Affective Disorder

This disorder is characterized by repeated (i.e., at least two) episodes in which the patient's mood and activity levels are significantly disturbed, this disturbance consisting on some occasions of an elevation of mood and increased energy and activity (mania or hypomania), and on others of a lowering of mood and decreased energy and activity (depression). Characteristically, recovery is usually complete between episodes, and the incidence in the two sexes is more nearly equal than in other mood disorders. As patients who suffer only from repeated episodes of mania are comparatively rare, and resemble (in their family history, premorbid personality, age of onset, and long-term prognosis) those who also have at least occasional episodes of depression, such patients are classified as bipolar.

Manic episodes usually begin abruptly and last for between 2 weeks and 4-5 months (median duration about 4 months). Depressions tend to last longer (median length about 6 months), though rarely for more than a year, except in the elderly. Episodes of both kinds often follow stressful life events or other mental trauma, but the presence of such stress is not essential for the diagnosis. The first episode may occur at any age from childhood to old age. The frequency of episodes and the pattern of remissions and relapses are both very variable, though remissions tend to get shorter as time goes on and depressions to become commoner and longer lasting after middle age.

Although the original concept of "manic-depressive psychosis" also included patients who suffered only from depression, the term "manic-depressive disorder or psychosis" is now used mainly as a synonym for bipolar disorder.

Includes: manic-depressive illness, psychosis or reaction

Excludes: bipolar disorder, single manic episode, cyclothymia

F31.6 Bipolar Affective Disorder, Current Episode Mixed

The patient has had at least one manic, hypomanic, or mixed affective episode in the past and currently exhibits either a mixture of a rapid alternation of manic, hypomanic, and depressive symptoms.

Diagnostic Guidelines:

Although the most typical form of bipolar disorder consists of alternating manic and depressive episodes separated by periods of normal mood, it is not uncommon for depressive mood to be accompanied for days or weeks on end by overactivity and pressure of speech, or for a manic mood and grandiosity to be accompanied by agitation and loss of energy and libido. Depressive symptoms and symptoms of hypomania or mania may also alternate rapidly, from day to day or even from hour to hour. A diagnosis of mixed bipolar affective disorder should be made only if the two sets of symptoms are both prominent for the greater part of the current episode of illness, and if that episode has lasted for at least 2 weeks.

Excludes: single mixed affective episode

F30 Manic Episode

Three degrees of severity are specified here, sharing the common underlying characteristics of elevated mood, and an increase in the quantity and speed of physical and mental activity. All the subdivisions of this category should be used only for a single manic episode. If previous or subsequent affective episodes (depressive, manic, or hypomanic), the disorder should be coded under bipolar affective disorder.

Includes: bipolar disorder, single manic episode

F30.0 Hypomania

Hypomania is a lesser degree of mania, in which abnormalities of mood and behaviour are too persistent and marked to be included under cyclothymia but are not accompanied by hallucinations or delusions. There is a persistent mild elevation of mood (for at least several days on end), increased energy and activity, and usually marked feelings of well-being and both physical and mental efficiency. Increased sociability, talkativeness, overfamiliarity, increased sexual energy, and a decreased need for sleep are often present but not to the extent that they lead to severe disruption of

work or result in social rejection. Irritability, conceit, and boorish behaviour may take the place of the more usual euphoric sociability.

Concentration and attention may be impaired, thus diminishing the ability to settle down to work or to relaxation and leisure, but this may not prevent the appearance of interests in quite new ventures and activities, or mild over-spending.

Diagnostic Guidelines:

Several of the features mentioned above, consistent with elevated or changed mood and increased activity, should be present for at least several days on end, to a degree and with a persistence greater than described for cyclothymia. Considerable interference with work or social activity is consistent with a diagnosis of hypomania, but if disruption of these is severe or complete, mania should be diagnosed.

Differential Diagnosis: Hypomania covers the range of disorders of mood and level of activities between cyclothymia and mania. The increased activity and restlessness (and often weight loss) must be distinguished from the same symptoms occurring in hyperthyroidism and anorexia nervosa; early states of "agitated depression", particularly in late middle-age, may bear a superficial resemblance to hypomania of the irritable variety. Patients with severe obsessional symptoms may be active part of the night completing their domestic cleaning rituals, but their affect will usually be the opposite of that described here.

When a short period of hypomania occurs as a prelude to or aftermath of mania, it is usually not worth specifying the hypomania separately.

F30.1 Mania Without Psychotic Symptoms

Mood is elevated out of keeping with the individual's circumstances and may vary from carefree joviality to almost uncontrollable excitement. Elation is accompanied by increased energy, resulting in overactivity, pressure of speech, and a decreased need for sleep. Normal social inhibitions are lost, attention cannot be sustained, and there is often marked distractability. Self-esteem is inflated, and grandiose or over-optimistic ideas are freely expressed.

Perceptual disorders may occur, such as the appreciation of colours as especially vivid (and usually beautiful), a preoccupation with fine details of surfaces or textures, and subjective hyperacusis. The individual may embark on extravagant and impractical schemes, spend money recklessly, or become aggressive, amorous, or facetious in inappropriate circumstances. In some manic episodes the mood is irritable and suspicious rather than elated. The first attack occurs most commonly between the ages of 15 and 30 years, but may occur at any age from late childhood to the seventh or eighth decade.

Diagnostic Guidelines:

The episode should last for at least 1 week and should be severe enough to disrupt ordinary work and social activities more or less completely. The mood change should be accompanied by increased energy and several of the symptoms referred to above (particularly pressure of speech, decreased need for sleep, grandiosity, and excessive optimism).

F30.2 Mania With Psychotic Symptoms

The clinical picture is that of a more severe form of mania as described above. Inflated self-esteem and grandiose ideas may develop into delusions, and irritability and suspiciousness into delusions of persecution. In severe cases, grandiose or religious delusions of identity or role may be prominent, and flight of ideas and pressure of speech may result in the individual becoming incomprehensible. Severe and sustained physical activity and excitement may result in aggression or violence, and neglect of eating, drinking, and personal hygiene may result in dangerous states of dehydration and self-neglect. If required, delusions or hallucinations can be specified as congruent or incongruent with the mood. "Incongruent" should be taken as including affectively neutral delusions and hallucinations; for example, delusions of reference with no guilty or accusatory content, or voices speaking to the individual about events that have no special emotional significance.

Differential Diagnosis: One of the commonest problems is differentiation of this disorder from schizophrenia, particularly if the stages of development through

hypomania have been missed and the patient is seen only at the height of the illness when widespread delusions, incomprehensible speech, and violent excitement may obscure the basic disturbance of affect. Patients with mania that is responding to neuroleptic medication may present a similar diagnostic problem at the stage when they have returned to normal levels of physical and mental activity but still have delusions or hallucinations. Occasional hallucinations or delusions as specified for schizophrenia may also be classed as mood-incongruent, but if these symptoms are prominent and persistent, the diagnosis of schizoaffective disorder is more likely to be appropriate.

Includes: manic stupor

F32 Depressive Episode

In typical depressive episodes of all three varieties described below (mild, moderate, and severe), the individual usually suffers from depressed mood, loss of interest and enjoyment, and reduced energy leading to increased fatigability and diminished activity. Marked tiredness after only slight effort is common. Other common symptoms are:

- (a) reduced concentration and attention;
- (b) reduced self-esteem and self-confidence;
- (c) ideas of guilt and unworthiness (even in a mild type of episode);
- (d) bleak and pessimistic views of the future;
- (e) ideas or acts of self-harm or suicide;
- (f) disturbed sleep;

(g) diminished appetite.

The lowered mood varies little from day to day, and is often unresponsive to circumstances, yet may show a characteristic diurnal variation as the day goes on. As with manic episodes, the clinical presentation shows marked individual variations, and atypical presentations are particularly common in adolescence. In some cases, anxiety, distress, and motor agitation may be more prominent at times than the depression, and the mood change may also be masked by added features such as irritability, excessive consumption of alcohol, histrionic behaviour, and exacerbation of pre-existing phobic or obsessional symptoms, or by hypochondriacal preoccupations. For depressive episodes of all three grades of severity, a duration of at least 2 weeks is usually required for diagnosis, but shorter periods may be reasonable if symptoms are unusually severe and of rapid onset.

Some of the above symptoms may be marked and develop characteristic features that are widely regarded as having special clinical significance. The most typical examples of these "somatic" symptoms are: loss of interest or pleasure in activities that are normally enjoyable; lack of emotional reactivity to normally pleasurable surroundings and events; waking in the morning 2 hours or more before the usual time; depression worse in the morning; objective evidence of definite psychomotor retardation or agitation (remarked on or reported by other people); marked loss of appetite; weight loss (often defined as 5% or more of body weight in the past month); marked loss of

libido. Usually, this somatic syndrome is not regarded as present unless about four of these symptoms are definitely present.

The categories of mild, moderate and severe depressive episodes described in more detail below should be used only for a single (first) depressive episode. Further depressive episodes should be classified under one of the subdivisions of recurrent depressive disorder.

These grades of severity are specified to cover a wide range of clinical states that are encountered in different types of psychiatric practice. Individuals with mild depressive episodes are common in primary care and general medical settings, whereas psychiatric inpatient units deal largely with patients suffering from the severe grades.

Acts of self-harm associated with mood (affective) disorders, most commonly self-poisoning by prescribed medication, should be recorded by means of an additional code from the ICD-10. These codes do not involve differentiation between attempted suicide and "parasuicide", since both are included in the general category of self-harm.

Differentiation between mild, moderate, and severe depressive episodes rests upon a complicated clinical judgement that involves the number, type, and severity of symptoms present. The extent of ordinary social and work activities is often a useful general guide to the likely degree of severity of the episode, but individual, social, and cultural influences that disrupt a smooth relationship between severity of symptoms and

social performance are sufficiently common and powerful to make it unwise to include social performance amongst the essential criteria of severity.

The presence of dementia or mental retardation does not rule out the diagnosis of a treatable depressive episode, but communication difficulties are likely to make it necessary to rely more than usual for the diagnosis upon objectively observed somatic symptoms, such as psychomotor retardation, loss of appetite and weight, and sleep disturbance.

Includes: single episodes of depression (without psychotic symptoms), psychogenic depression or reactive depression)

F32.0 Mild Depressive Episode

Diagnostic Guidelines:

Depressed mood, loss of interest and enjoyment, and increased fatigability are usually regarded as the most typical symptoms of depression, and at least two of these, plus at least two of the other symptoms described above should usually be present for a definite diagnosis. None of the symptoms should be present to an intense degree. Minimum duration of the whole episode is about 2 weeks.

An individual with a mild depressive episode is usually distressed by the symptoms and has some difficulty in continuing with ordinary work and social activities, but will probably not cease to function completely.

A fifth character may be used to specify the presence of the somatic syndrome:

F32.00 Without somatic symptoms

The criteria for mild depressive episode are fulfilled, and there are few or none of the somatic symptoms present.

F32.01 With somatic symptoms

The criteria for mild depressive episode are fulfilled, and four or more of the somatic symptoms are also present. (If only two or three somatic symptoms are present but they are unusually severe, use of this category may be justified.)

F32.1 Moderate Depressive Episode

Diagnostic Guidelines:

At least two of the three most typical symptoms noted for mild depressive episode should be present, plus at least three (and preferably four) of the other symptoms.

Several symptoms are likely to be present to a marked degree, but this is not essential if a particularly wide variety of symptoms is present overall. Minimum duration of the whole episode is about 2 weeks.

An individual with a moderately severe depressive episode will usually have considerable difficulty in continuing with social, work or domestic activities.

A fifth character may be used to specify the occurrence of somatic symptoms:

F32.10 Without somatic symptoms

The criteria for moderate depressive episode are fulfilled, and few if any of the somatic symptoms are present.

F32.11 With somatic symptoms

The criteria for moderate depressive episode are fulfilled, and four or more of the somatic symptoms are present. (If only two or three somatic symptoms are present but they are unusually severe, use of this category may be justified.)

F32.2 Severe Depressive Episode Without Psychotic Symptoms

In a severe depressive episode, the sufferer usually shows considerable distress or agitation, unless retardation is a marked feature. Loss of self-esteem or feelings of uselessness or guilt are likely to be prominent, and suicide is a distinct danger in particularly severe cases. It is presumed here that the somatic syndrome will almost always be present in a severe depressive episode.

Diagnostic Guidelines:

All three of the typical symptoms noted for mild and moderate depressive episodes should be present, plus at least four other symptoms, some of which should be of severe intensity. However, if important symptoms such as agitation or retardation are marked, the patient may be unwilling or unable to describe many symptoms in detail. An overall grading of severe episode may still be justified in such instances. The depressive episode should usually last at least 2 weeks, but if the symptoms are particularly severe and of very rapid onset, it may be justified to make this diagnosis after less than 2 weeks.

During a severe depressive episode it is very unlikely that the sufferer will be able to continue with social, work, or domestic activities, except to a very limited extent.

This category should be used only for single episodes of severe depression without psychotic symptoms; for further episodes, a subcategory of recurrent depressive disorder should be used.

Includes: single episodes of agitated depression; melancholia or vital depression without psychotic symptoms

F32.3 Severe Depressive Episode With Psychotic Symptoms*Diagnostic Guidelines:*

A severe depressive episode which meets the criteria given for severe depressive episode without psychotic symptoms and in which delusions, hallucinations, or depressive stupor are present. The delusions usually involve ideas of sin, poverty, or imminent disasters, responsibility for which may be assumed by the patient. Auditory or olfactory hallucinations are usually of defamatory or accusatory voices or of rotting filth or decomposing flesh. Severe psychomotor retardation may progress to stupor. If required, delusions or hallucinations may be specified as mood-congruent or mood-incongruent.

Differential Diagnosis: Depressive stupor must be differentiated from catatonic schizophrenia, from dissociative stupor, and from organic forms of stupor. This category should be used only for single episodes of severe depression with psychotic symptoms; for further episodes a subcategory of recurrent depressive disorder should be used.

Includes: single episodes of major depression with psychotic symptoms, psychotic depression, psychogenic depressive psychosis, reactive depressive psychosis

Reference:

World Health Organisation (1992). *ICD-10: The International Classification of*

Diseases and related health problems, 10th revision (ICD-10). Geneva:

Author.

APPENDIX D

Letter to Consultant Psychiatrists



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INVITATION LETTER (Consultants)

Project Title: The Emotional Impact of Early Experience in Bipolar Disorder

RESEARCHERS: Alex Fowke (Primary Researcher), Dr. Katie Ashcroft, Dr. Su Ross & Dr. Anke Karl

ETHICS NUMBER: 07/Q1702/68

VERSION: 3

Date: 19.06.07

Dear Colleague,

My name is Alex Fowke and I am a Trainee Clinical Psychologist at the University of Southampton. As a part of my Doctorate, I am conducting the above study with patients who have a primary diagnosis of Bipolar Disorder. This research is being conducted under the supervision of Dr. Su Ross, Consultant Clinical Psychologist, and Dr. Katie Ashcroft, Consultant Specialist Clinical Psychologist, both within the Clinical Psychology service. I also have an internal supervisor at the University, who is Dr. Anke Karl, Lecturer in Clinical Psychology.

This research project is investigating the childhood and adult experiences reported by people who have a diagnosis of Bipolar Disorder using a number of questionnaires and a brief interview. I will be comparing the responses of people with Bipolar Disorder on the questionnaires with the responses of matched healthy control participants with no history of mental health difficulties. In addition, I plan to interview participants with Bipolar Disorder about their experiences of their illness. These interviews are expected to last approximately 30 minutes and will be tape-recorded. These tapes will be transcribed by the researcher and any identifiable information will be removed.

We are hoping to recruit 40 patients who have a primary diagnosis of Bipolar Disorder and have been stable on medication for 6 months.

Our exclusion criteria are as follows:

- Patients with comorbid substance misuse
- Patients with a learning disability
- Patients whose first language is not English
- Patients who are in-patients in a psychiatric unit

I have enclosed an Information Sheet which provides you with more detailed information about the purpose of the study and what would happen to participants should they wish to take part. I would be grateful if you would be willing to allow me to contact those patients of yours who match these criteria and might be willing to take part. If so, I would like to meet them at an out-patient clinic to give them a similar Information Sheet to explain the study. If they express an interest in taking part, I will ask for a contact telephone number which I will use to contact them after 3 working days to discuss their interest further. This will give them the opportunity to read the Information Sheet and discuss the study with their family or friends if they wish and make an informed decision about their participation.

The study has been approved by the Southampton and South West Hampshire Research Committee. The study has also been reviewed by the University of Southampton School of Psychology Ethics Committee.

If you require further information about the study or have any queries or concerns, please contact me, the primary researcher via email at ajf105@soton.ac.uk or on (023) 8082 5531.

Many thanks,

Alex Fowke
Trainee Clinical Psychologist

APPENDIX E

Invitation Letter and Information Sheet

(Bipolar Disorder Group)



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INVITATION LETTER (Bipolar Disorder Participants)

Project Title: The Emotional Impact of Early Experience in Bipolar Disorder

RESEARCHERS: Alex Fowke (Primary Researcher), Dr. Katie Ashcroft, Dr. Su Ross & Dr. Anke Karl

ETHICS NUMBER: 07/Q1702/68

VERSION: 3

Date: 19.06.07

My name is Alex Fowke and I am a Trainee Clinical Psychologist at the University of Southampton. I am currently carrying out a piece of research along with some of the psychologists within the Clinical Psychology service. Our research is investigating the role of childhood experiences and their possible impact in people who have a diagnosis of Bipolar Disorder. I have asked the doctors at the hospital to pass on this information to all of their patients who they feel might be eligible to take part in the study. You have been approached because you have a diagnosis of Bipolar Disorder, and as such I am asking you to consider taking part.

Along with this letter I have included an Information Sheet which provides further details about the study and what you would be asked to do if you agreed to take part. I will contact you after 3 working days to discuss taking part in this study using the telephone number you have given me. If you have not had enough time to consider taking part, you can let me know when would be a convenient time to contact you again. If you would like to take some time now before providing me with any contact

information, then please do so and simply return the Expression of Interest form to me using the self-addressed envelope provided.

In the meantime, if you have any questions about the study or would like any further information, then please feel free to contact me on (023) 8082 5531 and I would be happy to answer any enquiries about the study.

Thank you for reading this letter,

Alex Fowke
Trainee Clinical Psychologist



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INVITATION LETTER (Bipolar Disorder Participants)

Project Title: The Emotional Impact of Early Experience in Bipolar Disorder

RESEARCHERS: Alex Fowke (Primary Researcher), Dr. Katie Ashcroft, Dr. Su Ross & Dr. Anke Karl

ETHICS NUMBER: 07/Q1702/68

VERSION: 3

Date: 19.06.07

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

We are interested in investigating the psychological factors related to Bipolar Disorder. For this, we will ask you to complete some questionnaires about your childhood and current life experiences.

This research is being completed as a part of the primary researcher's Doctorate in Clinical Psychology.

Why have I been chosen?

We have approached the doctors at Hampshire Partnership Trust and asked them to pass on this information to all patients in the service who have a diagnosis of Bipolar Disorder and are eligible for inclusion in this study.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do, you will be given this Information Sheet to keep and be asked to sign a Consent Form. You are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

What will happen to me if I take part?

You can choose to meet with the researcher at a Hampshire Partnership Trust resource, the University of Southampton, or if you prefer, at your home, whichever is most convenient to you. The researcher will meet with you and ask a few questions in a short interview which will be tape-recorded. These questions will ask you about your experience of having a diagnosis of Bipolar Disorder. It is expected that this interview will last approximately 30 minutes.

The researcher will then ask you to fill in some questionnaires. These questionnaires have been used many times before in similar research. In total you will be asked to complete 6 questionnaires, and it will probably take between 30 and 45 minutes to complete them, but you will be free to stop at any time and, if you agree, complete the remainder of the procedure later.

The researcher will only need to meet with you once. If you decide that you would like to take part and would prefer to do so at the University of Southampton or at a Hampshire Partnership Trust resource, your travel expenses will be reimbursed.

What do I have to do?

This just involves answering questions and filling in questionnaires. If you don't want to answer any of the questions, you do not have to do so. Your care would not be affected in any way by this.

What are the possible disadvantages and risks of taking part?

It is unlikely that you will experience any distress by taking part, but because the research may touch on some sensitive issues, it is possible that you could get temporarily upset. However, there will be plenty of time after the questionnaires have been completed to speak with the researcher who will be able to help you to deal with these issues. You will also be offered the opportunity to have a copy of your questionnaires should you wish which you can take with you to future appointments with your Key-Worker. However, these questionnaires have been used in research in the past and those people who have filled them in have not had any difficulties.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get might help improve the treatment of people with a diagnosis of Bipolar Disorder. By taking part in this study you have the opportunity to help people with Bipolar Disorder and share things that have been important to you.

What if there is a problem?

Any complaint about the way you have been dealt with during the study will be addressed. If you have a concern about any aspect of this study, you should ask to speak with the researchers who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this through the NHS Research and Development Manager, who you can call on (023) 8082 5054. Further details can be obtained from Hampshire Partnership Trust.

Will my taking part in the study be kept confidential?

Yes. All the information about your participation in this study will be kept strictly confidential. All the questionnaires that you complete will have any information about you, such as your name and address, removed so that you cannot be recognised from it. The tapes of the recorded interview will be stored in a secure place and will only be listened to by the researcher who will transcribe them and remove any identifiable information.

What will happen to the results of the research study?

The results of the research will be submitted for publication to scientific journal and may be presented at conferences and to local mental health teams when the study is finished. The researcher will offer to send you a copy of the published results will be available at that time. You will not be identified in any report/publication.

Who has reviewed the study?

The Southampton and South West Hampshire Research Committee have approved the study. The study has also been reviewed by the University of Southampton School of Psychology Ethics Committee.

Contact for Further Information

If you would like more information now or in the future, please contact the primary researcher on (023) 8082 5531. Thank you for your help.

You will be given a copy of the Information Sheet and signed Consent Form to keep.

APPENDIX F
Expression of Interest Form
(Bipolar Disorder Group)



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EXPRESSION OF INTEREST FORM

Title of Project: The Emotional Impact of Early Experience in Bipolar Disorder

RESEARCHERS: Alex Fowke, Dr. Katie Ashcroft, Dr. Su Ross, and Dr. Anke Karl

ETHICS NUMBER:

VERSION: 1

DATE: 19.06.07

Please initial box

1. I have read the Information Sheet regarding the above study and I am interested in taking part. I am happy for you to contact me using the details I have provided below to arrange a time to meet. I understand that I am still free to withdraw from the study at any time, without giving any reason, without my medical care or legal rights being affected.
2. I have read the Information Sheet regarding the above study. However, I am not interested in taking part at this time and would like no further information about the study. I understand that my medical care or legal rights will not be affected by my decision.

(Please provide the following contact details if you are interested in participating)

Name: _____ Telephone Number: _____

Address: _____

(signed) _____ Name _____ Date _____ Signature _____

Please return in the Stamped Addressed Envelope provided

APPENDIX G

Letter for members of the Southampton branch of
MDF The Bipolar Organisation



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INVITATION LETTER

(Manic Depression Fellowship)

Project Title: The Emotional Impact of Early Experience in Bipolar Disorder

RESEARCHERS: Alex Fowke (Primary Researcher), Dr. Katie Ashcroft, Dr. Su Ross & Dr. Anke Karl

ETHICS NUMBER: 07/Q1702/68

VERSION: 2

Date: 19.06.07

Dear Sir or Madam,

My name is Alex Fowke and I am a Trainee Clinical Psychologist at the University of Southampton. As a part of my doctorate, I am conducting the above questionnaire study with patients who have a primary diagnosis of Bipolar Disorder. This research is being conducted under the supervision of Dr. Su Ross, Consultant Clinical Psychologist, and Dr. Katie Ashcroft, Consultant Clinical Psychologist, both within the Clinical Psychology service at Hampshire Partnership Trust. I also have an internal supervisor at the University, who is Dr. Anke Karl, Lecturer in Clinical Psychology.

This research project is investigating the childhood and adult experiences reported by people with a diagnosis of Bipolar Disorder using a number of questionnaires and a brief interview. I will be comparing the responses of people with Bipolar Disorder on the questionnaires with the responses of matched healthy control participants with no mental health difficulties.

I am hoping to recruit as many people as possible with a primary diagnosis of Bipolar Disorder, and I would be very grateful if you would allow me to attend one of your group meetings at some point in the near future. At this meeting I would like to deliver a short presentation about this research and invite any of your members to discuss participating in my study.

I have attached a copy of the Information Sheet along with this letter. This provides you with more detailed information about the purpose of my study and what would happen to participants during the research.

The study has been approved by the Southampton and South West Hampshire Research Committee and the University of Southampton School of Psychology Ethics Committee.

If you require further information about the study or have any queries or concerns, please contact me, the primary researcher, via email at ajf105@soton.ac.uk or on (023) 8082 5531.

Many thanks,

Alex Fowke
Trainee Clinical Psychologist

APPENDIX H

Poster advertisement to recruit control participants

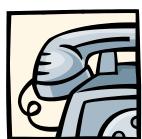
HEALTHY VOLUNTEERS WANTED!



I am a Trainee Clinical Psychologist and I am looking for healthy volunteers to help me with my study into Bipolar Disorder.

The study involves filling in a few questionnaires and takes just 30 minutes to complete.

If you are interested in taking part or finding out more information about the study, please contact me, Alex Fowke, on:



023 8082 5531



ajf105@soton.ac.uk

Study Start Date: 01.07.07
Study End Date: 01.06.08

Version 2
Date: 19.06.07
COREC Ethics:07/Q1702/68
School Ethics: CLIN/04/39

APPENDIX I

Invitation Letter and Information Sheet

(Control Group)



INVITATION LETTER (Healthy Volunteer Participants)

Project Title: The Emotional Impact of Early Experience in Bipolar Disorder

RESEARCHERS: Alex Fowke (Primary Researcher), Dr. Katie Ashcroft, Dr. Su Ross & Dr. Anke Karl

ETHICS NUMBER: 07/Q1702/68

VERSION: 3

Date: 19.06.07

Thank you for contacting me and expressing an interest in participating in my study which I am conducting as a part of my Doctorate in Clinical Psychology. Along with this letter I have included an Information Sheet which provides further details about the study and what you would be asked to do if you agreed to take part.

I will contact you after 3 working days by phone to discuss the study further and you can let me know if you are still interested in taking part. In the meantime, if you have any questions about the study or would like any further information, then please feel free to contact me, the primary researcher, on (023) 8082 5531 and I would be happy to answer any enquiries about the study.

Thank you once again,

**Alex Fowke
Trainee Clinical Psychologist**



INFORMATION SHEET (Healthy Volunteer Participants)

Project Title: The Emotional Impact of Early Experience in Bipolar Disorder

RESEARCHERS: Alex Fowke (Primary Researcher), Dr. Katie Ashcroft, Dr. Su Ross & Dr. Anke Karl

ETHICS NUMBER: 07/Q1702/68

VERSION: 3

DATE: 19.06.07

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

We are interested in understanding what life experiences may contribute to Bipolar Disorder. For this, we want to look at the responses of people who have a diagnosis with Bipolar Disorder on some questionnaires about their childhood and current life experiences and compare them with the responses given by people with no mental health difficulties.

This research is being completed as a part of the primary researcher's Doctorate in Clinical Psychology.

Why have I been chosen?

You have volunteered because you do not have a history of mental health difficulties. We want to look at the results of questionnaires completed by

people without any mental health difficulties and compare them with those completed by people with a diagnosis of Bipolar Disorder. To make the study as helpful as possible, we want to recruit healthy people who share similar personal details to the clinical group in terms of age, gender, employment history and social background.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do, you will be given this Information Sheet to keep and be asked to sign a Consent Form. You are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

A researcher will meet with you and help you fill in some questionnaires. These questionnaires will ask you about your childhood. Specifically, we are interested in finding out about any current levels of anxiety as well as any unpleasant early experiences. It will probably take between 30 and 45 minutes, but you will be free to stop at any time and, if you agree, complete the remainder of the procedure later. The researcher will only need to meet with you once. It is possible that the researcher could come to your home to do the research. However, if you decide that you would like to take part and would prefer to do so at the University of Southampton or at a Hampshire Partnership Trust resource. In this case any travel expenses will be reimbursed.

What do I have to do?

This just involves filling in some questionnaires. If you don't want to answer any of the questions, you do not have to do so.

What are the possible disadvantages and risks of taking part?

It is unlikely that you will experience any distress by taking part, but because the research may touch on some sensitive issues, it is possible that you could get temporarily upset. However, there will be plenty of time after the questionnaires have been completed to speak with the researcher who will be able to help you to deal with these issues. In the majority of cases, however, we have observed that participants do not experience this and have no difficulties with the process of taking part in this type of research.

In the unlikely event that you should get distressed, or you have any questions following taking part in the research, you will have plenty of time after the end of the procedure to talk with the researcher. In addition, they will leave you with some information so that you can get in touch with someone for further support.

What are the possible benefits of taking part?

By comparing the information we get from those with and without mental health difficulties, we might understand some more about what life experiences may contribute to Bipolar Disorder. By taking part in this study you have the opportunity to help those people who have a diagnosis of Bipolar Disorder and share things that have been important to you.

What if there is a problem?

Any complaint about the way you have been dealt with during the study will be addressed. If you have a concern about any aspect of this study, you should ask to speak with the researchers who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this through the University of Southampton Research and Development Manager, who you can call on (023) 8059 8848. Further details can be obtained from the University.

Will my taking part in the study be kept confidential?

Yes. All the information about your participation in this study will be kept strictly confidential. All the questionnaires that you complete will have any information about you, such as your name and address, removed so that you cannot be recognised from it.

What will happen to the results of the research study?

The results of the research will be submitted for publication to scientific journal and may be presented at conferences and locally to mental health teams when the study is finished. A copy of the published results will be available at that time. You will not be identified in any report/publication.

Who has reviewed the study?

The Southampton and South West Hampshire Research Committee have approved the study. The study has also been reviewed by the University of Southampton School of Psychology Ethics Committee.

Contact for Further Information

If you would like more information now or in the future, please contact the primary researcher on (023) 8082 5531.

Thank you for your help.

You will be given a copy of the Information Sheet and signed Consent Form to keep.

APPENDIX J

Letter to GPs



LETTER TO GPs

Project Title: The Emotional Impact of Early Experience in Bipolar Disorder

RESEARCHERS: Alex Fowke (Primary Researcher), Dr. Katie Ashcroft, Dr. Su Ross & Dr. Anke Karl

ETHICS NUMBER: 07/Q1702/68

VERSION: 2

Date: 19.06.07

Dear Colleague,

Patient name: *D.o.B.:*

We are conducting the above questionnaire study with patients who have a diagnosis of Bipolar Disorder. Your patient has agreed to participate and the Patient Information Sheet supplied to them is attached for you information.

This letter is simply to inform you of their participation and we are not asking for any direct involvement from you or your primary health care team.

If you require further information, please contact me, the primary researcher on 023 8082 5531

Sincerely,

**Alex Fowke
Trainee Clinical Psychologist**

APPENDIX K

Guidelines for the classification of Childhood Trauma
Questionnaire scale scores (Bernstein & Fink, 1998).

Guidelines for the classification of Childhood Trauma Questionnaire (CTQ) scale scores (Bernstein & Fink, 1998).

CTQ Subscale	CTQ Classification			
	None (or minimal)	Low (to Moderate)	Moderate (to Severe)	Severe (to Extreme)
Emotional abuse	5-8	9-12	13-15	≤16
Physical abuse	5-7	8-9	10-12	≤13
Sexual abuse	5	6-7	8-12	≤13
Emotional neglect	5-9	10-14	15-17	≤18
Physical neglect	5-7	8-9	10-12	≤13

Reference:

Bernstein, D. P., & Fink, L. (1998). *Childhood Trauma Questionnaire: a retrospective self-report*. San Antonio, TX: The Psychological Corporation.

APPENDIX L

Childhood Trauma Questionnaire – Revised (CTQ–Revised)

CTQ-Revised

Participant Code: _____

<i>Now that I am an adult...</i>	<i>Never True</i>	<i>Rarely True</i>	<i>Sometimes True</i>	<i>Often True</i>	<i>Very Often True</i>
1 I don't have enough to eat	•	•	•	•	•
2 I know that there is someone to take care of me and protect me	•	•	•	•	•
3 People in my family call me things like "stupid", "lazy" or "ugly"	•	•	•	•	•
4 People in my family are drunk or high	•	•	•	•	•
5 There is someone in my family who helps me feel that I am important or special	•	•	•	•	•
6 I have to wear dirty clothes	•	•	•	•	•
7 I feel loved	•	•	•	•	•
8 I think that my parents wished I had never been born	•	•	•	•	•
9 I get hit so hard by someone in the family that I have to see a doctor or go to the hospital	•	•	•	•	•
10 There is nothing I want to change about my family	•	•	•	•	•
11 People in my family hit me so hard that it leaves me with bruises or marks	•	•	•	•	•
12 I get punished with a belt, a board, a cord, or some other hard object by someone close to me.	•	•	•	•	•
13 People in my family look out for each other	•	•	•	•	•
14 People in my family say hurtful or insulting things to me	•	•	•	•	•
15 I believe that I get physically abused	•	•	•	•	•
16 I have the perfect life	•	•	•	•	•
17 I get hit or beaten so badly that it is noticed by someone like a doctor or a neighbour	•	•	•	•	•
18 I feel that someone in my family hates me	•	•	•	•	•
19 People in my family feel close to each other	•	•	•	•	•
20 Someone tries to touch me in an inappropriately sexual way, or tries to make me touch them	•	•	•	•	•
21 Someone threatens to hurt me or lie about me unless I do something sexual with them that I don't want to do.	•	•	•	•	•
22 I have the best family in the world	•	•	•	•	•
23 Someone tries to make me do sexual things or watch sexual things that I don't want to	•	•	•	•	•
24 Someone molests me	•	•	•	•	•
25 I believe that I am emotionally abused	•	•	•	•	•
26 There is someone to take me to the doctor if I need it	•	•	•	•	•
27 I believe that I am sexually abused	•	•	•	•	•
28 My family is a source of strength and support	•	•	•	•	•

APPENDIX M

Feedback from an impartial researcher from the University of Southampton School of Psychology

UNIVERSITY OF SOUTHAMPTON

Doctoral Programme in Clinical Psychology

FEEDBACK ON DISSERTATION PROPOSAL

Trainee's name: **Alex Fowke**Primary reviewer: **Dr Ineke Pit-ten Cate****Recommendation:**

Approved	<input type="checkbox"/>
Provisional approval with minor amendments	<input checked="" type="checkbox"/>
Re-submission with major amendments	<input type="checkbox"/>
Unfeasible	<input type="checkbox"/>

Costs: Approved / Not approved

COMMENTS ON THE PROPOSAL

General:

I think this will be an interesting study with good clinical relevance. However I have a few concerns that would require some consideration. Please discuss these with your supervisor and please provide me with a resubmit your revised proposal for approval.

Points that need attention at this stage:

Background

Bipolar disorder may be related to both childhood trauma and shame. There is some research on the relationship of these constructs and BP but no studies to date have taken into consideration both. To what extent may childhood trauma and shame be related? For example are people with childhood trauma more vulnerable for experiences of shame (related to low self esteem). This may be important for your research as it may be possible that shame mediates the relationship between trauma and BP.

Although I appreciate the research on shame may be scarce, this paragraph needs a bit more work. For example, your power calculations you use work by Gilbert that could be quoted here.

Rationale

The wording of this paragraph is a bit confusing. You have provided some research regarding trauma hence it is not a complete unknown. Furthermore in the rationale you report significant losses associated with manic behaviour but this has not been raised in the background.

Research questions:

You will study trauma and shame in people with BP. Why not also the relationship between the 3 constructs?

What is meant by the responses to these current experiences (RQ3)? Assuming you refer to the brief clinical interview, would this research question only apply to the clinical sample?

Method

Is there any particular reason to exclude inpatients?

Design

Shame is the DV for research question 2, trauma would be the DV for RQ 1.

Measures:

The revised CTQ, measuring trauma in adulthood is a measure of trauma not conservation of resources.

The use of the COR-E needs to be supported by background information and the link to the research questions needs to be clarified. The same applies to the SDP measure. In regards to the COR-E please explain the internal reliability of .05?

Procedure:

You will need to contact the patients via the psychiatrist/clinicians as they are not allowed to provide you with any personal data (such as name/address etc).

Brief clinical interview needs to be described under measures and linked to the research questions

Data management:

Regression analysis may be possible with $N = 70$. Check Cohen (1992?), a power primer in Psychological Bulletin. If you are able to conduct regression you may be able to test a mediation model (with shame mediating the effect of trauma on scores on the internal state scale). This would make your research much more interesting and substantial.

To what extent are you going to (be able to) link current experiences and trauma / shame and how do you plan to do this?

Ethics:

It may help in your ethics application if you have procedures in place in case a participant experiences distress due to the nature of the questions (both for your clinical as for your control group)

Points that you may want to consider for data analyses and write up:

Power calculation:

Indeed from the research by Gilbert you can compute an effect size (Cohen's $d = .59$) for the TOSCA measure of Shame. Not sure why you provided Cronbach alphas in the footnote. In regards to the proposed study: for any one comparison between the clinical group and the control group two equal sized groups of 35 will have .80 power to detect a large effect size at $\alpha = .05$ (two-tailed). As you have clear prediction regarding the direction of the effect your power you could suggest one tailed testing, in which case your power will increase.

Measures

You will need to elaborate on the description of the measures. The description will need to include the type of scores that can be derived and which you are going to use for the purpose of the study as well as their psychometric properties.

Data analysis

You may want to use MANOVA to test the group effect on trauma (Childhood and Adult)

Contribution to knowledge:

The contribution to knowledge will be significantly extended when you are able to address not only the associations between BP and trauma and shame respectively but also consider the relationships between the 3 constructs.

Ineke Pit 14/01//2007

APPENDIX N

University of Southampton School of Psychology
Ethics Committee Application Form, Risk Assessment, and
correspondence

ETHICS COMMITTEE CHECKLIST

Please use the tick boxes provided to indicate when the following items have been completed:

If appropriate, have you discussed this application with your Supervisor/Grant-holder

Attached copies of your consent documents

Attached copies of any letters to participants

Attached a copy of your debriefing statement

If applicable, have you attached a copy of the questionnaire/s you intend to use?

Attached a copy of your risk assessment

If applicable, attached a copy of your PsychoBook advert and other forms of recruitment

Applicant's signature

Supervisor's/Grant-holder signature

SCHOOL OF PSYCHOLOGY

OUTLINE OF PROPOSED RESEARCH TO BE SUBMITTED FOR ETHICAL COMMITTEE APPROVAL

PLEASE NOTE: You will need to discuss this form with your Supervisor or Grant-holder. In particular, you should ask him/her for any School guidelines relating to this area of research which you must read and understand. You should also read and understand the Ethical Principles for Conducting Research with Human Participants published by the British Psychological Society.

**You must not begin your study until ethical approval has been obtained.
Failure to comply with this policy will affect the viability of your research.**

1. **Name(s):** Alex Fowke
2. **Supervisor:** Dr. Anke Karl (University of Southampton), Dr. Katie Ashcroft & Dr. Su Ross (Department of Psychiatry)
3. **How may you be contacted?** email: ajf105@soton.ac.uk
4. **Into which category does your research fall?
(select from pull-down list)**
Clinical Psychology
5. **Title of Project:**
The Emotional Impact of Early Experience in Bipolar Disorder.
6. **Briefly describe the rationale for carrying out this project and its specific aims and hypotheses**
Existing studies regarding trauma in bipolar disorder have significant limitations, including small sample sizes, specific sub-classifications of the illness and inadequate data collection methods. As such, there is mixed evidence available regarding the prevalence of trauma in clients with bipolar disorder. Anecdotal clinical reports suggest that clients with bipolar disorder experience significant shame and suffer significant losses associated with their manic behaviour. However, this is relatively unsubstantiated in the literature. As such, there are 4 research questions for the current study:
 1. What is the level of trauma in clients with bipolar disorder?
 2. What level of internalised shame do clients with bipolar disorder report?
 3. What is the relationship between shame, trauma and bipolar disorder?
 4. What is the response to these current experiences?Based on the findings of previous research using different clinical samples, it is hypothesised that levels of trauma and shame will be higher in bipolar participants, and experimental participants will report more losses compared with matched control participants.

7. What intervention/procedure will be used? (Briefly describe the design. Explain what participants will experience, including duration of any task/test).

The current study is a between-subjects design. For all research questions, the Independent Variable (IV) is the participant group. For research question 1, the Dependent Variable (DV) is trauma, and shame is the DV for research questions 2. Shame and trauma are the predictor variables and Bipolar Disorder is the outcome measure for research question 3, and resource loss is the DV for research question 4.

All participants will be administered the questionnaires, and experimental participants will be briefly interviewed about their experiences of bipolar disorder. It is anticipated that the duration of the questionnaire testing will be approximately 30-45 minutes. The interview will last approximately 15 minutes. Control participants will not be interviewed.

8. What measurement procedures will be used? Please attach copies of any questionnaires to be used unless they are on the registered list.

Measures to be used are:

1. The Internal States Scale (Bauer et al., 1991)
2. The Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983)
3. The Childhood Trauma Questionnaire (Bernstein et al. 1994)
4. The Internalized Shame Scale (Cook, 1990)
5. Conservation of Resources - Evaluation (Hobfoll, Lilly & Jackson, 1991)

The brief clinical interview will involve questions regarding the participants' experiences of their illness. Questions will be:

- What was going on in your life at the time of your first/most recent period of illness?
- How do you feel these events impacted on your illness at the time?
- How did the people around you (e.g. family, friends etc) react to this period of illness?

Further questions will be asked around specific information and areas raised by each participant.

9. Who are the participants?

There will be 2 participant groups. The first group will be patients who have been given a primary diagnosis of Bipolar Disorder by a Consultant Psychiatrist. A second group will be control participants who will be matched for age, gender, social-economic status (occupation, annual income etc..)..

10. How will they be identified, approached and recruited?

Experimental participants will be recruited through psychiatrists and other clinicians at the Department of Psychiatry at the Royal South Hants hospital. In line with data protection policy, potential participants will be approached via their clinician using a cover letter and information sheet. Control participants will be recruited using local advertising.

11. How will you obtain the consent of participants?

(Please attach a copy of the consent form)

Participants will be asked to sign a Consent Form which will be stored separately from the participants' responses and both will be coded to maintain participants' anonymity. Exclusion of inpatients will ensure that participants are at an appropriate level of functioning to provide informed consent.

12. Is there any reason to believe participants may not be able to give full informed consent? If yes, what steps do you propose to take to safeguard their interests?

No difficulties in gaining consent are anticipated.

13. If participants are under the responsibility of others (such as parents/carers, teachers or medical staff) have you obtained permission to approach the participants to take part in the study?

Yes No

14. Detail any possible discomfort, inconvenience or other adverse effects the participants may experience, including after the study, and how this will be dealt with.

Participants may potentially experience some temporary distress as a result of completing the questionnaires, as sensitive issues including abuse and feelings of shame are being investigated. To reduce this distress, participants will be fully debriefed following the procedure. Using their skills as a Trainee Clinical Psychologist, the researcher will assess the participant's mood and coping relating to the issues discussed. Should participants become distressed, they will be asked "How will you cope?" and all participants will be asked "Is there anyone that you would like to inform about this research? Who is that person?" The researcher will suggest that a copy of the completed measures, or any specific issues raised during the test session can be sent to their Key Worker. They will also discuss linking with existing services should the need arise. Participants will be given a phone number so that they are able to contact the researcher after the end of the research with any further concerns or questions. If their mood is low during the procedure or at the end, the trainee will use their clinical judgment to ask about suicidal ideation (i.e. any plans they have made and any preventative factors). In the unlikely event that the trainee feels the participant needs additional support this will be arranged.

15. How will it be made clear to participants that they may withdraw consent to participate at any time without penalty?

It will be made explicit in the Information Sheet that participants may withdraw consent and this will be reiterated verbally at the time of testing.

16. Will the procedure involve deception of any sort?

Yes No

If yes, what is your justification?

n/a

17. How do you propose to debrief participants and/or provide them with information about the findings of the study?
(Please attach a copy of your debriefing statement)

As stated, participants will be debriefed after the procedure has been completed. Any distress will be dealt with as described. In addition to a verbal debrief, participants will be provided with a written debriefing statement to take away with them.

18. How will information obtained from or about participants be protected?

Participants will be given a unique code which will be written on their consent forms and completed questionnaires. These will be kept separate and in locked containers to maintain participants' anonymity. Personal information provided by experimental participants during the interview (e.g. names of family members, friends etc) will be anonymised by using initials. The researcher will acquire signed informed consent to tape-record the interview part of the procedure. Tape-recordings will be marked with each participants unique code and stored separately from the consent forms.

19. Experimental apparatus employed must be approved for safety by Martin Hall or Bryan Newman. Has this approval been given?

Yes No

20. Do you intend to make a submission to the Medical Research Ethics Committee?

(certain projects may need Medical Ethical Approval, please check with your Supervisor)

Yes No

21. Does this research involve work with children? Yes No

If yes, has a police check been carried out? Yes No

22. Outline any other information you feel may be relevant to this submission.

Supervisor/Grant-holder Declaration

I have discussed this application with the applicant and support it.

I can confirm that no breaches of copyright over questionnaires and/or other materials will occur.

Any further comments:

Signature: _____

Name:

Date:

Applicant Declaration

1. I confirm that I have a copy of, have read and understand the Ethical Principles for Conducting Research with Human Participants published by the British Psychological Society.

Yes No

2. I have considered the risks associated with conducting this research and have completed a risk assessment on behalf of the researcher and the participants.

Yes No

3. I have received, read and understood the School Ethical guidelines issued to me by my Supervisor relating to this work.

Yes

No

4. I/We are satisfied that I am not breaching copyright.

Yes

No

Signature: _____

Name:

Date:

Ethical Committee Approved

This application has been approved by:

Signature: _____

Name:

Date:

Has this application highlighted any issues to go to the full Ethics Committee?

Yes

No

If yes, please provide further information.

RISK ASSESSMENT FORM

RISK ASSESSMENT NUMBER:.....

Brief outline of work/activity:	Patients and control participants will be visited in their own homes (if convenient to them) and given questionnaires to complete. The questionnaires investigate participants' experiences of childhood and adult trauma and abuse and shame. Patients will also be interviewed about their experiences of bipolar disorder.
Location:	Participants will be visited at their own home if convenient, or if preferred at the Department of Psychiatry, Royal South Hants hospital in Southampton, or another NHS location (e.g. team base)
Significant hazards:	Two potential hazards have been identified: <ol style="list-style-type: none">Participants may experience some degree of distress as a result of completing the questionnaires and being interviewed about their experiences of their illness (for experimental participants).As the majority of participants will be visited in their own home, the researcher will be subject to the hazard of lone working.
Who might be exposed to the hazards:	Participants may be exposed to the potential distress. The researcher may be exposed to lone working.
Existing control measures:	<ol style="list-style-type: none">To control for potential distress, participants will be debriefed after the completion of the procedure. Using their skills as a Trainee Clinical Psychologist, the researcher will assess the participant's mood and coping relating to the issues discussed. Should participants become distressed, they will be asked "How will you cope?" and all participants will be asked "Is there anyone that you would like to inform about this research? Who is that person?" The researcher will suggest that a copy of the completed measures, or any specific issues raised during the test session can be sent to their Key Worker. They will also discuss linking with existing services should the need arise. Participants will be given a phone number so that they are able to contact the researcher after the end of the research with any further concerns or questions. If their mood is low during the procedure or at the end, the trainee will use their clinical judgment to ask about suicidal ideation (i.e. any plans they have made and any preventative factors). In the unlikely event that the trainee feels the participant needs additional support this will be arranged.To control for the potential hazards involved in lone working, the researcher will first check out with the participant's doctor or Key Worker for any history of violence. In cases where there is a history of violence or perceived risk to self and/or others, the researcher will not visit the participant at home alone. Furthermore, one of the supervisors will be nominated as a contact for each

	home visit. In each instance, the supervisor will be informed of the time and location of each visit, and the researcher will agree to call the nominated supervisor within a specified time-limit from their mobile-phone. If no call is received, the supervisor will attempt to contact the researcher twice. If no there is no response they will contact the police giving the location of the test procedure. If the researcher is able to answer the call, but is in trouble, they will respond with an agreed code so that the supervisor knows they are in trouble and the police should be contacted.
--	---

Are risks adequately controlled: YES/NO

If NO, list additional controls and actions required:	Additional controls:	Action by:

Completed by:	Name	Signature	Date
Supervisor:	Name	Signature	Date
Date of review:			

Insurance application for Projects requiring approval by Ethics Committee and involving Staff and/or Students of the University of Southampton

Ethics Submission No. **TBA**
&
Title of Study **The Emotional Impact of Early Experience in Bipolar Disorder**

ON NO ACCOUNT MUST THE PROJECT COMMENCE UNTIL INSURANCE AND ETHICS APPROVAL IS GIVEN

PLEASE COMPLETE ALL QUESTIONS

(Delete or complete as appropriate)

1. Is the study based solely on questionnaires, or other research **not** involving invasive techniques or drugs: No
IF NO: a copy of the Ethics Committee Submission (including consent forms) and protocol where appropriate **must** be enclosed with this questionnaire.
2. Are any of the investigators students of the University: No
3. Please estimate numbers of volunteers participating in the study, in terms of the following categories:

Patients and/or	<input type="circle"/> No
Healthy Human Volunteers	<input type="circle"/> No
Minors (under 18 years of age)	Yes <input type="circle"/>

Numbers
40
40
n/a
4. Does the study involve invasive techniques: Yes
5. Does the study involve the use of drugs: Yes

IF YES:

please state which phase category the study falls into: Phase 1 Phase 2
 Phase 3 Phase 4

6. Who is the projects Sponsor? University of Southampton

7. Is an ABPI Indemnity being given? Yes

IF YES:

the ABPI Indemnity form, preferably in triplicate, should be forwarded with this form for signature by an Authorised signatory on behalf of the University.

(Please print)

Please return this form, with the information sheet and consent form and any other required enclosures (See Q.1.) to:

**Ruth McFadyen,
Insurance Services Manager
Department of Finance,
University of Southampton**

Name: (Dr/Mr/Ms) Alex Fowke

University Dept. of: Clinical Psychology

Address 34 Bassett Crescent East, Bassett, Southampton, SO16 7PB

E-mail Address ajf105@soton.ac.uk

A copy of the Ethics Approval letter must be sent to the Insurance Services Manager as soon as it is available.

APPENDIX O

National Research Ethics Service Southampton and South West
Hampshire Research Ethics Committee A Application Form,
submission documents, and correspondence

APPLICANT'S CHECKLIST**All studies except clinical trials of investigational medicinal products**

REC Ref:	07/Q1702/68
Short Title of Study:	The Emotional Impact of Early Experience in Bipolar Disorder
CI Name:	Mr Alex Fowke
Sponsor:	University of Southampton

Please complete this checklist and send it with your application

- ◆ Send ONE copy of each document (except where stated)
- ◆ ALL accompanying documents must bear version numbers and dates (except where stated)
- ◆ When collating please do NOT staple documents as they will need to be photocopied.

Document	Enclosed?	Date	Version	Office use
Covering letter on headed paper	<input type="radio"/> Yes <input checked="" type="radio"/> No			
NHS REC Application Form, Parts A&B	Mandatory	04/05/2007	1	
Site-Specific Information Form (for SSA)	<input type="radio"/> Yes <input checked="" type="radio"/> No			
Research protocol or project proposal (6 copies)	Mandatory	21/04/2007	2	
Summary C.V. for Chief Investigator (CI) – Alex Fowke	Mandatory	04/05/2007		
Summary C.V. for supervisor (student research) – Dr. Anke Karl	<input checked="" type="radio"/> Yes <input type="radio"/> No	04/05/2007		
Research participant information sheet (PIS)	<input checked="" type="radio"/> Yes <input type="radio"/> No	08/05/2007	3	
Research participant consent form	<input checked="" type="radio"/> Yes <input type="radio"/> No	21/02/2007	2	
Letters of invitation to participants	<input checked="" type="radio"/> Yes <input type="radio"/> No	21/02/2007	2	
GP/Consultant information sheets or letters – Consultant Letter	<input checked="" type="radio"/> Yes <input type="radio"/> No	21/02/2007	2	
GP/Consultant information sheets or letters – Consultant Information Sheet	<input checked="" type="radio"/> Yes <input type="radio"/> No	17/03/2007	1	
Statement of indemnity arrangements	<input checked="" type="radio"/> Yes <input type="radio"/> No	08/05/2007		
Letter from sponsor	<input checked="" type="radio"/> Yes <input type="radio"/> No	08/05/2007		
Letter from statistician	<input checked="" type="radio"/> Yes <input type="radio"/> No	14/01/2007		
Letter from funder	<input type="radio"/> Yes <input checked="" type="radio"/> No			
Referees' or other scientific critique report – Same as Letter from Statistician	<input checked="" type="radio"/> Yes <input type="radio"/> No	14/01/2007		
Summary, synopsis or diagram (flowchart) of protocol in non-technical language	<input type="radio"/> Yes <input checked="" type="radio"/> No			
Interview schedules or topic guides for participants	<input checked="" type="radio"/> Yes <input type="radio"/> No	18/03/2007	1	
Validated questionnaire – Hospital Anxiety and Depression Scale (HADS), Conservation of Resources – Evaluation (COR-E), Childhood Trauma Questionnaire (CTQ), Internal States Scale, Internalized Shame Scale	<input checked="" type="radio"/> Yes <input type="radio"/> No			
Non-validated questionnaire – CTQ – revised	<input checked="" type="radio"/> Yes <input type="radio"/> No	20/11/2006	1	

Copies of advertisement material for research participants, e.g. posters, newspaper adverts, website. For video or audio cassettes, please also provide the printed script.	<input checked="" type="radio"/> Yes <input type="radio"/> No	18/02/2007	1	
Summary C.V. for supervisor (student research) – Dr. Susan Ross	<input checked="" type="radio"/> Yes <input type="radio"/> No		1	
Summary C.V. for supervisor (student research) – Dr. Katie Ashcroft	<input checked="" type="radio"/> Yes <input type="radio"/> No	14/03/2007	1	
Non-validated questionnaire – Demographics Questionnaire (experimental participant)	<input checked="" type="radio"/> Yes <input type="radio"/> No	15/01/2007	1	
Non-validated Questionnaire – Demographic Questionnaire (control participant)	<input checked="" type="radio"/> Yes <input type="radio"/> No	15/01/2007	1	
GP letter	<input checked="" type="radio"/> Yes <input type="radio"/> No	21/02/2007	1	
Manic Depression Fellowship letter	<input checked="" type="radio"/> Yes <input type="radio"/> No	21/02/2007	1	
Consent Form to contact Key Workers	<input checked="" type="radio"/> Yes <input type="radio"/> No	21/02/2007	1	
Debriefing Statement	<input checked="" type="radio"/> Yes <input type="radio"/> No	21/02/2007	2	
Control Participant letter	<input checked="" type="radio"/> Yes <input type="radio"/> No	21/02/2007	2	
Control Participant Information Sheet	<input checked="" type="radio"/> Yes <input type="radio"/> No	21/02/2007	2	
Control Participant Consent Form	<input checked="" type="radio"/> Yes <input type="radio"/> No	21/02/2007	2	
University of Southampton School of Psychology Ethics Committee approval letter	<input checked="" type="radio"/> Yes <input type="radio"/> No	26/04/2007	1	

WELCOME TO THE NHS RESEARCH ETHICS COMMITTEE APPLICATION FORM

An application form specific to your project will be created from the answers you give to the following questions.

1. Is your project an audit or service evaluation?

Yes No

2. Select one research category from the list below:

- Clinical trials of investigational medicinal products
- Clinical investigations or other studies of medical devices
- Other clinical trial or clinical investigation
- Research administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
- Research involving qualitative methods only
- Research limited to working with human tissue samples and/or data
- Research tissue bank

If your work does not fit any of these categories, select the option below:

Other research

2a . Please answer the following questions:

- a) Does the study involve the use of any ionising radiation?
- b) Will you be taking new human tissue samples?
- c) Will you be using existing human tissue samples?

Yes No
 Yes No
 Yes No

3. Is your research confined to one site?

Yes No

4. Does your research involve work with prisoners?

Yes No

5. Does your research involve adults unable to consent for themselves through physical or mental incapacity?

Yes No

6. Is the study, or any part of the study, being undertaken as an educational project?

Yes No

6a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

Yes No

NHS Research Ethics Committee **Application form for research administering questionnaires/interviews for quantitative analysis or mixed methodology study**

This form should be completed by the Chief Investigator, after reading the guidance notes. See glossary for clarification of different terms in the application form.

Short title and version number: (maximum 70 characters – this will be inserted as header on all forms)

The Emotional Impact of Early Experience in Bipolar Disorder

Name of NHS Research Ethics Committee to which application for ethical review is being made:

Southampton and South West Hampshire Research Ethics Committee

Project reference number from above REC: 07/Q1702/68

Submission date: 21/05/2007

PART A: Introduction**A1. Title of the research**

Full title: The Emotional Impact of Early Experience in Bipolar Disorder

Key words: Bipolar Disorder, Emotion, Trauma, Abuse, Shame.

A2. Chief Investigator

Title: Mr

Forename/Initials: Alex

Surname: Fowke

Post: Trainee Clinical Psychologist

Qualifications: B.Sc. (Hons) Psychology, M.Sc. in Health Psychology, Doctorate in Clinical Psychology (currently undertaking)

Organisation: Taunton & Somerset NHS Trust

Work Address: Department of Clinical Psychology

34 Bassett Crescent East, University of Southampton

Bassett, Southampton

Post Code: SO16 7PB

E-mail: ajf105@soton.ac.uk

Telephone: 023 8082 5531

Fax: N/A

Mobile: 07989 341559

A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application

A3. Proposed study dates and duration

Start date: 01/07/2007

End date: 01/06/2008

Duration: Years: 0 ; Months: 11

A4. Primary purpose of the research: (Tick as appropriate)

- Commercial product development and/or licensing
- Publicly funded trial or scientific investigation
- Educational qualification
- Establishing a database/data storage facility
- Other

Question(s) 5 disabled.

A6. Does this research require site-specific assessment (SSA)? (Advice can be found in the guidance notes on this topic.)

Yes No

If No, please justify:

The Chief Investigator will meet with participants either at a Hampshire Partnership Trust resource, the University of Southampton, or if they prefer in their own homes with their care co-ordinator, where they will obtain consent and conduct the research procedure. The tasks that participants will be invited to take part in are non-invasive and the rating scales are safe and standardised so the risk of physical and psychological harm is low.

If Yes, an application for SSA should be made for each research site on the Site-Specific Information Form and submitted to the relevant local Research Ethics Committee. Do not apply for SSA at sites other than the lead site until the main application has been booked for review and validated by the main Research Ethics Committee.

Management approval to proceed with the research will be required from the R&D office for each NHS care organisation in which research procedures are undertaken. This applies whether or not the research is exempt from SSA. R&D applications in England, Wales and Scotland should be made using the Site-Specific Information Form.

PART A: Section 1**A7. What is the principal research question/objective? (Must be in language comprehensible to a lay person.)**

The principle research objective is to identify the impact of early experience in Bipolar Disorder. Specifically, the aim is to investigate whether participants with a diagnosis of Bipolar Disorder report different levels of current and background trauma and levels of shame compared with matched healthy control participants with no mental health difficulties. The findings could provide valuable information about this issue and may improve or inform new psychological interventions in this client group.

A8. What are the secondary research questions/objectives? (If applicable, must be in language comprehensible to a lay person.)

There is a secondary objective which is to investigate whether participants with a diagnosis of Bipolar Disorder experience any significant gains or losses of personal resources (e.g. money, possessions, relationships) compared with healthy control participants.

A9. What is the scientific justification for the research? What is the background? Why is this an area of importance? (Must be in language comprehensible to a lay person.)

There is a wealth of background literature that suggests that early experience has a significant effect on the development of mental health problems in adulthood (for example, see Read & Hammersley, 2006). However, there is only a limited amount of literature available reporting the levels of early traumatic experiences specifically in samples of participants with a diagnosis of Bipolar Disorder. Neria, Bromet, Carlson & Naz (2005) report that 40% of a first-admission sample diagnosed with Bipolar Disorder with psychotic features reported exposure to trauma before their admission; 28% of patients reported having been assaulted in childhood. Similarly, Hyun, Friedman and Dunner (2000) report an increased rate of childhood abuse in patients with a diagnosis of Bipolar Disorder compared with depressed patients. As such, these existing studies have significant limitations such as small sample sizes, unsatisfactory methods of data collection and highly specific client groups. Consequently there is mixed evidence available regarding the prevalence of trauma in clients with a diagnosis of Bipolar Disorder.

It has been suggested that shame may result from incidents of childhood sexual abuse following the experience of the abuse as a personal attack on the self, leaving the individual feeling deeply defective and defeated. Survivors then continue to engage in activities that reinforce the low self-worth (Finkelhor & Browne, 1985). Furthermore, Feiring and Taska (2005) found that survivors of childhood sexual abuse were especially at risk for persistently high levels of shame 6 years following discovery and were more likely to report clinically significant feelings of intrusive recollections. As such, persistent shame may explain failure to process the abuse and the maintenance of PTSD symptoms. Further to PTSD symptomatology, Stockwell-Byde (2001) found significant correlations between internalized shame, depression and psychotism. However, despite these apparent links between early traumatic experiences and the subsequent development of mental health problems and ongoing feelings of shame, there is no literature available looking at these issues specifically in relation to patients with a diagnosis of Bipolar Disorder. Shame can be a particularly important emotion in patients with a diagnosis of Bipolar Disorder because of the behaviours and activities that patients become involved in during manic phases of their illness. Whilst no literature is currently available, anecdotal evidence suggests that following these manic episodes, patients with a diagnosis of Bipolar Disorder can experience significant levels of shame, and in addition can go on to experience significant resource loss, including job losses and the breakdown of significant interpersonal relationships.

In addition to its links with mental illness, shame associated with trauma can create a barrier in therapy. Macdonald and Morley (2001) found that many clinical participants do not disclose emotional incidents due to their anticipating negative responses, including labelling and judging responses. As such, by identifying trends in the levels of background trauma and feelings of shame, the current research can potentially inform clinical practice as to the sensitive handling of the experiences reported by patients with Bipolar Disorder.

A10-1. Give a full summary of the purpose, design and methodology of the planned research, including a brief explanation of the theoretical framework that informs it. It should be clear exactly what will happen to the research participant, how many times and in what order.

This section must be completed in language comprehensible to the lay person. It must also be self-standing as it will be replicated in any applications for site-specific assessment on the Site-Specific Information Form. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.

The research is informed by psychological theory which considers that patients with a variety of psychiatric illnesses report higher levels of background trauma and shame compared with healthy control participants. The aim of the current research is to assess the levels of background trauma, i.e. trauma experienced during childhood, in participants with a diagnosis of Bipolar Disorder. The research also aims to assess more recent traumatic experiences, as well as levels of shame reported by this client group.

The protocol has been peer-reviewed and a member of the target population has been consulted on the design and procedure of the study. Any ideas or recommendations have been incorporated into the protocol where possible.

Two groups of participants will be recruited. One group of clinical participants will be recruited through Consultant Psychiatrists and Staff Grade doctors from Hampshire Partnership Trust. A control group of healthy adults with no reported mental health difficulties will be recruited using local advertising.

Clinical participants will be adult out-patients (over the age of 18 years) with a primary diagnosis of Bipolar Disorder. Consultant Psychiatrists and mental health teams in Hampshire Partnership Trust will be approached to ask if they would consent to the Chief Investigator approaching patients of theirs who have a diagnosis of Bipolar Disorder to discuss the study. The patient's Consultant Psychiatrist will be provided with an Information Sheet outlining the purpose of the research and the procedure of the study. The individual patients will then be approached at out-patient clinics and will be given an explanation of the study and an Information Sheet and be asked if they would consider being involved. If they express an interest in participating, they will be asked for their name and a contact number which the Chief Investigator will use to contact them after 3 days to discuss their participation further.

If insufficient numbers of participants are recruited this way, the Chief Investigator will approach the Manic Depression Fellowship (MDF), the Bipolar Disorder organisation. The Chief Investigator will write a letter to the organisers of the local Southampton MDF group along with a copy of the Information Sheet, offering the opportunity for the group to participate in the study. The Chief Investigator will offer to present the study at one of the group's meetings and offer members the opportunity to give their contact details should they wish to participate or want further information about participation in the study. Following their consent to participate, the recruitment procedure outlined previously will be employed. Where possible, MDF members who are under the care of NHS mental health services but not Hampshire Partnership Trust will not be recruited. The Chief Investigator does not anticipate that this will happen, however, should there be sufficient numbers of non-Hampshire Partnership Trust NHS patients willing to participate, then an application to MREC will follow.

Control participants will be matched to clinical participants based on gender, age, and socio-economic status. In order to recruit appropriate control participants, three different recruitment procedures will be employed. The first method of recruitment will involve advertising by placing posters around the University of Southampton advertising for volunteers to participate in the study. Potential participants will be able to contact the Chief Investigator for further information using the contact telephone number and/or email address on the poster. Those who contact the Chief Investigator for further information will be asked for their name, address and contact telephone number. A copy of the Information Sheet will be sent to them along with a cover letter within 3 working days of the initial contact, which will provide them with sufficient information about the study. The letter will also explain that the Chief Investigator will contact them by telephone after 3 working days to discuss their participation in the study.

If insufficient numbers of appropriately-matched participants are recruited through the University, the Chief Investigator will recruit further participants through advertisements in local newspapers. The final recruitment procedure will use a 'snowballing technique' amongst family and friends, whereby people known to the Chief Investigator will be asked to pass on Information Sheets to acquaintances who match the profile of the clinical participants, that is, are similar in age, socio-economic status and gender to the clinical sample.

Following their decision to participate, the Chief Investigator will contact each clinical and control participant individually after 3 working days of their expressing an interest and agreeing to take part in the research to arrange a convenient time to meet with them and conduct the research. Participants may decide to meet at a Hampshire Partnership Trust resource, the University of Southampton or at their own home as convenient to them. At this meeting, participants will be asked to read and sign 3 identical Consent Forms (one copy of which will be retained by the Chief Investigator, one for the participant's medical notes, and one given to the

participant). A demographic form recording basic information about the participant, including date of birth, age, gender and years of education will be administered following the participant completing the Consent Forms.

As a part of the procedure all participants will be asked to complete each of the rating scales. These will be presented in sequence by the Chief Investigator in the following order: the Internal States Scale, the Hospital Anxiety and Depression Scale, the original format of the Childhood Trauma Questionnaire, the Internalized Shame Scale, the revised version of the Childhood Trauma Questionnaire, and the Conservation of Resources Evaluation. The Chief Investigator will be present throughout the procedure if they require any assistance, have any questions or concerns, or wish to withdraw. The Chief Investigator will offer each participant the opportunity to have the Consent Form, Information Sheet and all rating scales read to them to ensure thorough understanding and to avoid any difficulties caused by any potential undiagnosed learning disability or literacy difficulties.

Prior to completing the rating scales, the participants in the clinical group will be briefly interviewed following a semi-structured interview schedule about their experiences of Bipolar Disorder. Control participants will not be interviewed, because as a result of the exclusion criteria, they will not have a history of mental health problems.

It is expected that completing the rating scales will take about 30 to 45 minutes. The interview conducted with the clinical participants is expected to last approximately 15 minutes.

Following the completion of the rating scales (and the interview in the case of clinical participants), participants will be verbally debriefed and given a copy of the debriefing statement. Any questions they have will be answered before being thanked for their participation.

The Childhood Trauma Questionnaire has been used by researchers in Hampshire Partnership Trust in research with various psychiatric populations, including Schizophrenia and Borderline Personality Disorder, and no major difficulties have been encountered. However, it is acknowledged that the completion of rating scales looking at trauma and shame are areas in which participants may potentially become distressed. In the unlikely event that participants become upset as a result of completing the rating scales or answering questions in the interview, the Chief Investigator will allow the participant to discuss the issues causing them distress and will use their skills as a Trainee Clinical Psychologist to assess the participant's mood and coping relating to the issues discussed. Should participants become distressed, they will be asked "How will you cope?" and all participants will be asked "Is there anyone that you would like to inform about this research? Who is that person?" The Chief Investigator will suggest that should the participant wish so, a copy of the completed measures, or any specific issues raised during the test session can be sent to their Key Worker. Participants will be asked to sign a consent form if they wish for copies of their forms to be sent to a relevant member of staff involved in their care. They will also discuss linking with existing services should the need arise. The Chief Investigator will also suggest that if necessary, they will meet with the participant and their Key Worker to discuss ways to deal with the distress. If their mood is low during the procedure or at the end, the Chief Investigator will use their clinical judgment to ask about suicidal ideation (i.e. any plans they have made and any preventative factors). In the unlikely event that the they feel the participant needs additional support this will be arranged by contacting the Duty Worker and the Home Treatment Service.

There will be no deception involved in this study and all data will be anonymised. The name and address of any participant who wishes to receive information about the outcome of the study will be stored securely separately from the data sheets.

A10-2. In which parts of the research have patients, members of the public or service users been involved?

- As user-researchers
- As members of a research project group
- As advisor to a project
- As members of a departmental or other wider research strategy group
- None of the above

Please provide brief details if applicable:

A10-3. Could the research lead to the development of a new product/process or the generation of intellectual property?

Yes No Not sure

Question(s) 11–12 disabled.

A13. Give details of any non-clinical research-related intervention(s) or procedure(s). (These include interviews, non-clinical observations and use of questionnaires.)

Additional Intervention	Average number per participant	Average time taken (mins/hours/days)	Details of additional intervention or procedure, who will undertake it, and what training they have received.
Face to Face Interview	1	15 minutes	<p>Clinical participants will be briefly interviewed about their experiences of Bipolar Disorder. Questions will investigate issues in participants' lives around periods of illness, their perceived reactions of family and friends to their illness and any beliefs that they hold about their illness. Further questions will stem from participants' responses to these general questions.</p> <p>Healthy control participants will not be interviewed because as a result of the exclusion criteria, they will not have a history of mental health problems.</p> <p>The Chief Investigator is a Trainee Clinical Psychologist and has over 4 years experience of conducting face-to-face clinical interviews with NHS patients as well as experience conducting qualitative and quantitative research with clinical samples.</p> <p>This interview will take place either at a Hampshire Partnership Trust resource, the University of Southampton or their own homes, whichever is most convenient to them. Only the participant and the Chief Investigator will be present during the procedure unless participants prefer to meet at their own homes, when their Key Worker or care co-ordinator will also be present.</p>
Other Questionnaire	5	45 minutes	<p>The following standardised self-report rating scales will be used:</p> <ol style="list-style-type: none"> 1. Internal States Scale. 2. Hospital Anxiety and Depression Scale (HADS) 3. Childhood Trauma Questionnaire (CTQ) 4. Internalized Shame Scale 5. Conservation of Resources – Evaluation (COR-E) <p>A copy of the CTQ is re-worded for participants in this study to rate their experiences of trauma in their adulthood. As such, no reliability data for this version is available.</p> <p>A basic demographic questionnaire will be used to record the personal details of participants, including date of birth, gender and years of education.</p>

			<p>The Chief Investigator is a Trainee Clinical Psychologist and has over 4 years experience of conducting face-to-face clinical interviews with NHS patients as well as experience conducting qualitative and quantitative research with clinical samples.</p> <p>Each participant will complete all self-report rating scales with the assistance of the Chief Investigator as required. The completion of these scales will take place either at a Hampshire Partnership Trust resource, the University of Southampton or their own homes, whichever is most convenient to them. Only the participant and the Chief Investigator will be present during the procedure unless participants prefer to meet at their own homes, when their Key Worker or care co-ordinator will also be present.</p>
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A14. Will individual or group interviews/questionnaires discuss any topics or issues that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could take place during the study (e.g. during interviews/group discussions, or use of screening tests for drugs)?

Yes No

If Yes, give details of procedures in place to deal with these issues

Although there is no inherent risk in completing self-report rating scales or from answering demographic questions, it is acknowledged that some participants may experience some distress when asked questions about their experience of abuse. Participants may also be embarrassed discussing their manic behaviours.

The Chief Investigator is a Trainee Clinical Psychologist who has experience working with psychiatric patients and is considered to be competent to manage these situations. Should participants become distressed, they will be asked "How will you cope?" and all participants will be asked "Is there anyone that you would like to inform about this research? Who is that person?".

The Chief Investigator will suggest that should they wish, a copy of the completed measures, or any specific issues raised during the test session can be sent to their Key Worker. Participants will be asked to sign a consent form if they wish for copies of their forms to be sent to a relevant member of staff involved in their care. They will also discuss linking with existing services should the need arise. The Chief Investigator will also suggest that if necessary, they will meet with the participant and their Key Worker to discuss ways to deal with the distress. If their mood is low during the procedure or at the end, the Chief Investigator will use their clinical judgment to ask about suicidal ideation (i.e. any plans they have made and any preventative factors). In the unlikely event that they feel the participant needs additional support this will be arranged by contacting the Duty Worker or Home Treatment Service.

As one of the rating scales measures current experiences of trauma, there is the potential for disclosures of current and ongoing abuse, for example at the hands of a parent or partner. As such, participants will be made aware of the confidentiality agreement and Duty of Care, whereby the Chief Investigator will be required to report any disclosures of current abuse to the police and/or appropriate personnel.

It is unlikely that control participants will disclose information that may be upsetting to them, and as a result of the exclusion criteria, no control participants will fulfil the Vulnerable Adults criteria as outlined by the NHS Vulnerable Adults Steering Group. However, should any significant disclosures be made or any distress be evident during the course of the procedure, then the above risk management procedure will be initiated.

The Information Sheet should make it clear under what circumstances action may be taken

A15. What is the expected total duration of participation in the study for each participant?

For participants in the clinical group, the total duration of participation is estimated to be approximately 45 minutes to 1 hour including the interview. It is anticipated that for control group participants, who will not

interviewed, the expected duration is 30 to 45 minutes.

All participants will be given sufficient time to discuss any of the issues that have arisen as a result of the procedure, and as such, the Chief Investigator will allow sufficient time following the procedure for such a discussion.

Question(s) 16–17 disabled.

A18. What is the potential for benefit to research participants?

There are no guaranteed benefits for research participants. However, participants involved in similar research have reported its cathartic effect rather than any adverse effects (for example, see Griffin, Resick, Waldrop & Mechanic, 2003). In addition, many participants enjoy the opportunity to participate in research which may influence future treatment of people in a similar circumstance.

A19. What is the potential for adverse effects, risks or hazards, pain, discomfort, distress, or inconvenience to the researchers themselves? (if any)

Due to the possibility of the procedure being conducted in participants' own homes, there is an issue of lone working. Potential hazards that the Chief Investigator might face are violence and aggression, working in an unsuitable environment and allegations of abuse, inappropriate actions or theft.

The Chief Investigator will first check out with the clinical participant's doctor or Key Worker for any history of violence or socially unacceptable behaviour, alcohol/substance misuse, unpredictable behaviour or ownership of weapons. In addition, similar factors will be considered with regard to participants' families, carers or others that may be at the address. To avoid any potential difficulties that may result from lone-working, the Chief Investigator will not visit the participant at home alone but will be accompanied by the participant's care co-ordinator or Key Worker. In cases where violence or difficulties are suspected or known, the participant will not be visited at home. In the event of a visit whereby the level of risk is initially considered acceptable but then subsequently becomes considered unsafe, the Chief Investigator will withdraw from the visit as soon as is possible.

In line with Hampshire Partnership Trust Lone Working Policy, the Chief Investigator will ensure that they do not visit participants in participants' homes, that have not been assessed for potential hazards and unmanaged risks. The environment will be assessed for risk relating to the general safety of the area, the time of day, day of week, light and weather conditions and any unhygienic conditions.

One of the research supervisors will be nominated as a contact for each home visit. In each instance, the supervisor will be informed of the time and location of each visit, and the Chief Investigator will agree to call the nominated supervisor within a specified time-limit from their mobile phone. If no call is received, the supervisor will attempt to contact the Chief Investigator twice. If there is no response they will contact the police giving the location of the test procedure. If the Chief Investigator is able to answer the call, but is in trouble, they will respond with an agreed code so that the supervisor knows they are in trouble and the police should be contacted. The Chief Investigator has attended NHS training on Breakaway skills and general Health and Safety.

As per the Lone Working guidelines, the Chief Investigator will not offer transportation to participants who wish to meet at Hampshire Partnership Trust resources or at the University of Southampton. Similarly, the Chief Investigator will not accept offers of transportation from participants.

As healthy control participants will be recruited on the basis that they do not have any mental difficulties and match the clinical participants in terms of socio-economic status, age and gender, it is unlikely that there a risk assessment will be available about the participant's home environment. As such, to minimise risk, control participants will be encouraged to meet the Chief Investigator at a Hampshire Partnership Trust resource or at the University of Southampton. In instances whereby a home visit is necessary, the Chief Investigator will visit the participant along with one of the supervisors to ensure their safety, and the above risk management strategy will be instigated.

A20. How will potential participants in the study be (i) identified, (ii) approached and (iii) recruited?

Give details for cases and controls separately if appropriate:

Two groups of participants will be recruited. One group of clinical participants will be recruited through Consultant Psychiatrists and Staff Grade doctors from Hampshire Partnership Trust. A control group of healthy adults with no reported mental health difficulties will be recruited using local advertising.

Clinical participants will be adult out-patients (over the age of 18 years) with a primary diagnosis of Bipolar Disorder. Consultant Psychiatrists and mental health teams in Hampshire Partnership Trust will be approached to ask if they would consent to patients of theirs with a diagnosis of Bipolar Disorder being approached about entering this study. The patient's Consultant Psychiatrist will be provided with an Information Sheet outlining the purpose of the research and the procedure of the study. The individual patients will then be approached at out-patient clinics and will be given an explanation of the study and an Information Sheet and be asked if they would consider being involved. If they express an interest in participating, they will be asked for their name and a contact number which the Chief Investigator will use to contact them after 3 days to discuss their participation further.

If insufficient numbers of participants are recruited this way, the Chief Investigator will approach the Manic Depression Fellowship (MDF), the Bipolar Disorder organisation. The Chief Investigator will write a letter to the organisers of the local Southampton MDF group along with a copy of the Information Sheet, offering the opportunity for the group to participate in the study. The Chief Investigator will propose that they would come to a meeting and do a short presentation about the research and offer group members the opportunity to give their contact details should they wish to participate or want further information about participation in the study. Following their consent to participate, the recruitment procedure outlined previously will be employed. Where possible, MDF members who are under the care of NHS mental health services but not Hampshire Partnership Trust will not be recruited. The Chief Investigator does not anticipate that this will happen, however, should there be sufficient numbers of non-Hampshire Partnership Trust NHS patients willing to participate, then an application to MREC will follow.

Control participants will be matched to clinical participants based on gender, age, and socio-economic status. In order to recruit appropriate control participants, three different recruitment procedures will be employed. The first method of recruitment will involve advertising by placing posters around the University of Southampton advertising for volunteers to participate in the study. Potential participants will be able to contact the Chief Investigator for further information using the contact telephone number and/or email address on the poster. Those who contact the Chief Investigator for further information will be asked for their name, address and contact telephone number. A copy of the Information Sheet will be sent to them along with a cover letter within 3 working days of the initial contact, which will provide them with sufficient information about the study. The letter will also explain that the Chief Investigator will contact them by telephone after 3 working days to discuss their participation in the study.

If insufficient numbers of appropriately-matched participants are recruited through the university, the Chief Investigator will recruit further participants using the second method of recruitment through advertisement in local newspapers. The final recruitment procedure will use a 'snowballing technique' amongst family and friends, whereby people known to the Chief Investigator will be asked to pass on Information Sheets to acquaintances who match the profile of the clinical participants, that is, are similar in age, socio-economic status and gender to the clinical sample.

Following their decision to participate, the Chief Investigator will contact each clinical and control participant individually after 3 working days of their agreeing to participate in the research to arrange a convenient time to meet with them and conduct the research.

At the beginning of the procedure, participants will be informed of their right to change their minds or to withdraw from the study without any consequences, in relation to their legal rights and medical care.

A21. Where research participants will be recruited via advertisement, give specific details.

Not Applicable

Adverts will be placed around the University of Southampton inviting individuals to participate in this study. The advert will provide a contact number and an email address for the Chief Investigator which potential participants can call if they are interested in reading the Information Sheet about the study. Those who contact the Chief Investigator for further information will be asked for their name, address and contact telephone number. A copy of the Information Sheet will be sent to them along with a cover letter within three working days of their initial contact, which will provide them with sufficient information about the study. The letter will also explain that the Chief Investigator will contact them by telephone after 3 working days to

discuss their participation in the study. Written consent will be obtained from control participants at the start of the research appointment. Again, their right to withdraw at any time will be made clear, and confidentiality and anonymity of their participation will be reiterated.

If applicable, enclose a copy of the advertisement/radio script/website/video for television (with a version number and date).

A22. What are the principal inclusion criteria? (Please justify)

Clinical Participant Group:

- Patients with a primary diagnosis of Bipolar Disorder

Healthy Control Group:

- Participants who are similar to clinical participants based on age, gender and socio-economic status.

A23. What are the principal exclusion criteria? (Please justify)

Clinical Participant Group:

- Patients with a primary diagnosis of substance misuse
- Patients whose first language is not English, as the rating scales being used have been standardised in English, and limited resources dictate that the use of an interpreter is not a viable option for this study.
- Patients who have been identified as having a learning disability, as this might impair their ability to complete the measures accurately and impair their recall of early experiences.
- Patients who are in-patients in a psychiatric unit, as they are likely to be experiencing significant levels of distress and as such it would be unfair to ask them about adverse life experiences.

Healthy Control Group:

- People with a previous psychiatric diagnosis.
- People with a learning disability
- People with a head injury

A24. Will the participants be from any of the following groups? (Tick as appropriate)

- Children under 16
- Adults with learning disabilities
- Adults who are unconscious or very severely ill
- Adults who have a terminal illness
- Adults in emergency situations
- Adults with mental illness (particularly if detained under Mental Health Legislation)
- Adults with dementia
- Prisoners
- Young Offenders
- Adults in Scotland who are unable to consent for themselves
- Healthy Volunteers
- Those who could be considered to have a particularly dependent relationship with the investigator, e.g. those in care homes, medical students
- Other vulnerable groups

Justify their inclusion.

The study aims to look at the emotional impact of early experience in patients with Bipolar Disorder compared with healthy matched control participants. The study therefore needs to access adults with mental illness and healthy control participants.

No participants from any of the above groups

Question(s) 24 1–5–25 disabled.

A26. Will informed consent be obtained from the research participants?

Yes No

If Yes, give details of who will take consent and how it will be done. Give details of any particular steps to provide information (in addition to a written information sheet) e.g. videos, interactive material.

If participants are to be recruited from any of the potentially vulnerable groups listed in A24, give details of extra steps taken to assure their protection. Describe any arrangements to be made for obtaining consent from a legal representative.

If consent is not to be obtained, please explain why not.

Clinical participants who agree to participate in the study will be asked to sign 3 identical consent forms at the time of their appointment with the Chief Investigator to confirm their consent is informed and that they are willing to participate. One consent form will be retained by the Chief Investigator, one will be stored in the participant's medical notes and one will be given to the participant for their own records.

The procedure of gaining consent is the same for healthy control participants, although only 2 copies of the consent form will be signed as one will not be required for their medical records.

If participants express a desire for copies of their completed rating scales being forwarded to their Key Worker, they will be asked to sign another Consent Form. Again, one copy will be retained by the Chief Investigator, one will be stored in the participant's medical records, and one will be offered to the participant for their own records.

Copies of the written information and all other explanatory material should accompany this application.

A27. Will a signed record of consent be obtained?

Yes No

If Yes, attach a copy of the information sheet to be used, with a version number and date.

A28. How long will the participant have to decide whether to take part in the research?

Participants will be approached and asked to take part in the study and then given as long as they require to decide, for example, they may wish to wait until their next outpatient appointment. The Chief Investigator will contact potential participants by telephone 3 working days after their first contact at an out-patients clinic. If the potential participant has not yet decided whether they would like to participate in the research, the Chief Investigator will ask for a suitable time for them to contact them again.

Potential control participants who contact the Chief Investigator for further information will be asked for their name, address and contact telephone number. A copy of the Information Sheet will be sent to them along with a cover letter within three working days of their initial contact, which will provide them with sufficient information about the study. The letter will also explain that the Chief Investigator will contact them by telephone after 3 working days to discuss their participation in the study. Again, if they have not had the opportunity to make a fully informed decision, the Chief Investigator will ask them for an appropriate time to contact them again.

A29. What arrangements have been made for participants who might not adequately understand verbal explanations or written information given in English, or who have special communication needs? (e.g. translation, use of interpreters etc.)

The rating scales being used in the study have been standardised in English, and the interview with the clinical participants with a diagnosis of Bipolar Disorder is being done so without the use of interpreters due to limited resources. As such, only those whose first language is English will be recruited for participation in the study.

As stated, potential participants who have a learning disability will be excluded from the research. However, it is acknowledged that some participants may have an undiagnosed mild learning disability or may have literacy difficulties such as dyslexia and as such they may have difficulty in reading the Information Sheet and completing the Consent Form and rating scales. As such, the Chief Investigator will offer all participants the opportunity to have the Information Sheet, Consent Form and all rating scales read to them and completed collaboratively.

Question(s) 30–32b disabled.

A33. Will individual research participants receive any payments for taking part in this research?

Yes No

A34. Will individual research participants receive *reimbursement of expenses* or any other *incentives or benefits* for taking part in this research?

Yes No

If Yes, indicate how much and on what basis this has been decided:

If participants would prefer to meet at a Hampshire Partnership Trust resource or the University of Southampton rather than in their homes, they will be reimbursed their travel expenses. No other financial incentive will be offered.

A35. Insurance/indemnity to meet potential legal liabilities

Note: References in this question to NHS indemnity schemes include equivalent schemes provided by Health and Personal Social Services (HPSS) in Northern Ireland.

A35–1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research?

Note: Where a NHS organisation has agreed to act as the sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, describe the arrangements and provide evidence.

NHS indemnity scheme will apply
 Other insurance or indemnity arrangements will apply (give details below)

University of Southampton insurance will apply.

Please enclose a copy of relevant documents.

A35–2. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research?

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), describe the arrangements and provide evidence.

NHS indemnity scheme will apply to all protocol authors
 Other insurance or indemnity arrangements will apply (give details below)

University of Southampton insurance will apply.

Please enclose a copy of relevant documents.

A35-3. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of investigators/collaborators and, where applicable, Site Management Organisations, arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through NHS schemes or through professional indemnity. Indicate if this applies to the whole of the study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, describe the arrangements which will be made at these sites and provide evidence.

All participants will be recruited at NHS sites and NHS indemnity scheme or professional indemnity will apply
 Research includes non-NHS sites (give details of insurance/indemnity arrangements for these sites below)

University of Southampton insurance may also apply.

Please enclose a copy of relevant documents.

Question(s) 36 disabled.

A37. How is it intended the results of the study will be reported and disseminated? (Tick as appropriate)

Peer reviewed scientific journals
 Internal report
 Conference presentation
 Other publication
 Submission to regulatory authorities
 Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
 Written feedback to research participants
 Presentation to participants or relevant community groups
 Other/none e.g. Cochrane Review, University Library

A38. How will the results of research be made available to research participants and communities from which they are drawn?

Research participants will be informed during debriefing that if they wish to receive information on the outcome of the study they can be sent a lay summary of the outcome on completion of the study. In these cases, a list of participants names and addresses will be stored securely away from other data gathered as a part of the study until the summary has been prepared.

In addition, the Chief Investigator will offer to present the findings of the research to the local Southampton group of the Manic Depression Fellowship as well as to staff at local Community Mental Health Trust resources.

A39. Will the research involve any of the following activities at any stage (including identification of potential research participants)? (Tick as appropriate)

- Examination of medical records by those outside the NHS, or within the NHS by those who would not normally have access
- Electronic transfer by magnetic or optical media, e-mail or computer networks
- Sharing of data with other organisations
- Export of data outside the European Union
- Use of personal addresses, postcodes, faxes, e-mails or telephone numbers
- Publication of direct quotations from respondents
- Publication of data that might allow identification of individuals
- Use of audio/visual recording devices
- Storage of personal data on any of the following:
 - Manual files including X-rays
 - NHS computers
 - Home or other personal computers
 - University computers
 - Private company computers
 - Laptop computers

Further details:

Potential participants will be approached at out-patient clinics by the Chief Investigator and given a copy of the Patient Information Sheet. They will be asked if they would be interested in being involved, and if so they will be asked to provide a contact number for the Chief Investigator to use to contact them after a 3 days to discuss their participation further.

Participants who agree to take part will be asked to sign a consent form which, along with all other identifying information will be stored securely in a locked facility at the University of Southampton, in accordance with university policy, separate from anonymised rating scales, interview transcripts of tape recordings of the interview.

It will be necessary to take down the name, address and contact telephone number of any participant who wishes to receive details of the outcome of the study. This information will be kept separately from any of the anonymous data.

A40. What measures have been put in place to ensure confidentiality of personal data? Give details of whether any encryption or other anonymisation procedures have been used and at what stage:

Data will be treated as confidential at all times and all rating scales, interview transcripts and tapes will be anonymised. Data will be stored in coded fashion on a password protected computer to which only the Chief Investigator has access.

The 'key' which will link the codes with the participants will be stored separately in a locked facility at the University of Southampton in compliance with university policy.

Before the taping of the interviews with clinical participants, each participant will be informed that in order to maintain their anonymity and confidentiality, the Chief Investigator will not refer to them by name throughout the duration of the interview. These tapes and their transcripts will be coded and stored separately from the identifying information and the coded rating scales. Tapes will be transcribed by the Chief Investigator to further maintain participants' anonymity. In the final report, any direct quotations used will not include any identifiable information.

A41. Where will the analysis of the data from the study take place and by whom will it be undertaken?

The analysis of the data will take place at the University of Southampton by the Chief Investigator and the University supervisor.

A42. Who will have control of and act as the custodian for the data generated by the study?

The University of Southampton.

A43. Who will have access to research participants' or potential research participants' health records or other personal information? Where access is by individuals outside the normal clinical team, justify and say whether consent will be sought.

The Chief Investigator and supervisors only. The supervisors will only have access to anonymised data and have contracts within the NHS.

A44. For how long will data from the study be stored?

10 Years 0 Months

Give details of where they will be stored, who will have access and the custodial arrangements for the data:

Anonymised data (original paper form, tape transcripts, interview recordings and inputted group data on computer disk for analysis) will be kept in locked storage within the School of Psychology at the University of Southampton in line with current university guidelines on storage times.

A45-1. How has the scientific quality of the research been assessed? (Tick as appropriate)

- Independent external review
- Review within a company
- Review within a multi-centre research group
- Review within the Chief Investigator's institution or host organisation
- Review within the research team
- Review by educational supervisor
- Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:

An internal review at the University of Southampton was carried out by an academic other than the listed supervisor in the School of Psychology. In addition, the study has been reviewed and approved by the University of Southampton School of Psychology Ethics Committee.

A45-2. How have the statistical aspects of the research been reviewed? (Tick as appropriate)

- Review by independent statistician commissioned by funder or sponsor
- Other review by independent statistician
- Review by company statistician
- Review by a statistician within the Chief Investigator's institution
- Review by a statistician within the research team or multi-centre group
- Review by educational supervisor
- Other review by individual with relevant statistical expertise

In all cases give details below of the individual responsible for reviewing the statistical aspects. If advice has been provided

in confidence, give details of the department and institution concerned.

Title: Forename/Initials: Surname:

Dr. Ineke Pit-ten Cate

Department: School of Psychology

Institution: University of Southampton

Work Address: Highfield
Southampton

Postcode: SO17 1BJ

Telephone: 023 8059 5321

Fax:

Mobile:

E-mail: ip@soton.ac.uk

Please enclose a copy of any available comments or reports from a statistician.

Question(s) 46–47 disabled.

A48. What is the primary outcome measure for the study?

There are 2 primary outcome measures for the current study. The first is the score of shame as measured by the Internalized Shame Scale and the second is the level of trauma measured by the Childhood Trauma Questionnaire (both the original and revised format of the scale).

A49. What are the secondary outcome measures? (if any)

Current mental state:

Internal States Scale

Hospital Anxiety and Depression Scale (HADS)

Resource Loss:

Conservation of Resources – Evaluation (COR-E)

A50. How many participants will be recruited?

If there is more than one group, state how many participants will be recruited in each group. For international studies, say how many participants will be recruited in the UK and in total.

A total of 80 participants will be recruited (40 clinical participants and 40 healthy control participants).

A51. How was the number of participants decided upon?

This sample size was calculated using a formal power calculation.

If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.

Research by Gilbert (2000) comparing depressed participants with a healthy control group found a high significant difference between the two groups on a measure of shame (Depressed group $m=51.42$, $SD=9.87$ $\alpha=.82$. Healthy controls, $m=45.81$, $SD=9.06$, $\alpha=.76$). A Cohen's D effect size of .60 (power = 92.8%) was found. For this research, 80% power is sufficient (significance level of .05). A power calculation revealed that a sample size of 35 per group (experimental and control) is sufficient to find similar group differences. To allow for attrition, 5 extra participants will be recruited to each group to maintain the power of the study.

A52. Will participants be allocated to groups at random? Yes No**A53. Describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.**

To answer the research questions, Independent T-tests will be used to compare the experimental and control groups on each measure. Despite the low sample size, a regression analysis may be calculated using shame and trauma as predictors and Bipolar Disorder as the outcome measure in order to investigate research question 3.

It may be possible to use another regression approach where shame is the outcome variable and past and current trauma are the predictors to test the link between current experiences and trauma/shame. However, the potential difficulties of collinearity are acknowledged.

It is hoped that missing data will not be encountered. For participants who withdraw or do not comply with the instructions or procedure, additional participants will be recruited to provide the data required.

For the brief interview used to gather information about participants' experience of their illness, a content analysis will be used to analyse the qualitative data gathered. This will involve identifying any themes that run throughout each of the participants' to see if there are underlying similarities in the experiences of participants.

A54. Where will the research take place? (Tick as appropriate)

- UK
- Other states in European Union
- Other countries in European Economic Area
- Other

If Other, give details:

A55. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK, the European Union or the European Economic Area? Yes No**A56. In how many and what type of host organisations (NHS or other) in the UK is it intended the proposed study will take place?**

Indicate the type of organisation by ticking the box and give approximate numbers if known:

	Number of organisations
<input type="checkbox"/> Acute teaching NHS Trusts	
<input type="checkbox"/> Acute NHS Trusts	
<input type="checkbox"/> NHS Primary Care Trusts or Local Health Boards in Wales	
<input checked="" type="checkbox"/> NHS Trusts providing mental healthcare	1

- NHS Health Boards in Scotland
- HPSS Trusts in Northern Ireland
- GP Practices
- NHS Care Trusts
- Social care organisations
- Prisons
- Independent hospitals
- Educational establishments
- Independent research units
- Other (give details)

Other:

N/A

A57. What arrangements are in place for monitoring and auditing the conduct of the research?

Trust Research and Development (R&D) will be responsible for monitoring the conduct of the research. In addition, regular supervision sessions will be held with both the research supervisors to monitor progress and conduct of the study. As a part of the Doctoral Programme in Clinical Psychology dissertation process, the Chief Investigator is required to provide regular reports to the School of Psychology regarding the progress of the research.

Question(s) 57a disabled.

A58. Has external funding for the research been secured?

Yes No

If No, what arrangements are being made to cover any costs of the research? If no external funding is being sought, please say so:

No external funding is being sought.

A59. Has the funder of the research agreed to act as sponsor as set out in the Research Governance Framework?

Yes No

Has the employer of the Chief Investigator agreed to act as sponsor of the research?

Yes No

Lead sponsor (must be completed in all cases)

Name of organisation which will act as the lead sponsor for the research:

University of Southampton

Status:

NHS or HPSS care organisation Academic Pharmaceutical industry Medical device industry Other

If Other, please specify:

N/A

Address: Highfield,
Southampton.

Post Code: SO17 1BJ

Telephone: 023 8059 8848

Fax:

Mobile:

E-mail:

Sponsor's UK contact point for correspondence with the main REC (must be completed in all cases)

Title: Dr. Forename/Initials: Martina Surname: Dorward

Work Address: Room 4009, Legal Services, Building 37,
Highfield, Southampton
Hampshire

Post Code: SO17 1BJ

Telephone: 023 8059 8848

Fax: 023 8059 5781

Mobile:

E-mail: mad4@soton.ac.uk

Co-sponsors**Are there any co-sponsors for this research?** Yes No**A60. Has any responsibility for the research been delegated to a subcontractor?** Yes No**A61. Will individual *researchers* receive any personal payment over and above normal salary for undertaking this research?** Yes No**A62. Will individual *researchers* receive any other benefits or incentives for taking part in this research?** Yes No**A63. Will the host organisation or the researcher's department(s) or institution(s) receive any payment or benefits in excess of the costs of undertaking the research?** Yes No

A64. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share-holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

Yes No

A65. Research reference numbers: (give any relevant references for your study):

Applicant's/organisation's own reference number, e.g. R&D (if available): CLIN/04/39

Sponsor's/protocol number: RGO5117

Funder's reference number: N/A

Project website: N/A

A66. Other key investigators/collaborators (all grant co-applicants or protocol co-authors should be listed)

Title: Dr.

Forename/Initials: Anke

Surname: Karl

Post: Lecturer in Clinical Psychology

Qualifications: Vordiplom (B.A. Psychology); Diplom (MPhil Psychology); Dr.rer.nat. (PhD, summa cum laude).

Organisation: University of Southampton

Work Address: Shackleton Building (Building 44),
Highfield, Southampton,
Hampshire

Postcode: S017 1BJ

Telephone: 023 8059 2633

Fax:

Mobile:

E-mail: A.Karl@soton.ac.uk

Title: Dr

Forename/Initials: Katie

Surname: Ashcroft

Post: Consultant Specialist Clinical Psychologist

Qualifications: Hons degree (Applied Psychology); M.Phil., C.Clin.Psychol

Organisation: Hampshire Partnership Trust

Work Address: Early Intervention in Psychosis Service
Fairways House, Mount Pleasant Road
Southampton, Hampshire.

Postcode: SO14 0SP

Telephone: 023 8024 1339

Fax: 023 8024 1352

Mobile:

E-mail: katie.ashcroft@hantspt-sw.nhs.uk

Title: Dr

Forename/Initials: Susan

Surname: Ross

Post: Consultant Clinical Psychologist

Qualifications: BA (Hons); D.Clin.Psychol.; Diploma in Cognitive Therapy, Newcastle Cognitive Therapy Centre; MSc Clinical Psychology

Organisation: Hampshire Partnership Trust

Work Address: Department of Psychiatry,
Royal South Hants, Brintons Terrace,
Southampton, Hampshire
Postcode: SO14 0YG
Telephone: 023 8082 5531
Fax:
Mobile:
E-mail: Su.Ross@wht.nhs.uk

Question(s) 67 disabled.

PART A: Summary of Ethical Issues

A68. What are the main ethical issues with the research?

Summarise the main issues from the participant's point of view, and say how you propose to address them.

1. Participants experiencing distress during or following completion of questionnaires and/or interview.

To control for potential distress, participants will be debriefed after the completion of the procedure. Using their skills as a Trainee Clinical Psychologist, the Chief Investigator will assess the participant's mood and coping relating to the issues discussed. Should participants become distressed, they will be asked "How will you cope?" and all participants will be asked "Is there anyone that you would like to inform about this research? Who is that person?" The Chief Investigator will suggest that should they wish, a copy of the completed measures, or any specific issues raised during the test session can be sent to their Key Worker. Participants will be asked to sign a consent form if they wish for copies of their forms to be sent to a relevant member of staff involved in their care. They will also discuss linking with existing services should the need arise. The Chief Investigator will also suggest that if necessary, they will meet with the participant and their Key Worker to discuss ways to deal with the distress. If their mood is low during the procedure or at the end, the Chief Investigator will use their clinical judgment to ask about suicidal ideation (i.e. any plans they have made and any preventative factors). In the unlikely event that the Chief Investigator feels the participant needs additional support this will be arranged.

2. Breaching Confidentiality

No identifying information will be kept with data. As explained, all efforts will be made to maintain the confidentiality and anonymity of all participants. All completed rating scales, interview tapes and transcripts will be coded with a unique code and the 'key' linking these codes with participants will be stored separately and securely on a password-protected computer to which only the Chief Investigator has access. Only the Chief Investigator and the supervisors of the project will have access to data and even then, the supervisors will only be able to access the anonymised data. Any participants wishing to be sent details of the outcome of the research will need to provide details of where to send the information. The contact details of any participant wishing to be sent information of the research findings will be stored separately away from the anonymised data sets. The researcher responsible for keeping the data will do so in accordance with research governance guidelines and University of Southampton policy.

If participants become distressed during the completion of the rating scales, it may be necessary to breach confidentiality by reporting to the Duty Officer or Home Treatment Service. However, in the interests of maintaining transparency, this will be discussed with the participant and the protocol for reporting distress or feelings of suicidality will be explained to them thoroughly.

In addition, it is possible that as a result of completing rating scales about current experiences of trauma, participants may report current and ongoing abuse, for example at the hands of a partner or parent. As such, the Chief Investigator has a duty of care to inform the participant that they will need to breach confidentiality and report the disclosure to the police and/or the necessary personnel in order to maintain the physical and medical integrity of the participant. In all cases, any potential action will be discussed with the participant.

Indicate any issues on which you would welcome advice from the ethics committee.

Question(s) 69 disabled.

PART A: Student Page**A70. Give details of the educational course or degree for which this research is being undertaken:**

Name of student:

Alex Fowke

Name and level of course/degree:

Doctoral Training Programme in Clinical Psychology

Name of educational establishment:

University of Southampton

Name and contact details of educational supervisor:

Dr. Anke Karl
University of Southampton
Shackleton Building (Building 44)
Highfield
Southampton
SO17 1BJ

A71. Declaration of educational supervisor

I have read and approved both the research proposal and this application for the ethical review. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level. I undertake to fulfil the responsibilities of a supervisor as set out in the Research Governance Framework for Health and Social Care.

Signature:

Print Name: Dr. Anke Karl

Date: 09/05/2007 (dd/mm/yyyy)

A one-page summary of the supervisor's CV should be submitted with the application

PART B: Section 7 – Declarations**Declaration by Chief Investigator**

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
2. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.
3. If the research is approved I undertake to adhere to the study protocol, the terms of the full application of which the main REC has given a favourable opinion and any conditions set out by the main REC in giving its favourable opinion.
4. I undertake to seek an ethical opinion from the main REC before implementing substantial amendments to the protocol or to the terms of the full application of which the main REC has given a favourable opinion.
5. I undertake to submit annual progress reports setting out the progress of the research.
6. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer.
7. I understand that research records/data may be subject to inspection for audit purposes if required in future.
8. I understand that personal data about me as a researcher in this application will be held by the relevant RECs and their operational managers and that this will be managed according to the principles established in the Data Protection Act.
9. I understand that the information contained in this application, any supporting documentation and all correspondence with NHS Research Ethics Committees or their operational managers relating to the application:
 - Will be held by the main REC until at least 3 years after the end of the study.
 - May be disclosed to the operational managers or the appointing body for the REC in order to check that the application has been processed correctly or to investigate any complaint.
 - May be seen by auditors appointed by the National Research Ethics Service to undertake accreditation of the REC.
 - Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.

Optional – please tick as appropriate:

I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

Signature:

Print Name: Alex James Fowke

Date: 09/05/2007 (dd/mm/yyyy)

Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co-sponsors by a representative of the sponsor nominated to take the lead for the REC application.

I confirm that: (tick as appropriate)

- This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.
- An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.*
- Any necessary indemnity or insurance arrangements, as described in question A35, will be in place before this research starts.
- Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.
- Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.
- The duties of sponsors set out in the NHS Research Governance Framework for Health and Social Care will be undertaken in relation to this research.**

* Not applicable to student research (except doctoral research).

** Not applicable to research outside the scope of the Research Governance Framework.

Signature:

Print Name: Dr. Martina Dorward

Post: Research Governance Manager

Organisation: University of Southampton

Date: 09/05/2007 (dd/mm/yyyy)

Site-Specific Information Form

Does this application relate to a research site for which the NHS (or HPSS in Northern Ireland) is responsible or to a non-NHS research site?

NHS site
 Non-NHS site

For HPSS sites in Northern Ireland, separate arrangements are in place for R&D applications. There is no need to complete questions marked "R&D only" on this form.

This question must be completed before proceeding. The filter will customise the form, disabling questions which are not relevant to this application.

The data in this box is populated from Part A:

Short title and version number:

The Emotional Impact of Early Experience in Bipolar Disorder

Name of NHS Research Ethics Committee to which application for ethical review is being made:
Southampton and South West Hampshire Research Ethics Committee

Project reference number from above REC: 07/Q1702/68

Name of NHS care organisation to which application is being made for permission to conduct the research:
Hampshire Partnership Trust

NHS organisation reference (for R&D office use only):

1. Title of the research (populated from A1)

Full title: The Emotional Impact of Early Experience in Bipolar Disorder
Key words: Bipolar Disorder, Emotion, Trauma, Abuse, Shame.

2. Name of Chief Investigator (populated from A2)

Title: Forename/Initials: Surname:
Mr Alex Fowke

3. Name of organisation acting as lead sponsor for the study (populated from A59)

University of Southampton

4. Research reference numbers if known (populated from A65)

Applicant's/organisation's own reference number, e.g. R&D:	CLIN/04/39
Sponsor's/protocol number:	RGO5117
Funder's reference number:	N/A
Project website:	N/A

6. Give the name of the NHS site within or through which the research will take place under the responsibility of the PI or Local Collaborator. Please give the name only. Further details of locations should be given in question 8. The name of the site is normally the name of the relevant NHS organisation. Each NHS general or dental practice is a separate site unless a formal consortium/network is in place.

Hampshire Partnership Trust

Is this a primary care site?

Yes No

If Yes, give the name of the primary care organisation responsible for the site below:

8. Specify all locations, departments, groups or units at which or through which research procedures will be conducted at this site and describe the activity that will take place.

List all locations/departments etc where research procedures will be conducted within the NHS organisation, describing the involvement in a few words. Where access to specific facilities will be required these should also be listed for each location.

Name the main location/department first. Include details of any centres at other NHS organisations where potential participants may be seen or referred for inclusion in the research at this site. Give details of any research procedures to be carried out off site, for example in participants' homes.

	Location	Activity/facilities
1	Hampshire Partnership Trust	Completion of rating scales (and semi-structured interview with clinical participants)
2	Participants' own homes	Completion of rating scales (and semi-structured interview with clinical participants)
3	University of Southampton	Completion of rating scales (and semi-structured interview with clinical participants)

12. Who is the Principal Investigator or Local Collaborator for this research at this site?

Title: Forename/Initials: Surname:
Mr Alex Fowke

Post: Trainee Clinical Psychologist

Qualifications: B.Sc. (Hons) Psychology, M.Sc. Health Psychology

Organisation: Taunton and Somerset NHS Trust

Work Address: Department of Clinical Psychology

34 Bassett Crescent East, University of Southampton Telephone: 023 8059 5321
Southampton, Hampshire Fax: N/A

Postcode: SO16 7PB Mobile: 07989 341559

E-mail: ajf105@soton.ac.uk

R&D Only

a) Will this person interact with research participants, their organs, tissue or data in a way that has a direct bearing on the quality of care?

Yes No

b) Does this person hold a current substantive or honorary contract with the NHS organisation or accepted by the NHS organisation?

Yes No

Please provide a copy of the c.v. for the PI.

If an honorary contract is held, a copy of the contract should be submitted, unless previously provided to the R&D office.

14. Give details of all other members of the research team at this site, including academic supervisors and all people who will interact with research participants, their organs, tissue or data in a way that has a direct bearing on the quality of care.

1. Research Member

Title: Forename/Initials: Surname:

Dr Katie Ashcroft

Employing organisation: Hampshire Partnership Trust

Post: Consultant Specialist Clinical Psychologist

Qualifications: Hons degree (Applied Psychology); M.Phil., D.Clin.Psychol.

Role in research team: other: Research Supervisor

R&D Only

a) Will this person interact with research participants, their organs, tissue or data in a way that has a direct bearing on the quality of care?

Yes No

b) Does this person hold a current substantive or honorary contract with the NHS organisation or accepted by the NHS organisation?

Yes No

2. Research Member

Title: Forename/Initials: Surname:

Dr Su Ross

Employing organisation: Hampshire Partnership Trust

Post: Consultant Clinical Psychologist

Qualifications: BA (Hons); D.Clin.Psychol.; Diploma in Cognitive Therapy, Newcastle Cognitive Therapy Centre; MSc Clinical Psychology

Role in research team: other: Research Supervisor

R&D Only

a) Will this person interact with research participants, their organs, tissue or data in a way that has a direct bearing on the quality of care?

Yes No

b) Does this person hold a current substantive or honorary contract with the NHS organisation or accepted by the NHS organisation?

Yes No

3. Research Member

Title: Forename/Initials: Surname:

Dr Anke Karl

Employing organisation: University of Southampton

Post: Lecturer in Clinical Psychology

Qualifications: Vordiplom (B.A. Psychology); Diplom (MPhil Psychology); Dr.rer.nat. (PhD, summa cum laude).

Role in research team: other: Research Supervisor

R&D Only

a) Will this person interact with research participants, their organs, tissue or data in a way that has a direct bearing on the quality of care?

 Yes No

b) Does this person hold a current substantive or honorary contract with the NHS organisation or accepted by the NHS organisation?

 Yes No

15. Does the Principal Investigator or any other member of the site research team have any direct personal involvement (e.g. financial, share-holding, personal relationship etc) in the organisation sponsoring or funding the research that may give rise to a possible conflict of interest?

 Yes No

If Yes, give further details:

16. What is the proposed local start and end date for the research at this site?

Start date: 01/07/2007 (dd/mm/yyyy)

Duration (Months): 11

End date: 01/06/2008 (dd/mm/yyyy)

17. Summary of the research (populated from A10-1)

The research is informed by psychological theory which considers that patients with a variety of psychiatric illnesses report higher levels of background trauma and shame compared with healthy control participants. The aim of the current research is to assess the levels of background trauma, i.e. trauma experienced during childhood, in participants with a diagnosis of Bipolar Disorder. The research also aims to assess more recent traumatic experiences, as well as levels of shame reported by this client group.

The protocol has been peer-reviewed and a member of the target population has been consulted on the design and procedure of the study. Any ideas or recommendations have been incorporated into the protocol where possible.

Two groups of participants will be recruited. One group of clinical participants will be recruited through Consultant Psychiatrists and Staff Grade doctors from Hampshire Partnership Trust. A control group of healthy adults with no reported mental health difficulties will be recruited using local advertising.

Clinical participants will be adult out-patients (over the age of 18 years) with a primary diagnosis of Bipolar Disorder. Consultant Psychiatrists and mental health teams in Hampshire Partnership Trust will be approached to ask if they would consent to the Chief Investigator approaching patients of theirs who have a diagnosis of Bipolar Disorder to discuss the study. The patient's Consultant Psychiatrist will be provided with an Information Sheet outlining the purpose of the research and the procedure of the study. The individual patients will then be approached at out-patient clinics and will be given an explanation of the study and an Information Sheet and be asked if they would consider being involved. If they express an interest in participating, they will be asked for their name and a contact number which the Chief Investigator will use to contact them after 3 days to discuss their participation

further.

If insufficient numbers of participants are recruited this way, the Chief Investigator will approach the Manic Depression Fellowship (MDF), the Bipolar Disorder organisation. The Chief Investigator will write a letter to the organisers of the local Southampton MDF group along with a copy of the Information Sheet, offering the opportunity for the group to participate in the study. The Chief Investigator will offer to present the study at one of the group's meetings and offer members the opportunity to give their contact details should they wish to participate or want further information about participation in the study. Following their consent to participate, the recruitment procedure outlined previously will be employed. Where possible, MDF members who are under the care of NHS mental health services but not Hampshire Partnership Trust will not be recruited. The Chief Investigator does not anticipate that this will happen, however, should there be sufficient numbers of non-Hampshire Partnership Trust NHS patients willing to participate, then an application to MREC will follow.

Control participants will be matched to clinical participants based on gender, age, and socio-economic status. In order to recruit appropriate control participants, three different recruitment procedures will be employed. The first method of recruitment will involve advertising by placing posters around the University of Southampton advertising for volunteers to participate in the study. Potential participants will be able to contact the Chief Investigator for further information using the contact telephone number and/or email address on the poster. Those who contact the Chief Investigator for further information will be asked for their name, address and contact telephone number. A copy of the Information Sheet will be sent to them along with a cover letter within 3 working days of the initial contact, which will provide them with sufficient information about the study. The letter will also explain that the Chief Investigator will contact them by telephone after 3 working days to discuss their participation in the study.

If insufficient numbers of appropriately-matched participants are recruited through the University, the Chief Investigator will recruit further participants through advertisements in local newspapers. The final recruitment procedure will use a 'snowballing technique' amongst family and friends, whereby people known to the Chief Investigator will be asked to pass on Information Sheets to acquaintances who match the profile of the clinical participants, that is, are similar in age, socio-economic status and gender to the clinical sample.

Following their decision to participate, the Chief Investigator will contact each clinical and control participant individually after 3 working days of their expressing an interest and agreeing to take part in the research to arrange a convenient time to meet with them and conduct the research. Participants may decide to meet at a Hampshire Partnership Trust resource, the University of Southampton or at their own home as convenient to them. At this meeting, participants will be asked to read and sign 3 identical Consent Forms (one copy of which will be retained by the Chief Investigator, one for the participant's medical notes, and one given to the participant). A demographic form recording basic information about the participant, including date of birth, age, gender and years of education will be administered following the participant completing the Consent Forms.

As a part of the procedure all participants will be asked to complete each of the rating scales. These will be presented in sequence by the Chief Investigator in the following order: the Internal States Scale, the Hospital Anxiety and Depression Scale, the original format of the Childhood Trauma Questionnaire, the Internalized Shame Scale, the revised version of the Childhood Trauma Questionnaire, and the Conservation of Resources Evaluation. The Chief Investigator will be present throughout the procedure if they require any assistance, have any questions or concerns, or wish to withdraw. The Chief Investigator will offer each participant the opportunity to have the Consent Form, Information Sheet and all rating scales read to them to ensure thorough understanding and to avoid any difficulties caused by any potential undiagnosed learning disability or literacy difficulties.

Prior to completing the rating scales, the participants in the clinical group will be briefly interviewed following a semi-structured interview schedule about their experiences of Bipolar Disorder. Control participants will not be interviewed, because as a result of the exclusion criteria, they will not have a history of mental health problems.

It is expected that completing the rating scales will take about 30 to 45 minutes. The interview conducted with the clinical participants is expected to last approximately 15 minutes.

Following the completion of the rating scales (and the interview in the case of clinical participants), participants will be verbally debriefed and given a copy of the debriefing statement. Any questions they have will be answered before being thanked for their participation.

The Childhood Trauma Questionnaire has been used by researchers in Hampshire Partnership Trust in research with various psychiatric populations, including Schizophrenia and Borderline Personality Disorder, and no major difficulties have been encountered. However, it is acknowledged that the completion of rating scales looking at trauma and shame are areas in which participants may potentially become distressed. In the unlikely event that participants become upset as a result of completing the rating scales or answering questions in the interview, the Chief Investigator will allow the participant to discuss the issues causing them distress and will use their skills as a

Trainee Clinical Psychologist to assess the participant's mood and coping relating to the issues discussed. Should participants become distressed, they will be asked "How will you cope?" and all participants will be asked "Is there anyone that you would like to inform about this research? Who is that person?" The Chief Investigator will suggest that should the participant wish so, a copy of the completed measures, or any specific issues raised during the test session can be sent to their Key Worker. Participants will be asked to sign a consent form if they wish for copies of their forms to be sent to a relevant member of staff involved in their care. They will also discuss linking with existing services should the need arise. The Chief Investigator will also suggest that if necessary, they will meet with the participant and their Key Worker to discuss ways to deal with the distress. If their mood is low during the procedure or at the end, the Chief Investigator will use their clinical judgment to ask about suicidal ideation (i.e. any plans they have made and any preventative factors). In the unlikely event that the they feel the participant needs additional support this will be arranged by contacting the Duty Worker and the Home Treatment Service.

There will be no deception involved in this study and all data will be anonymised. The name and address of any participant who wishes to receive information about the outcome of the study will be stored securely separately from the data sheets.

19. Details of non-clinical interventions (populated from A13 where enabled)

Additional Intervention	Average number per participant	Anticipated average time taken	Details of additional intervention or procedure, who will undertake it, and what training they have received.
Face to Face Interview	1	15 minutes	<p>Clinical participants will be briefly interviewed about their experiences of Bipolar Disorder. Questions will investigate issues in participants' lives around periods of illness, their perceived reactions of family and friends to their illness and any beliefs that they hold about their illness. Further questions will stem from participants' responses to these general questions.</p> <p>Healthy control participants will not be interviewed because as a result of the exclusion criteria, they will not have a history of mental health problems.</p> <p>The Chief Investigator is a Trainee Clinical Psychologist and has over 4 years experience of conducting face-to-face clinical interviews with NHS patients as well as experience conducting qualitative and quantitative research with clinical samples.</p> <p>This interview will take place either at a Hampshire Partnership Trust resource, the University of Southampton or their own homes, whichever is most convenient to them. Only the participant and the Chief</p>

			<p>Investigator will be present during the procedure unless participants prefer to meet at their own homes, when their Key Worker or care co-ordinator will also be present.</p>
Other Questionnaire	5	45 minutes	<p>The following standardised self-report rating scales will be used:</p> <ol style="list-style-type: none"> 1. Internal States Scale. 2. Hospital Anxiety and Depression Scale (HADS) 3. Childhood Trauma Questionnaire (CTQ) 4. Internalized Shame Scale 5. Conservation of Resources – Evaluation (COR-E) <p>A copy of the CTQ is re-worded for participants in this study to rate their experiences of trauma in their adulthood. As such, no reliability data for this version is available.</p> <p>A basic demographic questionnaire will be used to record the personal details of participants, including date of birth, gender and years of education.</p> <p>The Chief Investigator is a Trainee Clinical Psychologist and has over 4 years experience of conducting face-to-face clinical interviews with NHS patients as well as experience conducting qualitative and quantitative research with clinical samples.</p> <p>Each participant will complete all self-report rating scales with the assistance of the Chief Investigator as required. The completion of these scales will take place either at a Hampshire Partnership Trust resource, the University of Southampton or their own homes, whichever is most convenient to them. Only the participant and the Chief Investigator will be present during the procedure unless participants prefer to meet at their own homes, when their Key Worker or care co-ordinator will also be present.</p>

20. Will any aspects of the research at this site be conducted in a different way to that described in Parts A and B or the study protocol?

Yes No

If Yes, explain and give reasons.

21. How many research participants/samples is it expected will be recruited/obtained from this site?

It is expected that 40 participants will be recruited from this site.

22. Give details of how potential participants will be identified locally and who will be making the first approach to them to take part in the study?

Two groups of participants will be recruited. One group of clinical participants will be recruited through Consultant Psychiatrists and Staff Grade doctors from Hampshire Partnership Trust. A control group of healthy adults with no reported mental health difficulties will be recruited using local advertising.

Clinical participants will be adult out-patients (over the age of 18 years) with a primary diagnosis of Bipolar Disorder. Consultant Psychiatrists and mental health teams in Hampshire Partnership Trust will be approached to ask if they would consent to patients of theirs with a diagnosis of Bipolar Disorder being approached about entering this study. The patient's Consultant Psychiatrist will be provided with an Information Sheet outlining the purpose of the research and the procedure of the study. The individual patients will then be approached at out-patient clinics and will be given an explanation of the study and an Information Sheet and be asked if they would consider being involved. If they express an interest in participating, they will be asked for their name and a contact number which the Chief Investigator will use to contact them after 3 days to discuss their participation further. If the participant has not yet made a fully informed decision at this time, the Chief Investigator will ask for another time to call.

If insufficient numbers of participants are recruited this way, the Chief Investigator will approach the Manic Depression Fellowship (MDF), the Bipolar Disorder organisation. The Chief Investigator will write a letter to the organisers of the local Southampton MDF group along with a copy of the Information Sheet, offering the opportunity for the group to participate in the study. The Chief Investigator will offer to come to one of their meetings and present the research

and offer group members the opportunity to give their contact details should they wish to participate or want further information about participation in the study. Following their consent to participate, the recruitment procedure outlined previously will be employed. Where possible, MDF members who are under the care of NHS mental health services but not Hampshire Partnership Trust will not be recruited. The Chief Investigator does not anticipate that this will happen, however, should there be sufficient numbers of non-Hampshire Partnership Trust NHS patients willing to participate, then an application to MREC will follow.

Control participants will be matched to clinical participants based on gender, age, and socio-economic status. In order to recruit appropriate control participants, three different recruitment procedures will be employed. The first method of recruitment will involve advertising by placing posters around the University of Southampton advertising for volunteers to participate in the study. Potential participants will be able to contact the Chief Investigator for further information using the contact telephone number and/or email address on the poster. Those who contact the Chief Investigator for further information will be asked for their name, address and contact telephone number. A copy of the Information Sheet will be sent to them along with a cover letter within 3 working days of the initial contact, which will provide them with sufficient information about the study. The letter will also explain that the Chief Investigator will contact them by telephone after 3 working days to discuss their participation in the study.

If insufficient numbers of appropriately-matched participants are recruited through the university, the Chief Investigator will recruit further participants using the second method of recruitment through advertisement in local newspapers. The final recruitment procedure will use a 'snowballing technique' amongst family and friends, whereby people known to the Chief Investigator will be asked to pass on Information Sheets to acquaintances who match the profile of the clinical participants, that is, are similar in age, socio-economic status and gender to the clinical sample.

Following their decision to participate, the Chief Investigator will contact each clinical and control participant individually after 3 working days of their agreeing to participate in the research to arrange a convenient time to meet with them and conduct the research.

At the beginning of the procedure, participants will be informed of their right to change their minds or to withdraw from the study without any consequences, in relation to their legal rights and medical care.

23. Who will be responsible for obtaining informed consent at this site? What expertise and training do these persons have in obtaining consent for research purposes?

1 <input checked="" type="checkbox"/>	Mr Alex Fowke	Training and practical experience in conducting clinical interviews with clients and research participants with psychiatric diagnoses.
2 <input type="checkbox"/>	Dr Katie Ashcroft	
3 <input type="checkbox"/>	Dr Su Ross	
4 <input type="checkbox"/>	Dr Anke Karl	

27. Is there a contact point where potential participants can seek independent advice about participating in the study?

Potential clinical participants can seek independent advice about participating in the study from the Research and Development managers at Hampshire Partnership Trust. Control participants can seek independent advice about their participation from the Research and Development managers at the University of Southampton. This information is made explicit in the Information Sheet.

R&D Only

28. Please provide a copy on headed paper of the participant information sheet and consent form that will be used locally. This must be the same generic version submitted to/approved by the main REC for the study while including relevant local information about the site, investigator and contact points for participants (see guidance notes).

If you consider that changes should be made to the generic content of the information sheet to reflect site-specific issues in the conduct of the study (see 20), give details below. A substantial amendment may need to be discussed with the Chief Investigator and submitted to the main REC.

29. What arrangements have been made for participants who might not adequately understand verbal explanations or written information given in English, or who have special communication needs? (e.g. translation, use of interpreters etc.) (Populated from A29)

The rating scales being used in the study have been standardised in English, and the interview with the clinical participants with a diagnosis of Bipolar Disorder is being done so without the use of interpreters due to limited resources. As such, only those whose first language is English will be recruited for participation in the study.

As stated, potential participants who have a learning disability will be excluded from the research. However, it is acknowledged that some participants may have an undiagnosed mild learning disability or may have literacy difficulties such as dyslexia and as such they may have difficulty in reading the Information Sheet and completing the Consent Form and rating scales. As such, the Chief Investigator will offer all participants the opportunity to have the Information Sheet, Consent Form and all rating scales read to them and completed collaboratively.

What local arrangements have been made to meet these requirements (where applicable)?n/a

30. What arrangements will be made to inform the GP or other health care professionals responsible for the care of the participants?

The researchers will inform the GP and any appropriate professional involved in their care of their patients' involvement in the study.

Participants will be offered copies of their questionnaires, or copies can be sent directly to those responsible for their care, to inform them of any issues that are disclosed during the course of the research. Participants will be asked to sign a consent form if they wish for copies of their forms to be sent to a relevant member of staff involved in their care.

33. What arrangements (e.g. facilities, staffing, psychosocial support, emergency procedures) will be in place at the site, where appropriate, to minimise the risks to participants and staff and deal with the consequences of any harm?

To control for potential distress, participants will be debriefed after the completion of the procedure. Using their skills as a Trainee Clinical Psychologist, the Chief Investigator will assess the participant's mood and coping relating to the issues discussed. Should participants become distressed, they will be asked "How will you cope?" and all participants will be asked "Is there anyone that you would like to inform about this research? Who is that person?" They will suggest that a copy of the completed measures, or any specific issues raised during the test session can be sent to their Key Worker. They will also discuss linking with existing services should the need arise. Participants will be asked to sign a consent form if they wish for copies of their forms to be sent to a relevant member of staff involved in their care. The Chief Investigator will also suggest that if necessary, they will meet with the participant and their Key Worker to discuss ways to deal with the distress. If their mood is low during the procedure or at the end, the Chief Investigator will use their clinical judgment to ask about suicidal ideation (i.e. any plans they have made and any preventative factors). In the unlikely event that they feel the participant needs additional support this will be arranged.

R&D Only**35. What are the arrangements for the supervision of the conduct of the research at this site? Give name and contact details of any supervisor not already listed in the application.**

The Chief Investigator will receive close clinical supervision by Dr. Su Ross and Dr. Katie Ashcroft. Academic Supervision will be provided by Dr. Anke Karl at the University of Southampton.

R&D Only**37. Will any external funding be provided for the research at this site?**

Yes No

If Yes, indicate the source and details of the funding:

R&D Only**38. Which organisation will receive and manage this funding?****R&D Only****39. Authorisations required prior to R&D approval**

This section deals with authorisations by managers within the NHS organisation. It should be signed in accordance with the guidance provided by the NHS organisation. This may include authorisation by line managers, service managers, support department managers, pharmacy, data protection officers or finance managers, depending on the nature of the research. Managers completing this section should confirm in the text what the authorisation means, in accordance with the guidance provided by the NHS organisation. This section may also be used by university employers or research staff to provide authorisation to NHS organisations, in accordance with guidance from the university.

Declarations**Declaration by Principal Investigator or Local Collaborator**

1. The information in this form is accurate to the best of my knowledge and I take full responsibility for it.
2. I undertake to abide by the ethical principles underpinning the World Medical Association's Declaration of Helsinki and relevant good practice guidelines in the conduct of research.
3. If the research is approved by the main REC and NHS organisation, I undertake to adhere to the study protocol, the terms of the application of which the main REC has given a favourable opinion and the conditions requested by the NHS organisation, and to inform the NHS organisation within local timelines of any subsequent amendments to the protocol.
4. If the research is approved, I undertake to abide by the principles of the Research Governance Framework for Health and Social Care.
5. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to the conduct of research.
6. I undertake to disclose any conflicts of interest that may arise during the course of this research, and take responsibility for ensuring that all staff involved in the research are aware of their responsibilities to disclose conflicts of interest.
7. I understand and agree that study files, documents, research records and data may be subject to inspection by the NHS organisation, the sponsor or an independent body for monitoring, audit and inspection purposes.
8. I take responsibility for ensuring that staff involved in the research at this site hold appropriate contracts for the duration of the research, are familiar with the Research Governance Framework, the NHS organisation's Data Protection Policy and all other relevant policies and guidelines, and are appropriately trained and experienced.
9. I undertake to complete any interim and/or final reports as requested by the NHS organisation and understand that continuation of permission to conduct research within the NHS organisation is dependent on satisfactory completion of such reports.
10. I undertake to maintain a project file for this research in accordance with the NHS organisation's policy.
11. I take responsibility for ensuring that all serious adverse events are handled within the NHS organisation's policy for reporting and handling of adverse events.
12. I understand that information relating to this research, and about me as a researcher, will be held by the R&D office and may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.
13. I understand that the information contained in this application, any supporting documentation and all correspondence with the R&D office and/or the REC system relating to the application will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
14. I understand that information relating to this research (including my contact details) may be publicly available through the National Research Register.

Signature of Principal Investigator
or Local Collaborator:

Print Name: Alex James Fowke
Date: 09/05/2007

The Emotional Impact of Early Experience in Bipolar Disorder

~ Research Protocol

Mr. Alex Fowke, (Chief Investigator) Trainee Clinical Psychologist, University of Southampton

Dr. Katie Ashcroft, Consultant Clinical Psychologist, Hampshire Partnership Trust

Dr. Su Ross, Consultant Clinical Psychologist, Hampshire Partnership Trust

Dr. Anke Karl, Lecturer in Clinical Psychology, University of Southampton

ETHICS NUMBER: 07/Q1702/68

VERSION: 2

DATE: 21.04.07

Bipolar disorder is a severe and enduring mental health problem. The estimated annual incidence is 7 per 100,000, with an estimated lifetime prevalence of 4-16 per 1000 in the general adult population. The condition is a cyclical mood disorder involving episodes of significant disruption to mood, characterised by periods of elevated mood or irritability, alternating with periods of depressed mood (National Institute for Clinical Excellence [NICE], 2006).

People with a serious mental illness (SMI) report a high incidence of background trauma, with a figure between 34% and 53% reporting childhood abuse (Darves-Bornoz, Lempérière, Degiovanni, & Gaillard, 1995). Draucker (1993) performed a content analysis on reflections of women who had disclosed a history of abuse and found different types of trauma including abandonment, powerlessness, violence, and shame.

Neria, Bromet, Carlson, & Naz (2005) report that 40% of a first-admission sample diagnosed with bipolar disorder with psychotic features reported exposure to trauma before their admission; 28% of patients reported having been assaulted in childhood. Similarly, Hyun, Friedman and Dunner (2000) report an increased rate of childhood abuse in patients with bipolar disorder compared with depressed patients. Conversely, Hammersley et al. (2003) consider patients with bipolar disorder to be no more traumatised than other groups. However, these studies are limited as they look at restricted samples of bipolar patients, or lack a control group for comparison, or limit trauma investigations to childhood sexual assault. As such, their conclusions have limited generalisability.

It has been suggested that internalized shame may result from incidents of childhood sexual abuse following the experience of the abuse as a personal attack on the self, leaving the individual feeling deeply defective and defeated. Survivors then continue to engage in activities that reinforce the low self-worth (Finkelhor & Browne, 1985). Furthermore, Feiring and Taska (2005) found that survivors of childhood sexual abuse were especially at risk for persistently high levels of shame 6 years following discovery and were more likely to report clinically significant feelings of intrusive recollections. As such, persistent shame may explain failure to process the abuse and the maintenance of PTSD symptoms. Further to PTSD symptomatology, Stockwell-Byde (2001) found significant correlations between internalized shame, depression and psychotism.

In addition to its links with mental illness, shame associated with trauma can create a barrier in therapy. Macdonald and Morley (2001) found that many clinical participants do not disclose emotional incidents due to their anticipating negative responses, including labelling and judging responses.

Anecdotal evidence suggests that individuals with bipolar disorder experience significant personal losses as a result of their being ill. For example, during manic episodes, clients can engage in activities so chaotic that they subsequently result in the breakdown of relationships and job losses. Individuals strive to obtain, retain, and protect those resources they consider valuable. Conservation of resources theory (COR; Hobfoll, 1988, 1989) proposes that when these resources are lost or threatened, the consequence is significant psychological stress. Acute stressful conditions often result in further stress because they result in rapid resource loss, as in the case of sudden illness or distress. In comparison, chronic stressful conditions gradually chip away at resources, even strong resource reservoirs. Freedy, Shaw, Jarrell and Master (1992) consider resource loss to be a risk factor for the development of clinically significant psychological distress. Furthermore, Schumm, Hobfoll and Keogh (2004) report that childhood abuse were associated with interpersonal resource loss in adulthood and were, in turn, seen to increase risk for the development of PTSD.

Rationale

The research is informed by psychological theory which considers that patients with a variety of psychiatric illnesses report higher levels of background trauma and shame compared with healthy control participants. Existing research regarding trauma in bipolar disorder have significant limitations, such as a small sample size, unsatisfactory methods of data collection and a restricted client group. As such, there is mixed evidence available

regarding the prevalence of trauma in clients with bipolar disorder. Anecdotal clinical reports suggest that clients with bipolar disorder experience significant shame and suffer significant losses associated with their manic behaviour. However, this is relatively unsubstantiated in the literature. As such, four research questions are proposed.

Research Questions

1. What is the level of trauma in clients with bipolar disorder?
2. What level of internalised shame do clients with bipolar disorder report?
3. What is the relationship between shame, trauma and bipolar disorder?
4. What is the response to these experiences in terms of resource loss?

Method

The following protocol has been peer-reviewed. In addition, a member of the target population has been consulted on the design and procedure of the study and any ideas or recommendations have been incorporated into the protocol where appropriate. This research is being conducted as part of the Doctoral Programme in Clinical Psychology at the University of Southampton.

Design

The current study is a between-subjects design. For all research questions, the Independent Variable (IV) is the participant group. For research question 1, the Dependent Variable (DV) is trauma, and shame is the DV for research questions 2. Shame and trauma are both predictor variables and bipolar disorder is the outcome measure for research question 3, and resource loss is the DV for research question 4.

Participants

Two groups of participants will be recruited. One group of clinical participants will be recruited through Consultant Psychiatrists and Staff Grade doctors from Hampshire Partnership Trust resource. A control group of healthy adults with no history of mental health difficulties will be recruited using local advertising.

Clinical participants will be adult out-patients (over the age of 18 years) with a primary diagnosis of bipolar disorder. Consultant Psychiatrists and mental health teams in Hampshire Partnership Trust will be approached to ask if they would consent to patients of theirs with a diagnosis of bipolar disorder being approached about entering this study. The patient's Consultant Psychiatrist will be provided with an Information Sheet outlining the

purpose of the research and the procedure of the study. The individual patients will then be approached at out-patient clinics and will be given an explanation of the study and an Information Sheet and be asked if they would consider being involved. If they express an interest in participating, they will be asked for their name and a contact number which the Chief Investigator will use to contact them after 3 days to discuss their participation further.

If insufficient numbers of participants are recruited this way, the Chief Investigator will approach the Manic Depression Fellowship (MDF), the bipolar disorder organisation. The Chief Investigator will write a letter to the organisers of the local Southampton MDF group along with a copy of the Information Sheet, offering the opportunity for the group to participate in the study. The Chief Investigator will propose that they would come to a meeting and do a short presentation about the research and offer group members the opportunity to give their contact details should they wish to participate or want further information about participation in the study. Following their consent to participate, the recruitment procedure outlined previously will be employed. Where possible, MDF members who are under the care of NHS mental health services but not Hampshire Partnership Trust will not be recruited. The Chief Investigator does not anticipate that this will happen, however, should there be sufficient numbers of non-Hampshire Partnership Trust NHS patients willing to participate, then an application to MREC will follow.

Clinical participants will be excluded if they have a primary diagnosis of substance misuse, a learning disability or who are currently inpatients in a psychiatric unit. Participants will also be excluded if their first language is not English, as the rating scales being used have been standardised in English, and limited resources dictate that the use of an interpreter is not a viable option for this study.

Control participants will be matched to clinical participants based on gender, age, and socio-economic status. In order to recruit appropriate control participants, three different recruitment procedures will be employed. The first method of recruitment will involve advertising by placing posters around the University of Southampton advertising for volunteers to participate in the study. Potential participants will be able to contact the Chief Investigator for further information using the contact telephone number and/or email address on the poster. Those who contact the Chief Investigator for further information will be asked for their name, address and contact telephone number. A copy of the Information Sheet will be sent to them along with a cover letter within three working days of their initial contact, which will provide them with sufficient information about the study. The letter will also

explain that the Chief Investigator will contact them by telephone after three working days to discuss their participation in the study.

If insufficient numbers of appropriately-matched participants are recruited through the university, the Chief Investigator will recruit further participants using the second method of recruitment through advertisement in local newspapers. The final recruitment procedure will use a 'snowballing technique' amongst family and friends, whereby people known to the Chief Investigator will be asked to pass on Information Sheets to acquaintances who match the profile of the clinical participants, that is, are similar in age, socio-economic status and gender to the clinical sample.

Control participants will be excluded if they have a previous psychiatric diagnosis or a learning disability or have had a head injury.

Procedure

Following their decision to participate, the Chief Investigator will contact each clinical and control participant individually after 3 working days of their agreeing to participate in the research to arrange a convenient time to meet with them and conduct the research. Participants may decide to meet at a Hampshire Partnership Trust resource, the University of Southampton or at their own home as convenient to them. At this meeting, participants will be asked to read and sign 3 identical consent forms (one copy of which will be retained by the Chief Investigator, one for the participant's medical notes, and one given to the participant). Participants will be asked to initially complete a form recording basic demographic information, including date of birth, age, gender and years of education.

At the beginning of the procedure, participants will be informed of their right to change their minds or to withdraw from the study without any consequences, in relation to their legal rights and medical care.

As a part of the procedure all participants will be asked to complete each of the rating scales. These will be presented in sequence by the Chief Investigator in the following order: the Internal States scale, the Hospital Anxiety and Depression Scale, the original format of the Childhood Trauma Questionnaire, the Internalized Shame Scale, the revised version of the Childhood Trauma Questionnaire, and the Conservation of Resources Evaluation. The Chief Investigator will be present throughout the procedure if they require any assistance, have any questions or concerns, or wish to withdraw. The Chief Investigator will offer each participant the opportunity to have the Consent Form, Information Sheet and all rating

scales read to them to ensure thorough understanding and to avoid any difficulties caused by any potential undiagnosed learning disability or literacy difficulties.

Prior to completing the rating scales, the participants in the clinical group will be briefly interviewed following a semi-structured interview schedule about their experiences of bipolar disorder. Control participants will not be interviewed, because as a result of the exclusion criteria, they will not have a history of mental health problems.

It is expected that completing the rating scales will take about 30 to 45 minutes. The interview conducted with the clinical participants is expected to last approximately 15 minutes.

Following the completion of the rating scales (and the interview with clinical participants), participants will be verbally debriefed and given a copy of the debriefing statement. Any questions they have will be answered before being thanked for their participation.

In the unlikely event that participants become upset as a result of completing the rating scales or answering questions in the interview, the Chief Investigator will allow the participant to discuss the issues causing them distress and will use their skills as a Trainee Clinical Psychologist to assess the participant's mood and coping relating to the issues discussed. Should participants become distressed, they will be asked "How will you cope?" and all participants will be asked "Is there anyone that you would like to inform about this research? Who is that person?" In a situation whereby a clinical participant becomes distressed, the Chief Investigator will also suggest that, should the participant wish so, a copy of the completed measures, or any specific issues raised during the test session can be sent to their Key Worker. Participants will be asked to sign a consent form if they wish for copies of their forms to be sent to a relevant member of staff involved in their care. The Chief Investigator will retain this, although a copy will also be given to the participant, and another will be stored in their medical records. They will also discuss linking with existing services should the need arise. The Chief Investigator will also suggest that if necessary, they will meet with the participant and their Key Worker to discuss ways to deal with the distress. If their mood is low during the procedure or at the end, the Chief Investigator will use their clinical judgment to ask about suicidal ideation (i.e. any plans they have made and any preventative factors). In the unlikely event that they feel the participant needs additional support this will be arranged by contacting the Duty Worker or the Home Treatment Service.

It is also possible that as a result of completing measures regarding current or recent trauma, participants may report current or ongoing episodes of abuse, for example at the hand of a parent or partner. In these circumstances, the Chief Investigator has a duty of care to report such incidents to the police and/or the appropriate personnel. However, any actions will initially be discussed with the participant.

When the study has concluded and all data have been gathered and analysed, the Chief Investigator will prepare a short summary of the research findings and will send a copy to each of the participants who expressed an interest at the time of their taking part. The name and address of any participant who wishes to receive information about the outcome of the study will be stored securely separately from the data sheets.

Power Calculation

Research by Gilbert (2000) comparing depressed participants with a healthy control group found a high significant difference between the two groups on a measure of shame¹. A Cohen's D effect size of .60 (power = 92.8%) was found. For this research, 80% power is sufficient. A power calculation revealed that a sample size of 35 per group is sufficient to find similar group differences. To allow for attrition, 40 participants per group will be recruited.

Measures

Brief Clinical Interview

Experimental participants will be asked about their experiences of their illness using a semi-structured interview schedule. The following questions will be used as prompts for participants to talk about their illness. Subsequent questions will be asked in relation to the information provided:

- What was going on in your life at the time of your first/most recent period of illness?
- How do you feel these events impacted on your illness at the time?
- How did the people around you (e.g. family, friends etc) react to this period of illness?

Internal State Scale (Bauer et al., 1991)

The Internal State Scale is a 15-item self-report scale with 4 subscales (Activation, Well-Being, Perceived Conflict and Depression). Relevant subscales are highly correlated with clinician ratings of mania and depression ratings (Bauer et al., 1991).

¹ Depressed group $m = 51.42$, $SD = 9.87$; Healthy controls, $m = 45.81$, $SD = 9.06$

Hospital Anxiety and Depression Scale (HADS; Snaith & Zigmond, 1994)

The HADS is a reliable instrument for assessing the symptom severity and caseness of anxiety disorders and depression in both somatic, psychiatric and primary care patients and in the general population. A review of the HADS literature revealed a mean Cronbach's Alpha of .83 (varying from .68 to .93) for Anxiety and .82 (range .67 to .90) for Depression (Bjelland, Dahl, Haug, & Neckelmann, 2002).

Childhood Trauma Questionnaire (CTQ; Bernstein et al. 1994)

The CTQ is a 28-item self-report inventory that provides reliable screening for histories of abuse and neglect. It measures five types of maltreatment - emotional, physical, and sexual abuse, and emotional and physical neglect. Good internal consistency is reported (Scher, Stein, Asmundson, McCreary, & Forde 2001). A copy of CTQ is re-worded for participants in this study to rate their experiences of trauma in their adulthood. Consequently, no reliability data for this version is available.

Internalised Shame Scale (Cook, 1994)

The Internalized Shame Scale is a 30-item self-report scale measuring shame and self-esteem. A Cronbach Alpha of .96 (shame) and .87 (self-esteem) is reported with a clinical sample (Cook, 1994).

Conservation of Resources-Evaluation (COR-E; Hobfoll, Lilly, & Jackson, 1991)

The COR-E is a 74-item measure of resources lost following exposure to a stressor event. Internal reliability is reported as 0.5. This internal reliability is low compared with the validity of other measures being used. However, this measure is the only one available which captures the elements sufficiently.

Data Management

Qualitative Analyses

For the brief interview used to gather information about participants' experience of their illness, a content analysis will be used to analyse the qualitative data gathered. This will involve identifying any themes that run throughout each of the participants' to see if there are underlying similarities in the experiences of participants.

Quantitative Analyses

To answer the research questions, Independent T-tests will be used to compare the experimental and control groups on each measure. Although the desired sample size is relatively low, a regression analysis may be calculated using shame and trauma as predictors and bipolar disorder as the outcome measure in order to investigate research question 3.

It may be possible to use another regression approach where shame is the outcome variable and past and current trauma are the predictors to test the link between current experiences and trauma/shame. However, the potential difficulties of collinearity are acknowledged.

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19th June, 2007

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Mr. Edward Carter,
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Dear Mr. Carter,

Full title of study: **The Emotional Impact of Early Experience in Bipolar Disorder**
REC reference number: **07/Q1702/68**

Thank you for your recent correspondence regarding my study and the helpful comments provided both during and following my meeting held on 12th June 2007. Please find enclosed all the documents with the recommended changes. Please note that I have included 2 copies of each document: one copy shows the changes made, including any information removed or changed; the second version shows how the new document will look when presented to participants following these amendments being made.

In addition to the recommended changes to the documents attached to this letter, the Committee made other recommendations and required clarification on other matters. I would like to confirm my responses made during the meeting. Specifically, at the meeting the Committee raised the issue of the exclusion criteria

and the differences in these criteria between the Bipolar Disorder participants and the Healthy Volunteers participants. I would like to reassure the Committee that these criteria will apply to both groups of participants. Furthermore, Healthy Volunteer participants will be recruited only through advertisement, and not using friends and family as originally suggested.

Please note that I have removed the Consultant Information Sheet from the procedure following the Committee's recommendations. I have now included a Reply Slip as discussed during the meeting which gives potential participants the opportunity to take the Information Sheet away with them and consider their involvement further before providing the researcher with any personal contact information. This can be sent later using the reply slip and can be posted in a Freepost envelope. These envelopes will be arranged with the School of Psychology at the University of Southampton following full ethical approval being granted.

The Committee raised a query about the potential support available to Healthy Volunteer participants should any distress be experienced. As stated in the Information Sheet, in the event of any distress, participants will be given the opportunity to discuss these issues with the researcher at the end of the study. In addition, the researcher will provide them with information about support available to them. This information has now been incorporated into a separate Debriefing Statement for Healthy Volunteer participants which includes information on how to access the University of Southampton counseling service, an excellent self-help manual and a useful website. In addition, the statement recommends that the participant contact their GP if they feel that they have any outstanding issues. The protocol detailed in the original application form for the disclosing of ongoing trauma and the breaching of confidentiality is the same for both Bipolar Disorder participants and Healthy Volunteer participants. That is, all information disclosed during the procedure will remain confidential unless there is a cause for concern which suggests that the participant is a risk to themselves and/or other people. If any instances of ongoing abuse or trauma are reported, then the researcher will discuss with the participant their responsibility to inform the police and/or social services in order to maintain that person's physical integrity. This will all be explained prior to the person's participation and as such, each participant has the choice as to what information is disclosed.

I hope that these changes assure the Committee with regard to any concerns about certain aspects of the procedure of my study. However, if there are any outstanding concerns then please contact me. I look forward to hearing from you soon.

Yours sincerely,

Mr. Alex Fowke
Trainee Clinical Psychologist

APPENDIX P

Hampshire Partnership Trust

Research & Development Approval and Data Protection

Agreement

APPENDIX Q

University of Southampton

Sponsorship and Professional Indemnity agreement documents

APPENDIX R

Document detailing the ethical issues relevant
to the Empirical Paper

The ethical issues relevant to the Empirical Paper are listed in this appendix. With reference to the BPS Code of Conduct, Ethical Principles and Guidelines and the DCP Professional Practice Guidelines, the resolutions to these issues are explained.

The British Psychological Society (BPS) Code of Conduct, Ethical Principles and Guidelines (BPS, 2000)

The *British Psychological Society Code of Conduct, Ethical Principles and Guidelines November 2000* identifies several key ethical principles for conducting research with human participants. These are as follows, and points 3-11 are considered with reference to the Empirical Paper:

1. *Introduction*
2. *General*
- 3. Consent**
- 4. Deception**
- 5. Debriefing**
- 6. Withdrawal from the investigation**
- 7. Confidentiality**
- 8. Protection of participants**
- 9. Observation research**

10. Giving advice**11. Colleagues**

The points relevant to the study are detailed and discussed here:

3. Consent

3.1. Whenever possible, the investigator should inform all participants of the objectives of the investigation. The investigator should inform the participants of all aspects of the research or intervention that might reasonably be expected to influence willingness to participate. The investigator should, normally, explain all other aspects of the research or intervention about which the participants enquire.

- The Information Sheet given to all participants before their participation describes the objectives of the investigation, and details all aspects of the study that would influence their willingness to participate. Specifically, the document contains information regarding what would be expected of participants during the study. In addition, the possible benefits and costs to the potential participant are described. At any point during their contact with the participant, any aspect of the research that was asked about was answered with as much information as was available to the researcher.

3.2. Research with children or with participants who have impairments that will limit understanding and/or communication such that they are unable to give their real consent requires special safe-guarding procedures.

- Only adult participants were recruited into the study, and the majority were identified through community mental health teams (CMHTs) working with clients of working age (18-65). The remaining participants were recruited from the Southampton branch of MDF The Bipolar Organisation (formerly the Manic-Depression Fellowship [MDF]), all of whom were aged over 18. As such, no children were recruited into the study. Similarly, known learning disabilities or difficulties with communication were detailed in the exclusion criteria and, as such, it was not necessary to consider any special safe-guarding procedures with respect to these issues.

3.3. Where possible, the real consent of children and of adults with impairment in understanding or communication should be obtained. In addition, where research involves any persons under 16 years of age, consent should be obtained from parents or from those in loco parentis. If the nature of the research precludes consent being obtained from parents or permission being obtained from teachers, before proceeding with the research, the investigator must obtain approval from an Ethics Committee.

- As detailed in response to Item 3.2, children and adults with impairment in understanding or communication were excluded from participating in

the study and as such, the issue of gaining consent for such participants was not applicable.

3.4. Where real consent cannot be obtained from adults with impairments in understanding or communication, wherever possible the investigator should consult a person well-placed to appreciate the participant's reaction such as a member of the person's family, and must obtain the disinterested approval of the research from independent advisors.

- As stated, this is not applicable in the current study.

3.5. When research is being conducted with detained persons, particular care should be taken over informed consent, paying attention to the special circumstances which may affect the person's ability to give free informed consent.

- Detained persons were not recruited into the study, and as such this is not applicable in the current investigation.

3.6. Investigators should realise that they are often in a position of authority or influence over participants who may be their students, employees or clients.

This relationship must not be allowed to pressurise the participants to take part in, or remain in, an investigation.

- No students, employees, or clients of the researcher were recruited into the study and as such, this is not applicable.

3.7. The payment of participants must not be used to induce them to risk harm beyond that which they risk without payment in their normal lifestyle

- No payment was offered to participants, other than the offer to reimburse for any travel expenses.

3.8. If harm, unusual discomfort or other negative consequences for the individual's future life might occur, the investigator must obtain the disinterested approval of independent advisors, inform the participants, and obtain informed, real consent from each of them.

- No negative consequences for the individual's future life were anticipated. However, following the submission of a proposed research protocol, approval was granted by an independent advisor at the University of Southampton, as well as from the ethics committees of the University of Southampton School of Psychology, and the National Research Ethics Service Southampton and South West Hampshire Research Ethics Committee A. The potential for distress or discomfort was highlighted in these applications, and an appropriate management plan for such an event was documented. These are detailed in each of the relevant ethics application forms submitted with this thesis, and the management plans were considered suitable and appropriate by both ethics committees.

3.9. In longitudinal research, consent may need to be obtained on more than one occasion.

- The design of the study was cross-sectional rather than longitudinal, and all the rating scales were administered during one session. As such, it was not necessary to obtain consent more than once.

4. Deception

4.1. The withholding of information or the misleading of participants is unacceptable if the participants are typically likely to object or show unease once debriefed. Where this is in doubt, appropriate consultation must precede the investigation. Consultation is best carried out with individuals who share the social and cultural background of the participants in the research, but the advice of ethics committees or experienced and disinterested colleagues may be sufficient.

- No information was withheld from participants at any point during the investigation.

4.2. Intentional deception of the participants over the purpose and general nature of the investigation should be avoided whenever possible. Participants should never be deliberately misled without extremely strong scientific or medical justification. Even then there should be strict controls and the disinterested approval of independent advisors.

- There was no intentional deception or misleading of participants over the purpose and general nature of the investigation.

5. Debriefing

5.1. In studies where the participants are unaware that they have taken part in an investigation, when the data have been collected, the investigator should provide the participants with any necessary information to complete their understanding of the nature of the research. The investigator should discuss with the participants their experience of the research in order to monitor any unforeseen negative effects of misconceptions.

- Participants were fully aware of their participation in the investigation; therefore it was not necessary to provide participants with any necessary information to complete their understanding of the nature of the research after taking part. However, prior to their participation, all participants were provided with detailed information, both written and verbal, to provide them with sufficient understanding of the nature of the research.

5.2. Debriefing does not provide a justification for unethical aspects of any investigation

- The study received favourable opinions by the University of Southampton School of Psychology Ethics Committee and the Southampton and South West Hampshire Research Ethics Committee A

as part of the National Research Ethics Service. Both were satisfied that there were no unethical aspects to the study. Consequently, the issue of justifying unethical aspects of the investigation is not necessary.

5.3. Some effects which may be produced by an experiment will not be negated by a verbal description following the research. Investigators have a responsibility to ensure that participants receive any necessary debriefing in the form of active intervention before they leave the research setting.

- There was no inherent risk in completing the self-report rating scales, although it was acknowledged that some participants may experience some distress when asked questions about their experience of abuse. The researcher was a Trainee Clinical Psychologist who had experience working with psychiatric patients and was considered to be competent in the management of these situations. If participants were to become distressed the action to be taken was that the researcher would ask them “How will you cope?” and all participants will be asked “Is there anyone that you would like to inform about this research? Who is that person?” The researcher would also suggest that, should they wish, a copy of the completed measures or any specific issues raised during the test session could be sent to their key worker. Participants would then be asked to sign a consent form if they wished copies of their form to be sent to a relevant member of staff involved in their care. They would

also discuss linking with existing services should the need arise. The researchers would also suggest that if necessary, they would meet with the participant and their key worker to discuss ways to deal with the distress. If their mood became low during the procedure or at the end, the researcher would use their clinical judgement to ask about suicidal ideation (i.e., any plans they have made and any protective factors). In the unlikely event that they feel the participant needs additional support this will be arranged by contacting the relevant Duty Worker or Home Treatment Service.

This information was included in the original application for ethical approval and both ethics committees were satisfied that the issue had been appropriately considered and that the proposed management plan was suitable.

6. Withdrawal from the investigation

6.1. At the onset of the investigation investigators should make plain to participants their right to withdraw from the research at any time, irrespective of whether or not payment or other inducements has been offered. It is recognised that this may be difficult in certain observational or organisational setting, but nevertheless the investigator must attempt to ensure that participants (including children) know of their right to withdraw. When testing children, avoidance of the testing situation may be taken as evidence of failure to consent to the procedure and should be acknowledged.

- Participants' right to withdraw from the research at any time was detailed in the Information Sheet and the Consent Form, as well as being verbally reiterated at the beginning of the procedure.
- Children were not recruited into the study, and as such, the issue of their avoiding the testing situation as evidence of failure to consent to the procedure was not applicable in this study.

6.2. In the light of experience of the investigation, or as a result of debriefing, the participant has the right to withdraw retrospectively any consent given, and to require that their own data, including recordings, be destroyed.

- Participants' right to withdraw retrospectively was discussed during the verbal debriefing at the end of the study.

7. Confidentiality

7.1. Subject to the requirements of legislation including the Data Protection Act, information obtained about a participant during an investigation is confidential unless otherwise agreed in advance. Investigators who are put under pressure to disclose confidential information should draw this point to the attention of those exerting such pressure. Participants in psychological research have a right to expect that information they provide will be treated confidentially and, if published, will not be identifiable as theirs. In the event that confidentiality and/or anonymity cannot be guaranteed, the participant must be warned of this in advance of agreeing to participate.

- During the initial contact, the researcher discussed the issue of confidentiality, and detailed how publication of the research would not include participant identifiable information. This was detailed in the Information Sheet and was reiterated at the end of the procedure in the verbal and written debriefing. It was also discussed at the beginning of the procedure that if participants became distressed during the completion of the rating scales, it may be necessary to breach confidentiality by reporting to the relevant Duty Officer or Home Treatment Service. However, participants were informed that in the interests of maintaining transparency, any breach of confidentiality would be discussed with the participant beforehand, and the protocol for reporting distress or feelings of suicidality would be explained to them thoroughly.

8. Protection of participants

8.1. Investigators have a primary responsibility to protect participants from physical and mental harm during the investigation. Normally, the risk of harm must be no greater than in ordinary life i.e. participants should not be exposed to risks greater than or additional to those encountered in their normal lifestyles. Where the risk of harm is greater than in ordinary life the provisions of 3.8 should apply. Participants must be asked about any factor in the procedure that might create a risk, such as pre-existing medical

conditions, and must be advised of any special action they should take to avoid risk.

- There was no identifiable risk of harm to participants in the current study. However, following the submission of a proposed research protocol, approval was granted by an independent reviewer at the University of Southampton, as well as from the ethics committees of the University of Southampton School of Psychology, and the National Research Ethics Service Southampton and South West Hampshire Research Ethics Committee A. The potential for distress or discomfort was highlighted in these applications, and an appropriate management plan for such an event was documented. These are detailed in each of the relevant ethics application forms submitted with this thesis.

8.2. Participants should be informed of procedures for contacting the investigator within a reasonable time period following participation should stress, potential harm, or related questions or concern arise despite the precautions required by the Principles. Where research procedures might result in undesirable consequences for participants, the investigator has the responsibility to detect and remove or correct these consequences.

- The debriefing statement emphasised that participants could contact the researcher should they wish following the end of the assessment session. In addition, participants were advised to contact their care co-ordinator or their GP where applicable, should they feel that this would

be more helpful to them in terms of receiving appropriate support from a familiar source. This was communicated to the care co-ordinator of each participant, and GPs were sent copies of the Information Sheet and Consent Form so that all relevant clinical individuals involved in each participant's care were aware of their participation in the research, and appropriate liaison between these individuals and the researcher could take place if necessary.

8.3. Where research may involve behaviour or experiences that participants may regard as personal and private, the participants must be protected from stress by all appropriate measures, including the assurance that answers to personal questions need to not be given. There should be no concealment or deception when seeking information that might encroach on privacy.

- The Information Sheet and discussion during the initial contact emphasised that participants could decline to answer any question.
- No deception or concealment was involved in the current study.

8.4. In research involving children, great caution should be exercised when discussing the results with parents, teachers or others acting in loco parentis, since evaluative statements may carry unintended weight.

- No children were recruited into the current study, and as such, this is not applicable.

9. Observational research

- The study was not an observational design, and as such, specific observational research ethical principles are not applicable here.

10. Giving advice

10.1. During research, an investigator may obtain evidence of psychological or physical problems of which a participant is, apparently, unaware. In such a case, the investigator has a responsibility to inform the participant if the investigator believes that by not doing so the participant's future well-being may be endangered.

- The research primarily involved investigating psychological conditions that were generally known of by the individual and their clinical teams, such as the level of depression, and experience of childhood maltreatment. However, in instances whereby evidence was obtained of psychological or physical problems of which the participants was apparently unaware, it was planned that this would be communicated to them when appropriate, and participants would be encouraged to seek suitable support, either from their psychiatrist, care co-ordinator, or GP. In these instances, it was planned that participants would be given the opportunity to take copies of their completed rating scales, as measures of their difficulties, so that they could be passed on to the relevant clinician to provide a context to the problem. Alternatively, participants would be given the option of having the researcher sending copies to

the relevant clinician. An additional Consent Form was developed for completion if this action was considered necessary. Furthermore, it was planned that the researcher might seek consent from participants to relay the relevant information back to their GP or care co-ordinator verbally to provide a context to the difficulty and ensure optimum care being provided.

10.2. If, in the normal course of psychological research, or as a result of problems detected in 10.1, participant solicits advice concerning educational, personality, behavioural or health issues, caution should be exercised. If the issue is serious and the investigator is not qualified to offer assistance, the appropriate source of professional advice should be recommended. Further details on the giving of advice will be found in the Society's Code of Conduct.

- Any advice that was sought regarding educational, personality, behavioural or health issues was carefully managed. In particular, participants were advised to raise the concern with their care coordinator, key worker, psychiatrist or GP, particularly when the researcher was not qualified to offer assistance (i.e., with regard to physical complaints, issues of medication, or other such queries).

10.3. In some kinds of investigation the giving of advice is appropriate if this forms an intrinsic part of the research and has been agreed in advance.

- The giving of advice to participants was carefully considered and managed as detailed in response to Item 10.2.

11. Colleagues

- The study was supervised by two Consultant Clinical Psychologists within Hampshire Partnership Trust, and a Clinical Research Tutor from the University of Southampton School of Psychology, who was a qualified Clinical Psychologist. All supervisors were experienced in conducting research within the NHS and were familiar with the process of gaining ethical approval. Furthermore, the protocol was reviewed by a highly experienced research psychologist within the University of Southampton School of Psychology, and subsequent approval was provided. Advice was sought regarding the ethical application process from a research psychologist working in the Clinical Governance department of the University of Southampton. The study was also presented to a team of Clinical Psychologists working within Hampshire Partnership Trust at a research meeting whereby the protocol was reviewed, and an opportunity was given to others to comment upon the study and any potential ethical concerns. As such, opportunities were available for a number of other psychologists to review the protocol and comment where necessary.

The British Psychological Society Division of Clinical Psychology Professional Practice Guidelines 1995 (BPS, 1995)

The *British Psychological Society Division of Clinical Psychology Professional Practice Guidelines 1995* document states specific guidelines for psychologists conducting research, audit and publication. These are as follows:

10.1 Psychologists must make a careful evaluation of the ethical acceptability of research proposals, and subject them to the scrutiny of an ethics committee, unless working with an entirely non-clinical population. Even in this event, the approval of an ethics committee is recommended

- The research proposal was given approval by an independent and impartial researcher at the University of Southampton School of Psychology. The protocol was also reviewed and approved by the University of Southampton School of Psychology Ethics Committee, and National Research Ethics Service approval was granted by the Southampton and South West Hampshire Research Ethics Committee A. These committees reviewed the protocol and the potential ethical issues that were highlighted in the application forms. In addition, attendance by the researcher at the Southampton and South West Hampshire Research Ethics Committee A panel allowed any further ethical concerns to be discussed. Both committees were satisfied that the information provided regarding any management strategies was sufficient in terms of reducing or removing

these potential difficulties, and the plans for the management of any distress experienced by participants as a result of the study.

10.2 Where clinical services are involved in a research project, psychologists must undertake a careful analysis of the potential impact of the research on the nature, timing and quality of care provided to clients, ensuring that as far as possible the quality of care remains primary. If there are any negative consequences these must be ethically justified, and should be explained to participants in advance of consent.

- The study did not use staff from clinical services and as such, this is not applicable.

10.3 Before seeking a client's consent to participate in a research project, psychologists should obtain the consent of any other professional having a significant responsibility for the client's well being. When clients have consented to take part, psychologists should take all reasonable steps to communicate this decision to others with an active role in the client's care.

- Potential participants were identified by psychiatrists and care coordinators, and therefore by default, by providing this information, consent was provided by the relevant clinicians to approach those clients recommended for recruitment. When clients consented to take part in the study, their decision to consent was communicated to their GP and consultant psychiatrist by sending copies of the signed Consent Form.

10.4 When considering research in a setting within which psychological services are provided by psychologists other than the investigation, the investigator should inform the psychologists concerned and obtain their consent before proceeding

- Some of the assessments with participants were conducted at a CMHT base, in the same setting in which psychologists were conducting their own work. However, the assessments with the researcher were separate from any of the work being undertaken by the psychologists, and none of the participants were involved in psychological intervention with any of the psychologists within Hampshire Partnership Trust at the time of their participation in the study. Nevertheless, the researcher took steps to ensure that the team psychologists were familiar with the study. Furthermore, the researcher informed the psychologist that they were present when at the team base for a meeting with a participant.

10.5 Participants should be informed of all features of the research that might reasonably be expected to influence their willingness to participate, including any anticipated risks of distress. The aims and value of the research should be described, but no pressure put on potential participants to consent. Clients and patients should be informed that neither consent nor refusal will in any way influence the nature of care they receive, and that they will be free to withdraw consent at any time during the research. In longitudinal research it may be

necessary to revisit consent at different stages of the research process. Consent must always be obtained in writing.

- All features of the study that would influence their willingness to participate were detailed in the Information Sheet, and participants were given a minimum of 48 hours to consider their participation. No pressure was placed on potential participants to take part. The Information Sheet and Consent Form refer to the withdrawal of participants at any time during the study, and how this would have no impact on the care they receive.
- The study was a cross-sectional design rather than a longitudinal design, and as such, rating scales were administered during a single assessment sessions. Consequently, there was no need to revisit consent.

10.6 Informed consent should address both the research procedures and the publication of results. The latter will become increasingly significant if detailed information about individual participants is to be reported, as in some qualitative approaches, for example, case examples. This has further relevance when clients are participants and where case study material refers to the details of individual or family experiences of intervention.

- The Information Sheet detailed how publication of any results would not include any participant identifiable information. This was reiterated in the written debriefing statement and the verbal debriefing.

10.7 Psychologists should be aware that clients may find it hard to say no, and should do their best to ensure that they do feel free to do so.

- In addition to being documented in the Information Sheet, participants' right to decline their participation or withdraw from the study was reiterated verbally during the session.

10.8 Participants should be informed of the level of detail at which material about them would be communicated in research reports and publication, and, if detailed information is to be used, of the ways in which their identity will be disguised. Consent should be obtained on this basis. For clients consenting to the publication of case studies, consent should be revisited at the end of therapy, since clients would then be aware of the nature of material that they are releasing.

- The Information Sheet and Debriefing Statement detailed how any publication or report of the study would not contain any participant identifiable information. The research did not include the presentation of any case studies, and as such, this latter issue is not relevant here.

10.9 It is advisable to inform clients that their psychologist may wish to draw on their experience of intervention within academic publications. This could be included as a general statement in department information sheets, and addressed with individual clients, so that their views about consent may be obtained. Specific consent should be obtained on the same basis as 10.8 above.

- The study was not a description of an intervention with a specific client, and as such, this point was not applicable in the current investigation.

10.10 Psychologists must not use any procedure likely to cause serious or lasting harm. If more distress is experienced than expected, procedures must be stopped and appropriate professional advice sought.

- It was not anticipated that the current study would result in and serious or lasting harm. However, the potential for participants to experience distress was considered in the ethical application process. As such, a protocol was developed to manage such an event, whereby the researcher would assess their emotional state and where necessary, refer to the relevant Duty Officer or the Home Treatment Service, or refer the participant back to their care coordinator or key worker.

10.11 In any instances where deception or the withholding of information is deemed necessary to a research protocol, where any form of stress or distress is anticipated or where privacy may be encroached upon, psychologists should seek the opinion of experienced and disinterested colleagues regarding the ethical basis of protocols. Such features should only be considered acceptable if psychologists are satisfied that the aims of the research cannot be achieved by any other means, and that the aims are ethically justified.

- The research protocol did not involve any deception, and no stress or distress was anticipated, nor was the privacy of participants encroached

upon. However, the protocol was reviewed and approved by an impartial and independent researcher from the University of Southampton School of Psychology, as well as by the University of Southampton School of Psychology Ethics Committee. Furthermore, National Research Ethics Service approval was granted by the Southampton and South West Hampshire Research Ethics Committee A.

10.12 If deception or concealment has been necessary, this should be revealed during debriefing following participation. If it has been substantial, informed consent must be revisited, and the participants given the option of withdrawing their data, which would then be destroyed.

- Neither deception nor concealment was used in the current study, and as such, the issue is not applicable in the current study.

10.13 Debriefing should normally follow participation unless this has been on an anonymous postal basis. Any participant misconceptions and concerns should be clarified, and any unhelpful or distressing reactions dealt with. Referral to an appropriate source of help should be offered if there are continuing negative effects of participation or participants has revealed previously unidentified psychological problems

- Every participant was given a written debriefing statement, and each was verbally debriefed. All participants were advised to contact their care coordinator or general practitioner if they experienced any continuing

negative effects of participation, or were encouraged to contact the researcher after the end of the research.

10.14 Research data must be treated with confidence and respect. It cannot be shared with others involved in a client's care without the explicit consent of the client. When details of individual participants are described in research reports they must be altered so that they will not be identifiable to third parties, and as far as possible would not be recognisable to the participants themselves.

- The Information Sheet and Debriefing Statement described how any published report would not contain any participant identifiable information. If participants agreed to their data being shared with others involved in a client's care, then participants signed a separate consent form. Data was only shared if participants felt that it would be beneficial to their ongoing care and support.

The British Psychological Society Code of Ethics and Conduct, March 2006 (BPS, 2006)

The *British Psychological Society Code of Ethics and Conduct March 2006* document identifies the standards for protecting research participants and providing them with debriefing. These standards are as follows:

Standard of Protection of Research Participants:

- (i) *Consider all research from the standpoint of research participants, for the purpose of eliminating potential risks to psychological well-being, physical health, personal values, or dignity*
 - The study was carefully designed and reviewed in order to avoid any of the potential risks to psychological well-being, physical health, personal values or dignity. As such, the study used well-validated measures that had previously been used in research with clinical samples without detrimental effects. In addition, participants were not offered financial incentives to participate in the study, so as to avoid a conflict between their personal values and their dignity.

- (ii) *Undertake such consideration with due concern for the potential effects of, for example, age, disability, education, ethnicity, gender, language, national*

origin, race, religion, marital or family status, or sexual orientation, seeking consultation as needed from those knowledgeable about such effects

- The study was not considered to be sensitive to the potential effects of age, disability, education, gender, ethnicity, national origin, race, religion, marital or family status, or sexual orientation.

Furthermore, participants were not excluded on the basis of any of these factors. Participants whose first language was not English were excluded because the measures used had been standardised in English and limited resources indicated that it was not possible to use translators in the current study. This issue was carefully considered and the two ethics committees who reviewed the study were satisfied that the rationale was sufficient to ensure the robustness of the study and was not unnecessarily discriminatory.

(iii) *Ask research participants from the first contact about individual factors that might reasonably lead to risk of harm, and inform research participants of any action they should take to minimise such risks*

- Participants were given a detailed description of the study and what the procedure entailed, both in the Information Sheet sent to them and at the first contact with the researcher. During this contact, any individual factors or potential sources of risk were assessed and if necessary, research participants were advised of any action they should take to minimise such risks. At the first contact, this

typically involved reminding participants of their right to withdraw from the study at any point or decline to respond to any question.

- (iv) *Refrain from using financial compensation or other inducements for research participants to risk harm beyond that which they face in their normal lifestyles.*
 - Participants were offered reimbursement for any travel expenses but no other financial compensation or inducements to participate in the study.
- (v) *Obtain the considered and non-subjective approval of independent advisors whenever concluding that harm, unusual discomfort, or other negative consequences may follow from research, and obtain supplemental informed consent from research participants specific to such issues*
 - The study was initially reviewed by an independent researcher, Dr. Ineke Pit-ten Cate, from the University of Southampton School of Psychology. The study was subsequently approved by the University of Southampton School of Psychology Ethics Committee, and National Research Ethics Service approval was granted by the Southampton and South West Hampshire Research Ethics Committee A. Any changes that were recommended by either committee were incorporated before final approval was

granted. Both committees were satisfied that harm, unusual discomfort, or any other negative consequences would not follow from the research, or where it potentially may follow, appropriate and adequate measures had been taken to protect and support participants.

(vi) *Inform research participants from the first contact that their right to withdraw at any time is not affected by the receipt or offer of any financial compensation or other inducements for participation*

- Participants were informed prior to their participation of their right to withdraw from the study at any time should they wish. This was reiterated on the consent form signed by each participant. No financial compensation or other inducements were offered and as such, this was not affected by their withdrawal.

(vii) *Inform research participants from the first contact that they may decline to answer any questions put to them, while conveying as well that this may lead to termination of their participation, particularly when safety issues are implicated*

- Before the completion of any of the questionnaires or the interview, participants were informed that they may decline to answer any of the questions in the interview or on any of the measures should they wish.

(viii) Inform research participants when evidence is obtained of a psychological or physical problem of which they are apparently unaware, if it appears that failure to do so may endanger their present or future well-being

- The research primarily involved investigating psychological conditions that were generally known of by the individual and their clinical teams, such as the level of depression, and experience of childhood maltreatment. However, in instances whereby evidence was obtained of psychological or physical problems of which the participants was apparently unaware, it was planned that this would be communicated to them when appropriate, and participants would be encouraged to seek suitable support, either from their psychiatrist, care co-ordinator, or GP. In these instances, it was planned that participants would be given the opportunity to take copies of their completed rating scales, as measures of their difficulties, so that they could be passed on to the relevant clinician to provide a context to the problem. Alternatively, participants would be given the option of

having the researcher sending copies to the relevant clinician. An additional Consent Form was developed for completion if this action was considered necessary. Furthermore, it was planned that the researcher might seek consent from participants to relay the relevant information back to their GP or care co-ordinator verbally to provide a context to the difficulty and ensure optimum care being provided.

(ix) *Exercise particular caution when responding to requests for advice from research participants concerning psychological or other issues, and offer to make a referral for assistance if the inquiry appears to involve issues sufficient serious to warrant professional services*

- In the case of any requests made by participants for support or assistance regarding any psychological or other issue, these were passed on to the participants' care coordinator with the participants' consent, or participants were advised to approach their care coordinator themselves. Participants from the control group were advised to contact their GP if they required any support.

(x) *When conducting research involving animals:*

- a. observe the highest standards of animal welfare, including reduction to the minimum of any pain, suffering, fear, distress, frustration, boredom, or lasting harm;*

b. *avoid the infliction of any of these conditions which cannot be strictly justified, in adherence to the Society's published Guidelines for Psychologists Working with Animals.*

- This issue is not relevant for this study, as no animals were used.

Standard of Debriefing of Research Participants:

(i) *Debrief research participants at the conclusion of their participation, in order to inform them of the outcomes and nature of the research, to identify any unforeseen harm, discomfort, or misconceptions, and in order to arrange for assistance as needed*

- A written debriefing statement was given to each research participant at the end of his or her participation. The statement included details regarding the nature of the research and gave information regarding potential sources of support and assistance if they experienced any unforeseen harm or discomfort.

and

(ii) *Take particular care when discussing outcomes with research participants, as seemingly evaluative statements may carry unintended weight.*

- Any suggestion of the outcomes of the research were carefully avoided during the debriefing following participation.

References:

British Psychological Society. (November, 2000). *Code of Conduct, Ethical Principles & Guidelines*. Author.

British Psychological Society. (2001). *Professional practice guidelines 1995. Division of Clinical Psychology*. Author.

British Psychological Society. (March, 2006). *Code of ethics and conduct*. Author

APPENDIX S
Consent Form
(Bipolar Disorder Group)



CONSENT FORM (Bipolar Disorder Participants)

Project Title: The Emotional Impact of Early Experience in Bipolar Disorder

RESEARCHERS: Alex Fowke (Primary Researcher), Dr. Katie Ashcroft, Dr. Su Ross & Dr. Anke Karl

ETHICS NUMBER: 07/Q1702/68

VERSION: 3

DATE: 19.06.07

**Please initial
box**

1. I confirm that I have read and understand the information sheet dated 21.02.07 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.
3. I agree to relevant professionals involved in my care being informed of my participation in the study.
4. I agree to allow parts of the procedure to be tape-recorded for research purposes. I understand that these will be stored separately from any identifying data.
5. I agree to take part in the above study.

Name of Patient _____

Date _____

Signature _____

Researcher _____

Date _____

Signature _____

When completed, 1 for patient; 1 for researcher site file; 1 (original) to be kept in medical notes

APPENDIX T

Consent Form

(Control Group)



CONSENT FORM (Healthy Volunteer Participants)

Project Title: The Emotional Impact of Early Experience in Bipolar Disorder

RESEARCHERS: Alex Fowke (Primary Researcher), Dr. Katie Ashcroft, Dr. Su Ross & Dr. Anke Karl

ETHICS NUMBER: 07/Q1702/68

VERSION: 3

DATE: 19.06.07

**Please
initial box**

1. I confirm that I have read and understand the information sheet dated 21.02.07 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.
3. I agree to allow parts of the procedure to be tape-recorded for research purposes. I understand that these will be stored separately from any identifying data.
4. I agree to take part in the above study.

Name of Patient

Date

Signature

Researcher

Date

Signature

When completed, 1 for patient; 1 for researcher site file;

APPENDIX U
Interview Schedule
(Bipolar Disorder Group)



INTERVIEW SCHEDULE

Project Title: The Emotional Impact of Early Experience in Bipolar Disorder

RESEARCHERS: Alex Fowke (Primary Researcher), Dr. Katie Ashcroft, Dr. Su Ross & Dr. Anke Karl

ETHICS NUMBER: 07/Q1702/68

VERSION: 2

DATE: 19.06.07

- What was going on in your life at the time of your first period of illness?
- How do you feel these events impacted on your illness at the time?
- How did the people around you, such as your family and friends, react to this original period of illness?
- What was going on in your life at the time of your most recent period of illness?
- How do you feel these events impacted on your illness at the time?
- How did the people around you, such as your family and friends, react to this recent period of illness?
- When you are in a manic phase of your illness, what kind of behaviours or activities do you get involved in?
- How do others react to these kinds of behaviours?
- Where are you at the moment in the 'lifetime' of your illness (e.g. involved in therapy, pre-therapy, stable after therapy)?

APPENDIX V
Background Information Sheet
(Bipolar Disorder Group)

Bipolar Disorder Participant ID _____

Version :2
 Date: 19.06.07

Background Information

DATE OF BIRTH:	
AGE:	
GENDER:	
YEARS OF EDUCATION: (e.g. 5 years old – 14 years old = 9 years of education)	
DO YOU WEAR SPECTACLES? (please circle) (they will be required to read information and questionnaires)	No / short / long / both sighted sighted
ARE YOU CURRENTLY ON ANY MEDICATION? (If yes, please specify)	
HAVE YOU CURRENTLY/PREVIOUSLY HAD ANY SIGNIFICANT HEALTH PROBLEMS?	
HAVE YOU EVER BEEN TREATED FOR ANY MENTAL HEALTH PROBLEMS?	
ARE YOU CURRENTLY IN EMPLOYMENT? WHAT IS/WAS YOUR MAIN OCCUPATION?	

APPENDIX W
Background Information Sheet
(Control Group)

Healthy Volunteer Participant ID _____

Version :2
 Date: 19.06.07

Background Information

DATE OF BIRTH:	
AGE:	
GENDER:	
YEARS OF EDUCATION: (e.g. 5 years old – 14 years old = 9 years of education)	
DO YOU WEAR SPECTACLES? (please circle) (they will be required to read information and questionnaires)	No / short / long / both sighted sighted
ARE YOU CURRENTLY ON ANY MEDICATION? (If yes, please specify)	
HAVE YOU CURRENTLY/PREVIOUSLY HAD ANY SIGNIFICANT HEALTH PROBLEMS?	
HAVE YOU EVER BEEN TREATED FOR ANY MENTAL HEALTH PROBLEMS?	
ARE YOU CURRENTLY IN EMPLOYMENT? WHAT IS/WAS YOUR MAIN OCCUPATION?	

APPENDIX X
Debriefing Statement
(Bipolar Disorder Group)



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Email ajf105@soton.ac.uk

PATIENT DEBRIEFING FORM (Bipolar Disorder Participants)

Project Title: The Emotional Impact of Early Experience in Bipolar Disorder

RESEARCHERS: Alex Fowke (Primary Researcher), Dr. Katie Ashcroft, Dr. Su Ross & Dr. Anke Karl

ETHICS NUMBER: 07/Q1702/68

VERSION: 3

DATE: 19.06.07

Thank you for taking part in our study and for providing us with lots of valuable information. We were investigating the role of childhood experiences and the consequences of these life-events. By taking part you are helping us to understand factors that may influence Bipolar Disorder. This will help us to inform doctors and other clinicians of ways to improve their assessment and treatment of patients.

When the research is completed it will be submitted for publication and may be presented at conferences with other researchers and clinicians. We may also present our findings to other local mental health teams. This final report will not include ANY identifying information but instead will group together the results of all participants. A summary of these findings will be available upon completion of the research. If you would like a copy of this report, please inform me and I will be happy to forward a copy of this report to you.

If you have any concerns regarding your participation in our study, please do not hesitate to contact me or your clinician who will direct your query to me.

Many thanks.

Alex Fowke
Trainee Clinical Psychologist

APPENDIX Y

Debriefing Statement (Control Group)



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Highfield Southampton
SO17 1BJ

Tel +44 (0)23 8059 5321
Fax +44 (0)23 8059 4597
Email ajf105@soton.ac.uk

PARTICIPANT DEBRIEFING FORM (Healthy Volunteer Participants)

Project Title: The Emotional Impact of Early Experience in Bipolar Disorder

RESEARCHERS: Alex Fowke (Primary Researcher), Dr. Katie Ashcroft, Dr. Su Ross&

Dr. Anke Karl

ETHICS NUMBER: 07/Q1702/68

VERSION: 1

DATE: 19.06.07

Thank you for taking part in our study and for providing us with lots of valuable information. We were investigating the role of childhood experiences and the consequences of these life-events. By taking part you are helping us to understand factors that may influence Bipolar Disorder. This will help us to inform doctors and other clinicians of ways to improve their assessment and treatment of patients.

When the research is completed it will be submitted for publication and may be presented at conferences with other researchers and clinicians. We may also present our findings to other local mental health teams. This final report will not include ANY identifying information but instead will group together the results of all participants. A summary of these findings will be available upon completion of the research. If you would like a copy of this report, please inform me and I will be happy to forward a copy of this report to you.

For some people, the issues that were being assessed in the questionnaires that you completed can cause mild feelings of depression or anxiety. These are normal experiences and some people have higher levels than others. If you feel that it is a significant problem for you, then there are various forms of help that you can access:

- Your GP will be able to provide you with more information and support for any outstanding issues or concerns.
- Staff/students of The University of Southampton can access the counselling service can be accessed (<http://www.counsel.soton.ac.uk/index/>).
- Greenberger, D., & Padesky, C. A. (1995). *Mind Over Mood*. The Guilford Press: New York. An excellent self-help guide!

- <http://www.babcp.com> (British Association for Behavioural and Cognitive Psychotherapies).

Many thanks.

Alex Fowke
Trainee Clinical Psychologist

APPENDIX Z

Results Tables

Table Z1.

One-sample Kolmogorov-Smirnov test to determine normality of the distribution of the data for subtests on the rating scales (N = 70).

Variable	Kolmogorov-Smirnov Z	P ¹
HADS ^a		
Anxiety	1.03	.24
Depression	1.69	.007*
CTQ ^b		
Emotional abuse	1.66	.008*
Physical abuse	2.87	<.001*
Sexual abuse	3.72	<.001*
Emotional neglect	1.42	.036*
Physical neglect	2.67	<.001*
Minimisation-Denial	3.07	<.001*
Internalised Shame Scale ^c		
Shame	1.28	.098
Self-esteem	.78	.577
CTQ-Revised ^d		
Emotional abuse	2.08	<.001*
Physical abuse	4.27	<.001*
Sexual abuse	4.19	<.001*
Emotional neglect	1.60	.012*
Physical neglect	1.69	.007*
Minimisation-Denial	2.63	<.001*
COR-Evaluation ^e		
Resource loss	1.69	.007*
Resource gain	1.37	.046*

^a HADS = Hospital Anxiety and Depression Scale (Snaith & Zigmond, 1994);

^b CTQ = Childhood Trauma Questionnaire (Bernstein & Fink, 1998);

^c Internalized Shame Scale (Cook, 1994);

^d CTQ-Revised = Childhood Trauma Questionnaire – Revised (for adult maltreatment);

^e COR-Evaluation = Conservation of Resources – Evaluation (Hobfoll, Lilly, & Jackson, 1991).

* p < .05 level; ** p < .01

¹ Where the p-value is less than .05, the assumption that the data are normally distributed is rejected. If the p-value is greater than .05, then one can proceed with the assumption of normality (Field, 2000).

Table Z2.

Results of Kruskal-Wallis test on each of the rating scales where the grouping variable is mood state as rated by bipolar disorder (BD) participants (n = 31)^a on the Internal States Scale (Bauer et al., 1991).

Variable	χ^2	df	p
HADS^b			
Anxiety	2.47	2	.29
Depression	5.06	2	.08
CTQ^c			
Emotional abuse	.17	2	.92
Physical abuse	2.50	2	.29
Sexual abuse	.86	2	.65
Emotional neglect	2.65	2	.27
Physical neglect	3.49	2	.18
Internalized Shame Scale^d			
Shame	1.94	2	.38
Self-esteem	4.56	2	.10
CTQ-Revised^e			
Emotional abuse	.99	2	.61
Physical abuse	5.48	2	.07
Sexual abuse	.42	2	.81
Emotional neglect	.12	2	.94
Physical neglect	2.97	2	.23
COR-Evaluation^f			
Resource loss	3.42	2	.18
Resource gain	.01	2	.99

^a Group categories used in the analyses were 'depression' (n = 8), 'euthymia' (n = 14), and '(hypo)mania' (n = 9). The raw data of participants in the 'mixed state' group (n = 4) were not included as groups with fewer than five participants are not appropriate for inclusion in a Kruskal-Wallis analysis.

^b HADS = Hospital Anxiety and Depression Scale (Snaith & Zigmond, 1994);

^c CTQ = Childhood Trauma Questionnaire (Bernstein & Fink, 1998);

^d Internalized Shame Scale (Cook, 1994);

^e CTQ-Revised = Childhood Trauma Questionnaire – Revised (for adult maltreatment);

^f COR-Evaluation = Conservation of Resources – Evaluation (Hobfoll, Lilly, & Jackson, 1991).

Table Z3.

Mean scores on the rating scales for bipolar disorder (BD) participants (n = 31)^a in the four mood states categorised using the Internal States Scale (Bauer et al., 1991).

Variable	Depression		Euthymia		Mixed State		(Hypo)mania	
	(n = 8)		(n = 14)		(n = 4)		(n = 9)	
	<i>m</i>	<i>SD</i>	<i>m</i>	<i>SD</i>	<i>m</i>	<i>SD</i>	<i>m</i>	<i>SD</i>
HADS^a								
Anxiety	9.88	6.71	6.57	5.83	13.50	0.58	10.00	6.36
Depression	8.13	4.42	3.93	4.03	7.00	2.16	5.33	5.58
CTQ^b								
Emotional abuse	11.50	6.87	12.21	6.19	19.75	4.11	11.11	4.86
Physical abuse	7.38	4.24	7.64	4.22	6.00	1.41	9.44	3.94
Sexual abuse	9.00	7.71	7.21	4.69	7.50	4.36	10.11	7.56
Emotional neglect	14.38	6.39	10.79	5.41	17.00	6.27	13.67	6.40
Physical neglect	8.75	5.73	7.14	3.96	7.50	1.92	9.33	3.74
Total trauma	51.00	28.93	45.00	21.10	57.75	11.44	53.67	19.75
Internalized Shame Scale^c								
Internalised shame	50.88	20.48	36.93	22.98	55.75	3.50	52.78	32.83
Self-esteem	11.50	4.11	16.29	4.75	12.25	3.20	12.56	7.62
CTQ-Revised^d								
Emotional abuse	8.88	6.71	8.79	4.32	11.75	6.50	9.78	4.09
Physical abuse	7.38	4.90	5.00	0.00	5.00	0.00	6.44	3.97
Sexual abuse	7.75	7.01	6.14	2.93	5.00	0.00	7.44	6.62
Emotional neglect	9.88	4.54	10.50	4.88	14.25	7.37	11.33	6.33
Physical neglect	8.63	4.44	8.21	2.91	9.00	2.83	11.00	4.09
Total trauma	42.50	23.59	38.43	9.20	45.00	14.07	46.00	21.17
COR-Evaluation^e								
Resource loss	93.50	63.97	48.43	43.87	69.00	18.11	74.89	47.33
Resource gain	61.88	47.74	53.21	37.46	54.75	36.28	57.11	36.53

^a HADS = Hospital Anxiety and Depression Scale (Snaith & Zigmond, 1994);

^b CTQ = Childhood Trauma Questionnaire (Bernstein & Fink, 1998);

^c Internalized Shame Scale (Cook, 1994);

^d CTQ-Revised = Childhood Trauma Questionnaire – Revised (for adult maltreatment);

^e COR-Evaluation = Conservation of Resources – Evaluation (Hobfoll, Lilly, & Jackson, 1991).

Table Z4.
Cronbach's alpha co-efficient scores of internal consistency for the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998), and the revised version of the CTQ (CTQ-Revised) measuring adult maltreatment (N = 70).

CTQ Subscale	Original CTQ	CTQ-Revised
Physical neglect	.89	.87
Physical abuse	.74	.62
Emotional abuse	.71	.89
Emotional neglect	.90	.74
Sexual abuse	.94	.89
Overall measure	.89	.90

Table Z5.

Mann Whitney U-test results identifying group differences between male (n = 13) and female (n = 22) participants within the control group (n = 35).

Variable	Male		Female		U-test	p
	<i>m</i>	<i>SD</i>	<i>m</i>	<i>SD</i>		
HADS^a						
Anxiety	6.92	4.68	5.50	2.63	122.5	.489
Depression	2.92	3.52	2.41	1.87	133.5	.749
CTQ^b						
Emotional Abuse	6.38	1.81	7.91	3.90	120.0	.448
Sexual Abuse	5.00	0.00	6.05	3.72	123.5	.511
Physical Abuse	5.38	0.87	5.64	2.17	132.5	.724
Physical Neglect	5.15	0.38	7.00	3.086	92.0	.085
Emotional Neglect	7.77	2.59	8.82	3.47	122.5	.489
Total CTQ Score	30.46	3.50	35.41	12.73	115.5	.353
Minimisation-Denial	0.85	0.99	0.64	0.95	122.5	.489
Internalized Shame Scale^c						
Internalised Shame	22.62	16.64	25.09	13.50	121.0	.468
Self-Esteem [†]	17.15	5.27	15.64	3.84	115.0	.353
CTQ-Revised^d						
Emotional Abuse – Revised	5.77	1.36	6.27	1.64	115.5	.353
Sexual Abuse – Revised	5.00	0.00	5.18	0.85	136.5	.827
Physical Abuse – Revised	5.00	0.00	5.00	0.00	143.0	1.000
Physical Neglect – Revised	6.23	1.42	6.32	1.94	135.5	.801
Emotional Neglect – Revised	6.77	1.96	7.18	2.67	142.0	.987
Total CTQ-Revised Score	28.77	3.03	29.95	5.59	143.0	1.000
Minimisation-Denial	0.85	1.07	0.91	0.92	133.5	.729
COR-Evaluation^e						
Resource Loss	12.46	19.03	12.00	13.30	130.0	.674
Resource Gain	24.46	28.66	32.05	50.43	140.5	.933

^a HADS = Hospital Anxiety and Depression Scale (Snaith & Zigmond, 1994);

^b CTQ = Childhood Trauma Questionnaire (Bernstein & Fink, 1998); ^c Cook (1994);

^d CTQ-Revised; Childhood Trauma Questionnaire – Revised;

^e COR-Evaluation = Conservation of Resources – Evaluation (Hobfoll, Lilly, & Jackson, 1991).

[†] The self-esteem subscale of the Internalized Shame Scale is not a complete measure of self-esteem, but instead is a cursory indication of positive self-esteem, and as such, the results should be interpreted with significant caution.

Table Z6.
Mean ranks for participants' scores on sub-scales of the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998).

CTQ subscale	Mean Rank
Emotional neglect	4.11
Emotional abuse	3.75
Physical neglect	2.53
Physical abuse	2.31
Sexual abuse	2.29

Table Z7.
Wilcoxon signed-ranks test results between sub-scales of the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998).

CTQ subscales		Z	p
Physical abuse	_	Emotional abuse	-5.29
Sexual abuse	_	Emotional abuse	-4.52
Physical neglect	_	Emotional abuse	-4.15
Emotional neglect	_	Emotional abuse	-1.00
Emotional neglect	_	Sexual abuse	-5.52
Physical neglect	_	Emotional neglect	-5.86
Emotional neglect	_	Physical abuse	-6.60
Physical neglect	_	Sexual abuse	-.47
Sexual abuse	_	Physical abuse	-.34
Physical neglect	_	Physical abuse	-1.33

** $p < .01$

**DON'T FORGET REFERENCES AFTER
CORRELATION MATRICES!!!!!!**

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Table Z8.

Pearson Product Moment correlation matrix of the rating scale scores of participants in the bipolar disorder group (n = 35), partially controlled for the effect of low mood using the Depression subscale of the Internal State Scale (Bauer et al., 1991).

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Internal State Scale																		
1 Activation	1																	
HADS ^a																		
2 Anxiety	.38	1																
3 Depression	-.10	.32	1															
CTQ ^b																		
4 Emotional abuse	.19	.42*	.18	1														
5 Physical abuse	.15	.13	-.05	.38*	1													
6 Sexual abuse	.04	.03	.04	.32	.57**	1												
7 Emotional neglect	.18	.34	.18	.66**	.59**	.48**	1											
8 Physical neglect	.08	.24	-.00	.47*	.69**	.71**	.65**	1										
9 Total CTQ	.20	.31	.11	.75**	.76**	.74**	.88**	.85**	1									
Internalized Shame Scale ^c																		
10 Shame	.20	.61**	.54**	.48**	.19	.16	.46*	.32	.43*	1								
11 Self-esteem [†]	-.13	-.34	-.50**	-.06	-.24	-.40*	-.28	-.46*	-.36	-.60**	1							
CTQ-Revised ^d																		
12 Emotional abuse	.15	.28	.15	.50**	.29	.37	.40*	.44*	.51**	.41*	-.40	1						
13 Physical abuse	.07	.03	.09	.05	.23	.40*	.21	.37	.28	.23	-.27	.47*	1					
14 Sexual abuse	.03	-.18	-.17	.04	.41*	.56**	.20	.38*	.36	.01	-.12	.42*	.77**	1				
15 Emotional neglect	.05	.17	.26	.01	-.05	.07	.18	.18	.11	.41*	-.35	.40*	.12	.09	1			
16 Physical neglect	.23	.29	.10	.22	.23	.40*	.36	.52**	.43*	.47*	-.46*	.57**	.47*	.42*	.58**	1		
17 Total CTQ-revised	.13	.16	.13	.26	.31	.47*	.39*	.50**	.48**	.42*	-.42*	.80**	.67**	.69**	.66**	.81**	1	
COR-Evaluation ^e																		
18 Resource Loss	.23	.15	.31	.28	.27	-.06	.29	-.01	.20	.41*	-.02	.14	.16	.10	.11	.16	.20	1
19 Resource Gain	.19	.27	-.12	.13	.06	-.21	.16	.05	.06	.08	-.05	.01	-.14	-.13	.02	-.10	-.07	.07

^a HADS – Hospital Anxiety and Depression Scale (Snaith & Zigmond, 1994); ^b CTQ = Childhood Trauma Questionnaire (Bernstein & Fink, 1998);

^c Internalized Shame Scale (Cook, 1994); ^d CTQ-Revised; Childhood Trauma Questionnaire – Revised; ^e COR-Evaluation = Conservation of Resources – Evaluation (Hobfoll, Lilly, & Jackson, 1991).

[†] The self-esteem subscale of the Internalized Shame Scale is not a complete measure of self-esteem, but instead is a cursory indication of positive self-esteem, and as such, the results should be interpreted with significant caution.

* p < 0.05 (two-tailed); ** p < 0.01 (two-tailed)

Table Z9.

Pearson Product Moment correlation matrix of the rating scale scores of participants in the bipolar disorder group (n = 35), partially controlled for the effect of mania using the Activation subscale of the Internal State Scale (Bauer et al., 1991).

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Internal State Scale																		
1 Depression	1																	
HADS ^a																		
2 Anxiety	.50	1																
3 Depression	.64**	.58**	1															
CTQ ^b																		
4 Emotional abuse	.14	.40*	.25	1														
5 Physical abuse	.14	.14	.07	.38*	1													
6 Sexual abuse	.16	.09	.13	.33	.58**	1												
7 Emotional neglect	.27	.39*	.33	.65**	.59**	.50**	1											
8 Physical neglect	.20	.29	.13	.48**	.69**	.72**	.67**	1										
9 Total CTQ	.25	.35	.26	.74**	.76**	.75**	.89**	.86**	1									
Internalized Shame Scale ^c																		
10 Shame	.37	.66**	.65**	.48**	.21	.20	.49**	.35	.46*	1								
11 Self-esteem [†]	-.44*	-.47*	-.64**	-.10	-.27	-.43*	-.35	-.49**	-.41*	-.65**	1							
CTQ-Revised																		
12 Emotional abuse	.02	.22	.14	.48**	.27	.36	.38*	.43*	.48**	.38*	-.35	1						
13 Physical abuse	.02	.01	.09	.04	.22	.39*	.20	.36	.27	.21	-.25	.46*	1					
14 Sexual abuse	.00	-.18	-.13	.04	.41*	.55**	.19	.37	.35	.00	-.10	.43*	.77**	1				
15 Emotional neglect	.38*	.32	.43*	.06	.00	.12	.25	.24	.19	.49**	-.46*	.38*	.12	.08	1			
16 Physical neglect	.29	.33	.28	.21	.23	.43*	.39*	.54**	.45*	.50**	-.51**	.54**	.45*	.41*	.62**	1		
17 Total CTQ-revised	.23	.22	.25	.27	.32	.49**	.42*	.52**	.50**	.45*	-.46*	.78**	.66**	.68**	.69**	.82**	1	
COR-Evaluation																		
18 Resource Loss	.26	.19	.42*	.27	.27	-.03	.31	.03	.22	.44*	-.11	.11	.15	.09	.19	.18	.22	1
19 Resource Gain	-.12	.12	-.16	.08	.01	-.23	.10	.01	-.01	-.01	-.03	-.02	-.15	-.14	-.04	-.18	-.12	-.01

^a HADS – Hospital Anxiety and Depression Scale (Snaith & Zigmond, 1994); ^b CTQ = Childhood Trauma Questionnaire (Bernstein & Fink, 1998);

^c Internalized Shame Scale (Cook, 1994); ^d CTQ-Revised; Childhood Trauma Questionnaire – Revised; ^e COR-Evaluation = Conservation of Resources – Evaluation (Hobfoll, Lilly, & Jackson, 1991).

[†] The self-esteem subscale of the Internalized Shame Scale is not a complete measure of self-esteem, but instead is a cursory indication of positive self-esteem, and as such, the results should be interpreted with significant caution.

* p < 0.05 (two-tailed); ** p < 0.01 (two-tailed)

Table Z10.

Pearson Product Moment correlation matrix of rating scale scores by participants in the control group (n = 35).

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
HADS ^a																	
1 Anxiety	1																
2 Depression	.52**	1															
CTQ ^b																	
3 Emotional abuse	.32	.24	1														
4 Physical abuse	.20	.13	.58**	1													
5 Sexual abuse	.15	.20	.51**	.74**	1												
6 Emotional neglect	-.18	-.12	.34*	.38*	.36*	1											
7 Physical neglect	.09	.10	.21	.13	.32	.45*	1										
8 Total CTQ	.19	.25	.71**	.67**	.71**	.77**	.61**	1									
Internalized Shame Scale																	
9 Shame	.49**	.45*	.32	.16	.11	.05	.19	.26	1								
10 Self-esteem [†]	-.45**	-.61**	-.26	-.01	-.18	.13	-.09	-.13	-.59**	1							
CTQ-Revised ^c																	
11 Emotional abuse	-.10	-.02	.36*	.18	.25	.12	.23	.29	.25	-.09	1						
12 Physical abuse	-	-	-	-	-	-	-	-	-	-	-	1					
13 Sexual abuse	.12	-	.50**	.84**	.90**	.34	.29	.68**	.17	-.11	.32	-	1				
14 Emotional neglect	.12	.13	.22	.06	.06	.14	.02	.18	.36*	-.32	.37*	-	.10	1			
15 Physical neglect	.22	.45*	.23	.17	.15	.08	-.09	.20	.35*	-.34*	.42*	-	.10	.64**	1		
16 Total CTQ-Revised	.10	.22	.36*	.25	.27	.19	.10	.34*	.41*	-.31	.70**	-	.30	.86**	.84**	1	
COR-Evaluation ^d																	
17 Resource Loss	.21	.23	-.11	.04	.14	-.08	.02	.07	.19	-.12	-.04	-	-.04	-.02	.29	.09	1
18 Resource Gain	-.36	-.19	-.20	.07	.15	-.05	-.29	-.07	-.23	.22	-.07	-	.08	-.19	-.03	-.12	.45*

a

HADS = Hospital Anxiety and Depression Scale (Snaith & Zigmond, 1994); ^b CTQ = Childhood Trauma Questionnaire (Bernstein & Fink, 1998);

^c CTQ-Revised; Childhood Trauma Questionnaire – Revised; ^d COR-Evaluation = Conservation of Resources – Evaluation (Hobfoll, Lilly, & Jackson, 1991).

* $p < 0.05$ (two-tailed); ** $p < 0.01$ (two-tailed)

[†] The self-esteem subscale of the Internalized Shame Scale is not a complete measure of self-esteem, but instead is a cursory indication of positive self-esteem, and as such, the results should be interpreted with significant caution.

Table 2.

Mean scores on the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998) reported in studies investigating the levels of childhood maltreatment in participants from psychiatric, community, and undergraduate student samples.

Authors	Samples	CTQ subscales (Mean, SD)						Total CTQ Score
		Emotional abuse	Sexual abuse	Physical abuse	Emotional neglect	Physical neglect		
Psychiatric samples:								
Allison, Grilo, Masheb, & Stunkard (2007)	Binge-Eating Disorder (<i>n</i> = 176)	10.5 (n/a)	6.7 (n/a)	7.4 (n/a)	13.0 (n/a)	8.2 (n/a)	n/a ^a	n/a
Bernet & Stein (1999)	Night-Eating Disorder (<i>n</i> = 57)	10.0 (n/a)	7.7 (n/a)	7.4 (n/a)	6.7 (n/a)	10.8 (n/a)		
Didie et al. (2006)	Depression (<i>n</i> = 47)	30.3 (12.5)	10.3 (5.8)	14.5 (7.1)	39.9 (14.0)	12.0 (3.8)	n/a	n/a
	Control group (<i>n</i> = 41)	20.8 (8.9)	8.2 (3.5)	10.5 (4.4)	31.1 (15.9)	10.2 (3.5)		
Lochner et al. (2002)	Body Dysmorphic Disorder: females (<i>n</i> = 52)	12.0 (6.4)	8.6 (6.6)	8.0 (4.7)	12.7 (5.4)	7.5 (3.6)	n/a	n/a
	Body Dysmorphic Disorder: males (<i>n</i> = 23)	9.2 (6.4)	5.3 (6.4)	7.6 (6.4)	12.6 (6.4)	7.1 (6.4)		
Roy (1999)	Obsessive-Compulsive Disorder (<i>n</i> = 74)	10.3 (5.5)	7.3 (4.5)	7.2 (3.8)	10.1 (5.1)	5.9 (1.7)	40.8 (15.6)	
	Trichotillomania (<i>n</i> = 36)	9.9 (5.6)	7.1 (5.3)	7.9 (4.2)	10.3 (4.8)	6.5 (2.2)	41.8 (16.8)	
	Control group (<i>n</i> = 31)	7.8 (3.6)	6.4 (3.3)	5.8 (1.1)	6.7 (2.5)	5.6 (1.2)	32.4 (8.7)	
Sarchiapone, Carli, & Cuomo, & Roy (2007)	Euthymic depressed alcoholics (<i>n</i> = 23)	14.3 (5.1)	9.6 (5.1)	14.4 (5.9)	26.9 (9.3)	14.5 (5.1)	n/a	n/a
	Never depressed alcoholics (<i>n</i> = 20)	7.6 (3.4)	6.6 (1.2)	7.9 (2.6)	16.1 (6.2)	11.9 (3.5)		
Non-psychiatric samples:								
Paivio & Cramer (2004)	Undergraduate sample: females (<i>n</i> = 280)	9.0 (4.5)	6.2 (3.6)	6.3 (2.7)	9.2 (4.3)	6.1 (2.0)	n/a	n/a
	Undergraduate sample: males (<i>n</i> = 153)	7.9 (3.3)	5.5 (2.1)	6.5 (2.5)	9.2 (3.6)	6.3 (2.2)		
Scher, Stein, Asmundson, McGreary, & Forde (2001)	Community sample: females (<i>n</i> ≈ 520)	6.5 (2.6)	5.7 (2.6)	6.5 (2.5)	6.8 (3.5)	6.0 (2.1)	31.8 (11.2)	
	Community sample: males (<i>n</i> ≈ 470)	6.9 (3.7)	5.2 (1.4)	6.7 (2.3)	7.0 (3.6)	6.4 (2.1)	31.7 (9.1)	

^a Data not published.

Table 4.

Mann Whitney U-test results identifying group differences between participants in the bipolar disorder (BD) group (n = 35) and the control group (n = 35).

Variable	BD		Control		U-test	p
	<i>m</i>	<i>SD</i>	<i>m</i>	<i>SD</i>		
HADS^a						
Anxiety	9.00	6.09	6.03	3.54	455.0	.064
Depression	5.60	4.54	2.60	2.57	378.0	.005**
CTQ^b						
Emotional Abuse	12.63	6.19	7.34	3.33	254.5	<.001**
Sexual Abuse	8.40	6.11	5.66	2.97	451.5	.008**
Physical Abuse	7.86	3.93	5.54	1.79	364.5	.001**
Physical Neglect	8.11	4.16	6.31	2.60	479.0	.079
Emotional Neglect	13.06	6.10	8.43	3.17	338.5	.001**
Total CTQ Score	50.06	21.61	33.57	10.51	319.5	.001**
Minimisation-Denial	0.46	0.74	0.71	0.96	535.5	.298
Internalized Shame Scale^c						
Internalised Shame	46.34	24.61	24.17	14.55	291.5	<.001**
Self-Esteem [†]	13.77	5.58	16.20	4.41	447.5	.052
CTQ-Revised^d						
Emotional Abuse – Revised	9.40	5.00	6.09	1.54	322.0	<.001**
Sexual Abuse – Revised	6.71	4.96	5.11	0.68	524.0	.046*
Physical Abuse – Revised	5.91	3.11	5.00	0.00	525.0	.021*
Physical Neglect – Revised	9.11	3.64	6.29	1.74	278.0	<.001**
Emotional Neglect – Revised	11.00	5.39	7.03	2.41	320.5	.001**
Total CTQ-Revised Score	42.06	16.74	29.51	4.79	230.0	<.001**
Minimisation-Denial	0.54	0.82	0.89	0.96	490.5	.115
COR-Evaluation^e						
Resource Loss	67.89	49.58	12.17	15.40	138.0	<.001**
Resource Gain	56.37	38.07	29.23	43.30	303.5	<.001**

^a HADS = Hospital Anxiety and Depression Scale (Snaith & Zigmond, 1994);

^b CTQ = Childhood Trauma Questionnaire (Bernstein & Fink, 1998);

^c Internalized Shame Scale (Cook, 1994);

^d CTQ-Revised; Childhood Trauma Questionnaire – Revised (for adult maltreatment);

^e COR-Evaluation = Conservation of Resources – Evaluation (Hobfoll, Lilly, & Jackson, 1991).

** $p < .01$; * $p < .05$

[†] The self-esteem subscale of the Internalized Shame Scale is not a complete measure of self-esteem, but instead is a cursory indication of positive self-esteem, and as such, the results should be interpreted with significant caution.

Table 5.

Mann Whitney U-test results identifying group differences between male (n = 13) and female (n = 22) participants within the bipolar disorder (BD) group (n = 35).

Variable	Male		Female		U-test	p
	<i>m</i>	<i>SD</i>	<i>m</i>	<i>SD</i>		
Internal State Scale^a						
Activation	159.38	106.51	146.86	117.58	137.0	.72
Depression	31.23	19.16	54.05	46.97	117.0	.39
HADS^b						
Anxiety	6.31	4.94	10.59	6.24	89.0	.067
Depression	3.15	2.88	7.05	4.77	76.5	.022*
CTQ^c						
Emotional Abuse	9.08	4.15	14.73	6.31	62.5	.005**
Sexual Abuse	5.23	0.60	10.27	7.09	90.0	.073
Physical Abuse	6.46	2.11	8.68	4.54	109.0	.257
Physical Neglect	6.31	2.43	9.18	4.65	90.5	.073
Emotional Neglect	10.00	5.55	14.86	5.78	75.5	.020*
Total CTQ Score	37.08	12.50	57.73	22.38	53.5	.002**
Minimisation-Denial	0.54	0.77	0.41	0.73	130.0	.674
Internalized Shame Scale^d						
Internalised Shame	32.85	18.07	54.32	24.79	70.5	.012*
Self-Esteem [†]	16.77	5.25	12.00	5.08	72.0	.015*
CTQ-Revised^e						
Emotional Abuse – Revised	6.54	1.71	11.09	5.54	59.0	.003**
Sexual Abuse – Revised	5.00	.00	7.73	6.07	104.0	.191
Physical Abuse – Revised	5.38	1.12	6.23	3.83	142.0	.987
Physical Neglect – Revised	7.92	2.75	9.82	3.97	105.0	.203
Emotional Neglect – Revised	10.08	5.77	11.55	5.22	113.0	.319
Total CTQ-Revised Score	34.69	7.43	46.41	19.21	81.0	.034*
Minimisation-Denial	0.54	0.88	0.55	0.81	139.5	.906
COR-Evaluation^f						
Resource Loss	55.38	49.98	75.27	48.97	104.0	.191
Resource Gain	51.46	29.54	59.27	42.71	138.0	.880

^a Internal State Scale (Bauer et al., 1991);

^b HADS = Hospital Anxiety and Depression Scale (Snaith & Zigmond, 1994);

^c CTQ = Childhood Trauma Questionnaire (Bernstein & Fink, 1998);

^d Internalized Shame Scale (Cook, 1994);

^e CTQ-Revised; Childhood Trauma Questionnaire – Revised (for adult maltreatment);

^f COR-Evaluation = Conservation of Resources – Evaluation (Hobfoll, Lilly, & Jackson, 1991);

** $p < .01$; * $p < .05$

[†] The self-esteem subscale of the Internalized Shame Scale is not a complete measure of self-esteem, but instead is a cursory indication of positive self-esteem, and as such, the results should be interpreted with significant caution.

Table 7.

Pearson Product Moment Correlation matrix of rating scale scores of participants in the bipolar disorder (BD) group (n = 35).

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
Internal State Scale ^a																			
1 Activation	1																		
2 Depression	.26	1																	
HADS ^b																			
3 Anxiety	.38*	.57**	1																
4 Depression	.15	.68**	.58**	1															
CTQ ^c																			
5 Emotional abuse	.20	.24	.49**	.36*	1														
6 Physical abuse	.22	.26	.25	.19	.46**	1													
7 Sexual abuse	.14	.25	.18	.21	.37*	.61**	1												
8 Emotional neglect	.25	.40*	.51**	.45**	.73**	.66**	.54**	1											
9 Physical neglect	.21	.33	.39**	.25	.51**	.72**	.75**	.71**	1										
10 Total CTQ	.27	.38*	.48**	.38*	.79*	.79**	.75**	.92**	.86**	1									
Internalized Shame Scale ^d																			
11 Shame	.30	.49**	.71**	.68**	.54**	.37*	.31	.63**	.48**	.59**	1								
12 Self-esteem [†]	-.29	-.56**	-.56**	-.69**	-.25	-.39*	-.50**	-.51**	-.59**	-.54**	-.74**	1							
CTQ-Revised ^e																			
13 Emotional abuse	.23	.19	.37*	.27	.55**	.36*	.43**	.51**	.52**	.58**	.47**	.48**	1						
14 Physical abuse	.11	.09	.08	.13	.09	.26	.42*	.24	.39*	.30	.25	.29	.48**	1					
15 Sexual abuse	.08	.07	-.09	-.05	.09	.43*	.57**	.24	.41*	.38*	.10	.18	.45**	.77**	1				
16 Emotional neglect	.15	.39*	.31	.55**	.25	.16	.17	.40*	.29	.33*	.52**	.47**	.39*	.14	.11	1			
17 Physical neglect	.35*	.39*	.42*	.42*	.36*	.35*	.46**	.51**	.58**	.56**	.56**	.58**	.45**	.41*	.68**	1			
18 Total CTQ-Revised	.24	.35*	.33	.40*	.41*	.43**	.53**	.55**	.58**	.61**	.55**	.56**	.79**	.63**	.66**	.73**	.85**	1	
COR-Evaluation ^f																			
19 Resource Loss	.28	.41*	.37*	.46**	.37*	.38*	.13	.49**	.24	.41*	.63**	.36*	.30	.20	.16	.21	.28	.34*	
20 Resource Gain	.08	-.13	.15	-.15	.10	.02	-.25	.08	-.02	.01	-.03	.05	-.04	-.15	-.15	-.01	-.15	-.11	
																		-.03	

^aInternal State Scale (Bauer et al., 1991); ^b HADS – Hospital Anxiety and Depression Scale (Snaith & Zigmond, 1994); ^c CTQ = Childhood Trauma Questionnaire (Bernstein & Fink, 1998);

^d Internalized Shame Scale (Cook, 1994); ^e CTQ-Revised; Childhood Trauma Questionnaire – Revised; ^f COR-Evaluation = Conservation of Resources – Evaluation (Hobfoll, Lilly, & Jackson, 1991).

[†] The self-esteem subscale of the Internalized Shame Scale is not a complete measure of self-esteem, but instead is a cursory indication of positive self-esteem, and as such, the results should be interpreted with significant caution.

* p < 0.05 (two-tailed); ** p < 0.01 (two-tailed).