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Faculty of Environmental and Life Sciences

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Psychological Outcomes and the Role of Compassion in Men Who Have Experienced a Betrayal

by

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Thesis for the degree of Doctorate in Clinical Psychology

18 August 2023

University of Southampton

Abstract

Faculty of Environmental and Life Sciences

School of Psychology

Doctorate in Clinical Psychology

Psychological Outcomes and the Role of Compassion in Men Who Have Experienced a Betrayal

by

Alexandra Charlotte Clarisse Newman

The first chapter of this thesis is a systematic literature review that examined the psychological impact of an interpersonal betrayal on men's mental health. It is well known that men in general may express mental health difficulties differently from women and due to a general reluctance in men to discuss their emotional problems, men may therefore be prone to shame. As shame is a key feature of betrayal trauma, it was expected that men may experience self-criticism and shame in response to betrayal, compounded by the increased risk of experiencing shame in response to emotional problems in general. A narrative synthesis of eight studies that varied in methodological design indicated a range of negative psychological outcomes that men reported from a betrayal by a trusted other. The findings provided evidence of men experiencing some degree of distress; however, the nature and severity of this distress is not wholly clear and requires further investigation. Further exploration of gender differences is recommended to inform appropriate intervention.

The second chapter of this thesis is an empirical study that investigated the impact of a brief compassion intervention compared with guided relaxation in men that have been interpersonally betrayed. In total, 52 men participated with 26 randomised into each group. The study employed a 2 x 3 design using two conditions (compassionate-imagery and relaxation) tested at three time points (pre, post and one-week follow-up). Results showed an effect of time on scores but no differences between compassion and relaxation. Specifically, this study's findings demonstrated preliminary evidence of efficacy with both brief compassionate imagery and guided relaxation for improving positive mood, reducing negative mood, and increasing betrayed men's motivation to act in ways that alleviate suffering. Further research is warranted to understand the mechanisms of change involved so that psychologists can effectively meet men's emotional needs.

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Research Thesis: Declaration of Authorship

Print name: Alexandra Charlotte Clarisse Newman

Title of thesis: Psychological Outcomes and the Role of Compassion in Men Who Have Experienced a Betrayal

I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

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3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
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7. None of this work has been published before submission.

Signature:

Date: 19th May 2023

Acknowledgements

This thesis is in dedication to L. J. W. who first inspired my passion into male psychology and interpersonal betrayal. May you be filled with love and kindness and compassion; may you be peaceful and at ease; may you be well; and may you be happy so that you can reclaim your life.

One of the greatest pleasures of completing this Doctoral thesis is to say a heartfelt thank you to all those that have impacted me throughout this long, slow, and at times painful journey. In no particular order, I should like to thank the following for their constant support…

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made me really enjoy statistics during my time at university. Words cannot give justice to how much I have valued your expertise and your patience with me when trying to interpret the complex analysis of my data.

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Abbreviations

(S-)CEAS ..... (State) Compassionate Engagement and Action Scales

(S-)TCRS ..... (State) Trust in Close Relationships Scale

BBTS ..... Brief Betrayal Trauma Survey

BTT ..... Betrayal Trauma Theory

CAT..... Child Abuse Trauma Scale

CFT ..... Compassion Focused Therapy

CMT ..... Compassionate Mind Training

DAS ..... Dysfunctional Attitudes Scale

DERS ..... Difficulties in Emotion Regulation Scale

DES-II ..... Dissociative Experiences Scale

ERGO ..... Ethics and Research Governance Online

ETHoS ..... E-theses Online

GAD-7 ..... Generalised Anxiety Disorder Scale

HB ..... High Betrayal

IES ..... Impact of Events Scale

IES-R ..... Impact of Events Scale Revised

IPA ..... Interpretative Phenomenological Analysis

IPV ..... Interpersonal Violence

LB ..... Low Betrayal

M ..... Mean

MANOVA ..... Multivariate Analysis of Variance

MMAT ..... Mixed Methods Appraisal Tool

N ..... Number of Participants

PANAS ..... Positive and Negative Affect Scale

PCL-S ..... Post-traumatic Stress-Disorder Checklist Specific

PHQ-9 ..... Patient Health Questionnaire

PICO ..... Participants, Intervention, Control, Outcomes

PIS ..... Participant Information Sheet

PRISMA ..... Preferred Reporting Items for Systematic Reviews and Meta-Analyses

PROSPERO ..... International Prospective Register of Systematic Reviews

PTSD ..... Post-Traumatic Stress Disorder

R-CMS ..... Revised Civilian Mississippi Scale

RSE ..... Rosenberg Self Esteem Scale

SD ..... Standard Deviation

SPM ..... Shame Posture Measure

S-SES ..... State Self Esteem Scale

TAS-20 ..... Toronto Alexithymia Scale

TSC-40 ..... Trauma Symptom Checklist

TSQ ..... Trauma Screening Questionnaire

University of Southampton

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Chapter 1: What is the psychological impact of interpersonal betrayal on men? A systematic review.

by

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What is the psychological impact of interpersonal betrayal on men? A systematic review.

Title page and abstract

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Short title:

PSYCHOLOGICAL IMPACT OF BETRAYAL ON MEN

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Conflict of Interest

None.

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Data availability statement:

The data that support the findings of this study are not applicable to this comprehensive review as no new data was created or analysed in this article.

Author Contributions

Alexandra Newman: Conceptualisation, Methodology, Validation, Formal Analysis, Investigation, Visualisation, Writing – Original Draft **Alison Bennetts:** Conceptualisation, Supervision, Project Administration, Writing – Review and Editing **Lusia Stopa:** Conceptualisation, Supervision, Project Administration, Writing – Review and Editing

Abstract

This systematic review aimed to synthesise the literature to investigate the psychological impact of an interpersonal betrayal on men's mental health. A total of eight studies were eligible for inclusion that varied in methodological design. The main findings indicated 13 psychological outcomes that fell broadly into four conceptually related categories of post-traumatic experiences, anxiety, depression, and shame and related processes. Taken together, the synthesis of research included in this review points to some men reporting some degree of negative symptoms from a betrayal trauma by a close and trusted other. It is possible that broadly accepted social gender norms influence underlying processes such as shame around mental health difficulties and emotions. Recommendations for future research include investigating shame and self-criticism to understand why some men report mild levels of symptoms while others experience more enduring difficulties. It is important to understand what the impact is as well as how men may express their psychological difficulties. Further exploration of gender differences is recommended to inform appropriate intervention.

Key Practitioner Message

- This is the first review examining the psychological impact of betrayal on men.
- Evidence showed that men reported symptoms that fell within the mild range.
- Self-concept and shame are important outcomes within the profile of betrayal.
- Theories of masculinity are recommended to account for men-specific experiences.

Keywords:

MALE PSYCHOLOGY, BETRAYAL TRAUMA THEORY, INTERPERSONAL

BETRAYAL TRAUMA

Introduction

Why is it important to understand the impact of a betrayal on men? It is well known that men in general may express mental health difficulties differently from women (Whitley, 2021). Due to a general reluctance in men to discuss their emotional problems, men may be prone to shame by focusing on how others think and feel about them (Hine et al., 2020). As shame is a key feature of betrayal trauma, it is expected that men may experience self-criticism and shame in response to betrayal trauma, compounded by the increased risk of experiencing shame in response to emotional problems in general. However, the vast majority of research has focused on betrayal trauma and subsequent outcomes in women. This systematic review synthesises the available literature to understand men's experience of an interpersonal betrayal and its psychological effects on men's mental health.

Psychological outcomes following a traumatic event have been widely researched and are known to include mental health disorders such as anxiety, depression, and post-traumatic stress (PTSD), as well as specific symptoms such as shame, self-blame and guilt (Brown, 2013; Grant et al., 2008; Laugharne et al., 2010). Such traumatic incidents can vary between natural disasters, accidents, violence, and abuse. Where traumas are perpetrated by someone known to the victim, and perceived as a betrayal of a relationship of trust, individuals experience an additional range of difficulties as they have to contend with not only *what* the traumatic incident involved but also the added complexity of *who* was involved in it happening (Freyd, 2003). These types of trauma, collectively termed betrayal traumas, can have damaging consequences for an individual's psychological recovery; however, to date these effects have largely been studied in women. In the current review, a systematic analysis of the literature sought to further understand the unique experiences facing men who have been betrayed.

Interpersonal Betrayal

The most common types of betrayal are infidelity, failure to offer assistance in a time of need, disclosure to a third party of personal information, dishonesty, and disloyalty (Rachman, 2010). Such traumas are classified as a high betrayal (HB) when they occur within the context of an interpersonal relationship (Freyd, 1994). Betrayal Trauma Theory (BTT; Freyd (1994) describes how the violation of trust by a close other, such as between a caregiver and child, romantic partners, or friends, can shatter beliefs in the safety and security of that attachment. In order to preserve this interpersonal attachment, the betrayed party may avoid focussing on the actions of the betrayer and instead make negative appraisals about the self (Freyd, 1996). The term self-appraisal refers to the evaluation of one's own behaviour, thoughts, and emotions. Individuals may consequently make self-appraisals that focus on how a situation involving a betrayal of trust made them think and feel.

Similar to PTSD-related appraisals, individuals who have experienced interpersonal traumas can make post-betrayal misappraisals that centre on self-blame, excessive guilt, and self-criticism (Gagnon et al., 2019). This compounds the problem because focusing attention on the self negatively, can lead individuals to experience secondary trauma-related symptoms such as anxiety and depression. These negative self-appraisals may take the form of shame, where individuals blame themselves and ruminate on the betrayal such that they no longer feel valued, leading to feelings of isolation (Bernstein & Freyd, 2014).

Linked to these ideas of how individuals view themselves, is how they perceive *others* see them (Lewis, 2003). Seeking acceptance and social approval allows individuals to gain an understanding of how they are viewed by others that enables them to evaluate their self-worth. Creating a positive image in other's minds contributes to a felt-sense of safety and

security in trusting attachments and builds the individual's positive sense of self (Lewis, 2003).

Conversely in betrayal experiences, an individual may make self-critical evaluations concluding that they are no longer viewed positively by the person who betrayed them and appraise this experience in terms of their own self-worth. The experience of relating to the self in this particular way may derive from shame whereby how one sees oneself is highly fused with how others are seen to relate to the self (Gilbert & Irons, 2009). Shame is defined as a sense of living negatively in the minds of others and oneself that may lead to rejection, and is inextricably linked with self-criticism (Gilbert & Irons, 2009). As such, the psychological impact following an interpersonal betrayal can include not only just the trauma but also appraisals that result in a high degree of shame toward the self (Matos & Pinto-Gouveia, 2010). Critically, the shame experienced from an interpersonal betrayal may not be different to that experienced in PTSD, in which there is a violation of trust, that in some way involves the traumatised individual perceiving themselves as existing negatively in their own and other's minds.

Psychological Outcomes and the Role of Shame

The impact of an interpersonal betrayal can cover an array of psychological outcomes that include distress, anger, loss, grief, shock, poor self-esteem, self-doubt, worthlessness, and dissociation, that may be further intensified in situations where the betrayed individual needs to maintain their attachment to the betrayer and cope temporarily while still dependent on them, e.g., parent, boss, partner (DePrince & Freyd, 2004). In this way, the type of betrayal is important for understanding post-traumatic outcomes, according to Freyd and DePrince (2001). Betrayals that involve harm caused by a trusted other (high betrayal) will be experienced differently to traumas that do not include betrayal in a close relationship (low

betrayal). Where individuals want to preserve and maintain an attachment, such as between close friends, the need to be accepted and viewed positively by the trusted other (which is not necessarily present in other contexts) may compound the difficulties experienced if that trust is betrayed. This is because people's sense of self and self-identities are tied to important others (Gilbert & Irons, 2009). Crucially, the attachment relationship is central to this difference: the case of being a victim of investment fraud by a scammer will no doubt be traumatic and shatter beliefs in the safety of the world (low betrayal), but will lack a specific relationship of trust and interpersonal security that would exist between close others (high betrayal) (Bernstein & Freyd, 2014). This added complexity of the attachment relationship may serve to prolong exposure to stress in cases of individuals who have ongoing contact with their betrayers, meaning they are unlikely to be able to avoid memories of the betrayal.

The psychological impact of high-betrayal traumas can initiate reactions that are similar to PTSD symptoms such as avoidance, intrusive thoughts, isolation, rumination, and difficulties with regulating emotions (Rachman, 2010). However, not everyone who experiences betrayal and PTSD symptoms develops full PTSD and this can be due to the absence of re-experiencing and flashbacks to the initial threat following the index event (Herman, 1992). Betrayals can nevertheless still be experienced as traumatic due to the insidious nature of effects that can develop following a breach of trust. As the individual attempts to make sense of the event, the threat of losing the safety and security of a close attachment may evoke fears of rejection (Gilbert & Irons, 2009). The experience of these feelings can be associated with reduced self-esteem and confidence as the betrayed person may attribute explanations for the betrayal internally (Santor & Walker, 1999). For example, a child whose parent failed to offer support during time of need may believe the parent no longer loves them, contributing to the child's sense of self as unlovable and devalued (Leary et al., 1995).

One way to explain the relationship between how misappraisals about a betrayal event leads to psychological difficulty is by looking more closely at the role of shame and self-blame. Following a betrayal, individuals may ruminate on how the betrayal reflects on them; whether they look bad to others, and what that means for their self-worth (DePrince et al., 2011). For example, a man whose partner cheated on him may refocus the betrayal onto confirming beliefs about himself as inferior or inadequate to explain why the partner committed infidelity. Through self-blame and apportioning responsibility for the betrayal to himself rather than the partner, these misappraisals may activate feelings of shame due to fears of how others perceive him and the possibility that these perceptions could lead to humiliation and rejection (Andrews et al., 2000). It would appear then that an individual's sense of worth and self-esteem are strongly linked to how they appraise the betrayal; such that attributing and internalising feelings of shame is associated with anxiety and depression, whereas externalising feelings of humiliation to the betraying other reduces focus on the self and thus negative outcomes (Gilbert & Irons, 2009). The consequences may be particularly pronounced for individuals whose identities and sense of self are tied closely to the person who betrayed a relationship of trust, such as partners and parents, due to the shattering effects on beliefs in the safety and security of their attachment (Gagnon et al., 2019).

Trends and Limitations in the Literature to Date

To date, much of the research into betrayal has centred on women victims of interpersonal violence (IPV; Chiu et al., 2017; Platt et al., 2017; St. Vil et al., 2021). Where studies have looked at gender differences, these have concentrated on the number of betrayals, with the findings consistently showing that women experience more high-betrayal traumas than men (DePrince & Freyd, 2002). This may be linked to shame about reporting in samples of men, with one recent study exploring barriers to seeking help in men who

experienced interpersonal abuse (Lysova et al., 2022). In experimental designs that have investigated psychological outcomes following a betrayal, data for men and women were not analysed separately (e.g., Freyd et al., 2005). As the majority of these studies had a significantly higher proportion of women participants in the overall sample, it would not be possible to interpret the findings without separating men from the women (DePrince et al., 2010; DePrince et al., 2011). This has meant that any significant effects on psychological outcomes from a betrayal for men in the research literature, may have been overshadowed by the average score of the women saturating the sample.

Recent literature in the field of betrayed men has focussed on their victimisation in the context of IPV. Bates and Carthy (2020) reported age-specific findings from the experience of older men who had been convinced they were developing Alzheimer's and cognitive decline. Within their review of the literature, evidence found the types of abuse men experienced including bullying, threats, gaslighting, financial manipulation, and false allegations (Drijber et al., 2013). Although interpersonal violence can be considered as a betrayal of trust, the research that has investigated the accounts of men has focused specifically on intimate relationships alone (Bates & Carthy, 2020; Drijber et al., 2013), rather than the broader spectrum of interpersonal relationships identified by Betrayal Trauma Theory. This means that the findings may not accurately represent the experience of men who have been betrayed by a close and trusted other who is not a romantic partner. Though it is encouraging that research is raising awareness of the rates of men experiencing domestic abuse and the inequalities in service provision, typically these studies fail to investigate and report findings on the psychological outcomes incurred by an interpersonal betrayal. Instead, they have utilised qualitative methodologies to explore counsellors' experiences of working with men (Hogan et al., 2012), support provider call handlers' accounts (Hine et al., 2020), or

quantitative prevalence studies to describe the types of abuse experienced (Hines et al., 2007).

An additional critique of the evidence base concerns the methodological designs used when investigating interpersonal betrayals. Hypothetical scenarios require participants to imagine a betrayal such as infidelity and predict how they would react; however, such designs strongly lack ecological validity as these might not reflect actual responses (Bates et al., 2019; Berman & Frazier, 2005). Other studies have utilised computer-based cognitive tasks with betrayed participants to test for dissociative tendencies and revictimization risk (DePrince, 2005; Devilly et al., 2007). Consequently, there remains a lack of studies looking at psychological outcomes following a betrayal, particularly for men. Where research has investigated outcomes, samples are based largely on university students completing cross-sectional surveys (e.g., Elwood & Williams, 2007). As well as the absence of men in the literature, these issues of methodology remain unresolved making it difficult to draw conclusions and generalise to men that have experienced an interpersonal betrayal.

Previous Reviews

Reviews in this area have included narrative papers and descriptive prevalence studies, which have reported that the lasting effects of a betrayal trauma include increased levels of shame, self-blame, social isolation, guilt, and depression, as well as reduced trust in relationships (Dockler & Mueller, 2017). These reactions have been investigated more in women, who are also more likely to experience a high betrayal trauma than men (DePrince & Freyd, 2002). Policy and practice recommendation papers have centred on service provision and help-seeking by men experiencing domestic abuse and interpersonal violence (Dutton & White, 2013). Propositions included understanding the service preferences for men and determining the level of revictimization risk (Huntley et al., 2020). However, prevalence

rates for betrayal trauma in men are likely to be below the actual number as societal barriers may make men reluctant to disclose and seek out support when services might be exclusively targeted towards women (Perryman & Appleton, 2016).

A recent meta-analysis examined betrayal trauma in relation to social support and symptoms of post-traumatic stress (Tirone et al., 2021). Although this found that the degree of social support was an important buffer against PTSD symptoms, further exploration of psychological outcomes and men was not evaluated.

Rationale, Aims, and Scope of the Current Review

To date, there has been no systematic review of the literature looking at the psychological impact of interpersonal betrayal in men. While quantitative randomised experimental studies are the gold standard, the current review intends to include a variety of methodological designs due to the already limited research in this field. After a systematic search of the evidence base, studies eligible for inclusion were critically appraised to understand the quality of their research methodology when discussing the interpretation of findings. This may help to inform future researchers investigating interpersonal betrayals where studies are currently largely dominated by women.

Given that men as well as women can experience betrayal by a close and trusted other, and that a great deal of the research has pertained to the impact on women, it is important to understand whether men experience the same psychological effects. By gaining an awareness of the type and prevalence of outcomes on men's mental health, this review may offer a preliminary justification for more targeted research in this emerging field.

For this reason, this systematic review aims to synthesise the literature to address the following question: what is the psychological impact of interpersonal betrayal on men?

Methods

Literature Search

Once the proposed research question was decided upon, the Participants, Intervention, Comparators and Outcomes (PICO) checklist was used to develop an effective search strategy (Shamseer et al., 2015). A preliminary search to assess the existing literature on the psychological impact of interpersonal betrayal trauma revealed a sufficient amount of research. However, studies specifically focusing on adult men were far fewer, supporting the rationale for an updated review on the emotional and mental health difficulties experienced in men following a betrayal by a close and trusted other. A protocol was written and published on PROSPERO in July 2022 detailing how the systematic review would be undertaken, with the registration number CRD42022340681.

An initial search of the evidence-base was conducted in October 2022 including the following electronic research databases: MEDLINE, APA PsycArticles, and APA PsycINFO. Keyword search terms included "betray* trauma." A definitive search was then completed in late March 2023 to identify any additional papers that might be eligible for inclusion that had been published since the original search.

A search of additional records from other sources involved grey literature from the British Library database EThOS and by using PsycINFO to screen for ProQuest dissertation records. So that a systematic search strategy was followed, Google Scholar was not used as this platform did not allow for advanced search functions to be replicable in the future. In addition to grey literature, hand searching of reference lists was undertaken. The decision to include unpublished studies is supported by research from McLeod & Weisz (2004), who suggest that the strong methodologies and treatment fidelity in dissertations justify their inclusion in psychological reviews of the evidence-base. There were no restrictions on the

publication date, but all studies had to be written in English to be included. The search strategy also focused on main terms, rather than MeSH or subject-terms and headings. The initial scoping strategy was too sensitive and specific when gender was included as all results were excluded and the search became too narrow. Conversely, when broadening the search terms to include betrayal and trauma separately, searches returned between 700,000 to 18,000,000 results. Instead, by using a simple systematic phrase search with truncation, the list of results was under a maximum of 500 and was both specific and sensitive. The search mode selected was to find all search terms, and expanders included applying equivalent subjects.

Selection Criteria

Research studies were assessed for eligibility against the PICO predetermined checklist. A detailed breakdown of these inclusion and exclusion criteria can be seen in Table 1.1.

Study Selection Process

Analysis of research studies comprised three stages: 1) Title screening, 2) Abstracts Screening, 3) Full-text screening. See Figure 1 for The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) diagram of studies (Moher et al., 2009). Appropriate study titles associated with the research question were hand-searched and abstracts screened for inclusion. Suitable articles were inspected in full text to ensure eligibility with the inclusion and exclusion criteria and reference lists of each included study reviewed to ensure any additional evidence was not overlooked. Where suitable articles screened on a database did not have open access to the full text, Google Scholar was used to download full texts and assess eligibility.

[INSERT TABLE 1.1]

Data Extraction

All results from the initial main search were exported to the reference manager Zotero (Version 6.0.18) and duplicates removed. Titles and abstracts were then screened against the inclusion criteria and those papers that were eligible were read in full by the main reviewer. Where data was missing, study authors were contacted to request the information needed. Reasons for excluding studies were recorded. A second reviewer screened the final shortlist to confirm inclusion. Where there were uncertainties or disagreements regarding whether a paper was eligible for the review from the title/abstract, then these papers were considered against the inclusion/exclusion criteria by the third reviewer.

The author independently extracted the following data from the included studies, presented in Table 2: Authors, journal, study location, date of publication, number of participants, characteristics of study population (including type of interpersonal betrayal), control group characteristics (if present), intervention details or methodology and study design, outcome measures, results (psychological outcomes), and limitations.

Quality Assessment

In line with PRISMA guidelines, a checklist quality assessment tool was used to check the quality of studies meeting the inclusion/exclusion criteria at the point of data extraction. Quality assessment was conducted after the data extraction stage, to reduce bias. As this review intended to include studies with a range of different designs, any risk of bias tool had to be appropriate for assessing randomised and non-randomised studies. It was decided that a single tool would have advantages over using multiple tools for different designs as it would facilitate comparison between studies with different designs. As the study

designs were expected to vary, The Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018) was chosen to assess the quality of the included studies. This had the advantage of being relatively easy to use and it was hoped would therefore reduce the likelihood of errors in data extraction. It has shown good interrater reliability and is easy for readers to interpret. The 2018 Version discourages users from calculating a score for the methodological quality of studies or categorising into low or high. However, the more "Yes" ratings a study has for each criterion, the stronger the quality indicated (Hong et al., 2018). The results of the quality assessment are presented in Table 3. To ensure consistency and reduce subjective bias in the quality ratings, a second independent reviewer evaluated all eight included studies, with differences in ratings discussed and resolved. Cohen's *k* was run to determine the inter-rater reliability, which indicated a substantial strength of agreement, $k = .695$ (95% CI, .254 to 1.000), $p < .001$ (Cohen, 1960; Landis & Koch, 1977).

[INSERT FIGURE 1]

Results of Data Synthesis

Eight studies were included in this review and a formal narrative synthesis was conducted as the data was heterogeneous in nature, with results presented in Table 1.2. Due to this being an emerging field of research and the variability in outcome reporting, a meta-analysis was not attempted (Popay et al., 2006). Instead, narrative synthesis included a preliminary synthesis that described the studies' characteristics to identify patterns both across and between the included list of studies, followed by a narrative discussion of the main themes, to answer the review question. Psychological impact factors explored in relation to interpersonal betrayal were grouped into conceptually related categories. Assessment of how robust the synthesis was involved an evaluation of the methodological quality of studies

using the Mixed Methods Appraisal Tool, see Table 3. Recommendations for future studies are made based on the review's findings.

Study Characteristics

Of the eight studies eligible for inclusion, two used a qualitative methodology and six were quantitative. Both qualitative studies were unpublished doctoral psychology theses (n = 2), with one at a UK university and the other in the USA. Within the quantitative studies, two were unpublished doctoral psychology theses completed in the USA that used non-randomised study designs (n = 2). Of the remaining quantitative studies, only one of these had a randomised controlled design (n = 1), with the rest being non-randomised (n = 3). Five of the six quantitative studies were cross-sectional with one quantitative thesis collecting longitudinal data during two time points.

Three out of the four published papers were accepted by the journal Psychological Trauma: Theory, Research, Practice and Policy, and conducted in the State of Oregon. The period of completed studies spanned from the earliest in 2005 to the most recent in 2022 (17 years). Across all eight studies, 1057 men participated and made up on average 35.8% of the gender distribution. There was variability across studies in how age of the sample was reported so the reader is referred to Table 2 for an individual breakdown of demographics.

The quality of the included studies was generally excellent with five meeting all the criteria (see Table 1.3). Two studies were generally good, meeting at least four of the quality criteria (Martin et al., 2013; Platt & Freyd, 2012), with one study meeting three quality criteria (Goldsmith, 2005).

Betrayal Experiences

All six quantitative studies used the Brief Betrayal Trauma Survey (BBTS), which is a measure that assesses the presence of interpersonal betrayal by a close and trusted other, classed as a high betrayal (HB), and allows the assessor to determine the number of betrayal traumas that an individual has experienced. The results were categorised into having experienced less than one high betrayal, at least one, or two or more. Whereas Martin et al. (2013) reported men (n = 85) experienced less than one high interpersonal betrayal trauma on average, in Goldsmith (2005) and Goldsmith et al.'s (2013) men (n = 306) had experienced on average at least two or more betrayals. The remaining three studies mostly focused on the number of men who had experienced a HB and so varied slightly in how they reported results, but found support for at least one (n = 314.92; Platt & Freyd, 2012; Sinha, 2016; Tang & Freyd, 2012). Overall, these studies showed that the majority of men across the studies had experienced either physical, sexual, or emotional trauma within a close interpersonal relationship, which was classed as a high betrayal trauma. Contributing to these findings, Rooney (2016) and Treviranus (2022) conducted qualitative interviews with men (n = 7) who had also experienced IPV, gaslighting, failure to offer assistance, harmful disclosure, disloyalty, and dishonesty. These studies are in line with other research that has looked at the types of abuse men have been subjected to (Bates & Carthy, 2020; Drijber et al., 2013; Hines et al., 2007), which can have importance when considering the type of betrayal on psychological outcomes (Freyd & DePrince, 2001).

[INSERT TABLE 1.2]

[INSERT TABLE 1.3]

Psychological Outcomes

Outcome measures across the six quantitative studies varied with 11 scales reported that measured 13 psychological outcomes, some of which measured the main symptoms of recognised disorders. The BBTS was utilised by all quantitative papers (n = 6), the Trauma Symptom Checklist (TSC-40) was used in four studies, and the Revised Civilian Mississippi Scale (R-CMS) within two. Depression was the most commonly reported psychological condition and was measured in four of the six quantitative studies. The two qualitative papers have been used to help provide a narrative interpretation of these numerical data to answer the review question. To capture and consolidate all 13 identified psychological outcomes, symptoms that frequently co-occur were grouped together (e.g., intrusions, avoidance, arousal, and re-experiencing grouped under Post-Traumatic Experiences). Within the studies, these co-occurring symptoms were mostly assessed using the subscales that were part of the same outcome measure, providing a rationale for organising the findings into conceptually related themes.

Post-Traumatic Experiences

Traumas high in betrayal are widely associated in the literature with psychological difficulties (Tang & Freyd, 2012). This section comprises a range of psychological outcomes that broadly fell under the overarching theme of trauma: PTSD symptoms, dissociation, intrusions, avoidance, arousal, and reexperiencing were looked at across five studies. Two of the studies in the review measured the level of PTSD symptoms in relation to high betrayal. As well as both using a different outcome measure, results also varied. Martin et al. (2013) found men averaging within the mild range of symptoms using the R-CMS (M = 52.86), whereas Sinha (2016) found using the Post-Traumatic Stress-Disorder Checklist Specific (PCL-S) that men scored just within the clinical level for PTSD (M = 35.52, clinical cut off is

35). Both studies had a similar percentage distribution of men in the entire sample, which was of undergraduate students, using a cross-sectional methodology, and both measures were reported to have good internal reliability in each study. However, looking at the variability in scores, Sinha (2016) did not report standard deviations or subscale scores from the PCL-S, but did explain that preliminary data checks revealed no extreme outliers. Choosing to only report the total mean of the questionnaire for men could provide a distorted view of the picture. For example, some men may have scored high on a particular subscale, but much lower on another leading to a similar mean but with a very different clinical profile. Despite meeting the clinical cut-off for PTSD, this score alone does not reveal information about whether there were particular symptom difficulties. For Martin et al. (2013), the standard deviation reported suggested a range of scores on the R-CMS bringing into question the meaningfulness of the total mean score on its own.

Sinha (2016) also measured men's level of dissociation using the Dissociative Experiences Scale (DES-II; $M = 21.03$) as did Goldsmith (2005), who used the TSC-40 to measure dissociation at two time-points ($M^1 = 2.02$; $M^2 = 2.09$). For both studies, men scored within the mild range suggesting that most men who have experienced a betrayal, do not report significant dissociative difficulties. To have found extremely minimal difference over two time points lends more support to this interpretation.

Only one study looked specifically at intrusions following a betrayal (Goldsmith et al., 2013), and found that overall men within the sample were at the milder end of scores on the Impact of Events Scale (IES; $M = 7.46$). This study also examined avoidance symptoms using the same measure and found these were also low ($M = 7.75$). This finding is corroborated by another study in the review that reported low scores for avoidance ($M = 1.92$) using the R-CMS (Tang & Freyd, 2012). Similarly, men were assessed on the other subscale

levels of arousal (M = 2.28) and reexperiencing (M = 1.82) in the R-CMS and both scores did not indicate interpersonally betrayed men experienced difficulties (Tang & Freyd, 2012).

The evidence suggests post-traumatic experiences fall within the mild range of symptoms. The single finding from Sinha (2016) that found men's scores met the clinical cut-off for PTSD is an exception. A difference in the outcome measure used for PTSD symptoms may offer one interpretation for this, where two of the studies found in this review utilised the R-CMS, unlike Sinha (2016) that used the PCL-S. Furthermore, Sinha (2016) did not report standard deviations or subscale scores from the PCL-S, choosing to only report the total mean which may have biased the results.

Overall, the review of these data trends fits with the wider literature that indicates although betrayal can produce reactions that are similar to PTSD symptoms, these are usually less acutely severe (Herman, 1992). Fundamentally, the findings from these studies suggest that betrayal of trust by a close other may only mildly shatter beliefs in the safety and security of interpersonal relationships (Gagnon et al., 2019).

Anxiety

Across three studies (Goldsmith, 2005; Goldsmith et al., 2013; Tang & Freyd, 2012), the TSC-40 was used to measure anxiety, making the scores more comparable, with one of the studies measuring anxiety at two time points (Goldsmith, 2005). Clinical interpretation of the four mean scores all revealed anxiety within the mild range (total M = 3.60), suggesting that while men may have experienced a slight degree of anxiety, this was unlikely to produce difficulties in functioning. However, it should be noted that one of these studies did not provide standard deviations (Goldsmith, 2005), which suggests that the mean scores alone should be interpreted tentatively.

In one of the two qualitative studies (Treviranus, 2022), participants described continuing fear and anxiety long after they had left their abusive relationship. This study recruited participants who had been subjected to IPV within a same-sex relationship. Their sense of worry and doubt permeated interactions with other people that coincided with their shattered trust in the safety of the world. For the men in this study, their prolonged anxiety since the time of the betrayal might reflect a sample of men experiencing greater symptoms than self-reported anxiety in the quantitative studies. Treviranus' (2022) findings corroborate other research that has also reported homosexual men experiencing symptoms of anxiety following a betrayal (C. P. Smith et al., 2016).

Ascertaining patterns on the psychological impact of anxiety from a betrayal, there is only slight variability in the findings, with three suggesting a mild level of anxiety symptoms and a qualitative study suggesting more enduring difficulties. These differences could be explained broadly by the methodological design where items on the TSC-40 might tap into specific experiences, whereas the open-response style in a semi-structured interview might have allowed for a greater range and depth. In this way, it might not be possible to compare findings meaningfully with a scale using cut-off values to categorise levels of symptoms against rich idiosyncratic accounts. Specifically recruiting betrayed men who also faced minority stressors in relation to their homosexuality, could mean that the two participants within the qualitative study may represent a sub-section of the target population experiencing more symptoms of anxiety (Treviranus, 2022). This may limit conclusions as it is not always possible to determine whether poor psychological outcomes are the result of the minority stressors, the betrayal, or both (Newheiser & Barreto, 2014).

Overall, the review provides evidence from three of the four studies that men experience a mild level of anxiety symptoms as a psychological outcome following an interpersonal betrayal.

Depression

As with anxiety, depression was measured across four quantitative studies using the TSC-40 (Goldsmith, 2005; Goldsmith et al., 2013; Martin et al., 2013; Tang & Freyd, 2012). This outcome measure is well validated and reliability statistics in each study were good ranging from alpha coefficients of .71 to .76. This allows for more confidence and comparability when interpreting results. Scores revealed depression fell in the mild range across all four studies, with the total mean being 5.37 (Goldsmith (2005) measured two time-points). Interestingly, only Tang and Freyd (2012) reported close to floor-effects for depression and anxiety, unlike the other studies. This was also the only study in which the mean depression score was slightly lower than the mean anxiety score. A tentative conclusion is that while men may have experienced a slight degree of depression, for most this was unlikely to cause great distress.

Shame and Related Processes

As well as a range of psychological symptoms including those more closely identified with anxiety and depression, the studies under review also examined the impact of betrayal on shame, sense of self, negative beliefs, and difficulties with regulating emotions. Rather than being unique to a singular presentation, the experience of shame can impact upon how an individual manages their emotions as they may ruminate on how the betrayal reflects on them and whether they look bad to others (DePrince et al., 2011). These self-critical thoughts that they are no longer viewed positively by the person who betrayed them may centre upon their self-worth and thus take the form of shame (Gilbert & Irons, 2009). As such, these

processes were grouped together in response to the growing consensus that many psychological symptoms are in fact part of a transdiagnostic clinical profile, with underlying processes such as shame and self-criticism cutting across a range of presentations (Hogg et al., 2022).

Within the included studies in this review, Platt and Freyd (2012) used outcome measures to assess participant's negative beliefs and level of shame. Out of the total sample of men (n = 104), 36 had experienced at least one high betrayal and measures were analysed separately for this group. Looking at dysfunctional attitudes, results indicated that highly betrayed men demonstrated mild to moderate negative underlying assumptions and mild levels of shame (Platt & Freyd, 2012). A limitation of this study was that it was not clear whether the results were due to the experimental manipulation or consequences of the betrayal.

Similarly, difficulties with regulating emotions, and identifying and describing emotions (conceptualised as alexithymia) can be experienced across a range of diagnoses and as a result of being betrayed (Rachman, 2010). Specifically, these were looked at within a longitudinal study which concluded that there was no presence of Alexithymia (Goldsmith, 2005), and that emotion regulation difficulties were mild-to-moderate on average (Goldsmith et al., 2013). This suggests that while men may experience some difficult emotions following a betrayal, these did not fall within the moderate-to-severe range that may be expected to then impact functioning significantly.

In the qualitative papers, as well as looking at abuse and IPV, other types of betrayal were explored including dishonesty, disloyalty, disclosure of information, failure to offer assistance, and gaslighting (Rooney, 2016; Treviranus, 2022). Across both studies, men voiced feelings of distrust in others, isolation, self-blame, shame, and guilt following the

harmful relationship. Other effects included difficulties with the loss of identity and negative self-image (Rooney, 2016). Treviranus (2022) noted that men were lacking confidence and feeling depressed as a result of their betrayal trauma. This impacted upon their self-esteem and self-worth, as they believed their sense of self was flawed in some way, which may have contributed to them falling victim a second time to an abusive relationship (Treviranus, 2022). These underlying processes related to sense of self and depressive symptoms align with the wider literature that suggests gay men are three times more likely to experience depression than the general public (Lee et al., 2017). However, it is not always possible to differentiate whether specific symptoms are a consequence of IPV, stigmatisation fears, or both (Newheiser & Barreto, 2014). In this way, the two qualitative studies may provide a more general overview of the underlying processes related to men's experiences of being interpersonally betrayed.

Altogether, the eight studies in this review point to men experiencing mostly mild levels of shame and critical thoughts from a betrayal trauma by a close and trusted other.

Discussion

This systematic review aimed to synthesise the literature to investigate the psychological impact of an interpersonal betrayal on men's mental health. A narrative synthesis approach was used to integrate the findings. A total of eight studies were eligible for inclusion that varied in methodological design. The main findings indicated 13 psychological outcomes that fell broadly into four conceptually related categories of post-traumatic experiences, anxiety, depression, and shame and related processes. The quantitative evidence showed that men who had experienced betrayal trauma reported symptoms that fell within the mild range and suggested that for most this was unlikely to create difficulties with functioning. Only one quantitative study explored underlying processes such as shame and

self-criticism. This indicated that men demonstrated mild to moderate negative beliefs and mild levels of shame following a high betrayal (Platt & Freyd, 2012).

The two qualitative papers provided a richer narrative of betrayal experiences. Across both studies, men voiced feelings of distrust in others, lack of confidence, isolation, self-blame, shame, and guilt following the betrayal trauma (Rooney, 2016; Treviranus, 2022). Other enduring effects included difficulties with the loss of identity and negative self-image that impacted upon their self-esteem and self-worth. These outcomes, although not quantitatively measured, appeared to cut across men's psychological experiences of being interpersonally betrayed. Taken together, these qualitative findings thus tentatively support the quantitative data from the studies included in this review that suggests some men experience a degree of negative symptoms from a betrayal trauma by a close and trusted other.

Links with the Wider Literature

The overall findings from the quantitative studies that show evidence of men not experiencing a significant psychological impact from a betrayal is surprising. This is because research studies in general have reported high levels of shame, depression, PTSD symptoms, and dissociation (Dockler & Mueller, 2017). One reason for this difference could be that when looking at the psychological outcomes following a betrayal, results from the majority of studies have tended to either analyse or only report data for men and women collectively (e.g., Freyd et al., 2005), meaning it is not possible to know whether significant effects found were due to women's scores saturating the sample (DePrince & Freyd, 2002). Relative to the mild levels of symptoms in men found in this systematic review, studies that investigated outcomes in betrayed women reported high levels of anxiety, depression, dissociation,

emotional dysregulation, and post-traumatic stress symptoms (Cromer & Smyth, 2010; Goldsmith et al., 2013; Tang & Freyd, 2012).

Examining the wider literature for why men may not be as significantly impacted by betrayal as women, research into men-specific experiences may provide one explanation. The findings in this review may in fact reflect a wider issue concerning the difference in how men and women express mental health difficulties such as depression and trauma (Farrell et al., 2016). Drawing on gender-role socialisation theories, these outline the different ways men can express psychological difficulties from women with evidence from the field of male psychology suggesting that men in general respond to stressors with externalising behaviours such as anger, irritability towards others, and alcohol abuse or drugs (Whitley, 2021). Furthermore, whereas women in general are socialised to use introspection and discuss feelings, coping strategies used by men tend to be more solution-focused and action-orientated and in some cases may be a protective factor for mental health by men not dwelling on traumatic events (Martin et al., 2013).

In relation to this review's finding, men may not be affected by betrayal in the same way as women due to engaging less in ruminative processes such as self-critical thinking, particularly about a trauma (Accortt et al., 2008). In this way, varying outcomes between men and women may be the result of differences in trauma-related appraisals (Kucharska, 2017). Cognitive accounts posit that subjective interpretations of betrayal traumas that focus negatively on the self increase the severity of PTSD symptoms and depression (DePrince et al., 2011), with this effect being found in women (Kucharska, 2017). This is because attention may be directed to the threatening image or memory and in efforts to make meaning of the memory, can lead individuals to feel responsible or bad about it, that takes place in a cycle of rumination (Accortt et al., 2008). On the other hand, if men internalise fewer

negative appraisals by turning away from experiences linked to feelings of shame either through emotional numbing or avoidance, they may be less vulnerable to experiencing significant psychological difficulties from being betrayed by a trusted other (Pollack, 1998). This would fit with research that has reported the development of maladaptive beliefs about the self and the world following a trauma to be more strongly associated with women than men (Andrews et al., 2000). In this way, post-traumatic outcomes may have less of an impact if men perceive the betrayal as less threatening and less personal (Kucharska, 2017). However, as the studies found did not report coping strategies, we do not know what factors may have moderated or mediated the impact of the betrayal on psychological outcomes.

Beyond the quantitative studies included in this review, the findings of the qualitative studies allow an insight into the rich narratives of men (n = 7), who did perceive their interpersonal betrayals as having a negative psychological impact on levels of shame, self-blame, excessive guilt, and self-criticism, as well as reduced trust in relationships (Rooney, 2016; Treviranus, 2022). For these men, they recounted attempts at preserving and maintaining the attachment in which the betrayal occurred and may have been vulnerable to prolonged symptoms of anxiety and depression by having ongoing contact with their betrayers, meaning they were unlikely to be able to avoid memories of the betrayal. However, it is of note that both these papers had methodological limitations. Within the study by Rooney (2016), the focus of the interviews with men involved questions that centred on their experiences of disclosing the betrayal trauma. It is possible that the reason for the more significant psychological difficulties voiced may have been the result of secondary trauma from the negative reactions of the people they disclosed to, such as being dismissed, belittled, silenced, and disbelieved, by professionals, friends, and family (Rooney, 2016). In this way, the impact of the betrayal for the men in this study may be based more upon the aftermath, as opposed to the interpersonal event itself. Similarly, when looking at the interview questions

within Treviranus (2022), these led participants to reflect directly upon how their traumatic experiences had affected them emotionally and psychologically, as well as how the traumas impacted their sense of self and others. These leading questions may have biased the men's responses by priming their attention to the harmful effects on themselves and have pushed the men to inadvertently voice more psychological outcomes such as low self-esteem, loss of confidence and identity, and distrust in potential partners (Treviranus, 2022). Therefore, these methodological limitations make it difficult to draw objective inferences on the psychological impact of betrayal on men. The fact that these two papers were doctoral dissertations and therefore not peer-reviewed, further limits the accuracy of conclusions as any scholarly interpretations made have not been scrutinised by experts (Kelly et al., 2014).

As well as identifying the differential outcomes between genders, the array of psychological outcomes found within this systematic review of the literature highlights the importance of addressing self-concept and shame within the profile of betrayal. By improving understanding of these underlying processes, targeted quantitative research might be undertaken that investigates the psychological impact of interpersonal betrayals as experienced by men using more outcome measures that focus on shame and the self (Hogg et al., 2022). This might also draw on theories of masculinity to take account of men-specific experiences (Barry et al., 2021).

Evidence Base

Overall, the eight included studies demonstrated good methodological quality despite being heterogeneous in design. However, limitations of the quantitative papers concerned the cross-sectional nature of data collection that limits causal conclusions being made, three studies lacking sufficient statistical power to test hypotheses, and samples being predominantly White University students with a mean age of 20.91 (see Table 2). Where

samples used in two of the studies (Goldsmith, 2005; Martin et al., 2013) were highly homogenous (in terms of age, culture, race, and students), conclusions drawn may not be representative of the general population and reduce generalisability to older men and those from a different ethnic or socioeconomic background. Furthermore, sociocultural norms around gender may be relevant when considering sexuality and gender of the perpetrator. Despite this limitation, the consistency of psychological outcomes found to be mild across the studies, on balance lends confidence to these data trends. Generally, the included research investigated betrayal occurring within romantic relationships alone, rather than the broader spectrum of interpersonal relationships within Betrayal Trauma Theory. This may thus limit the findings being representative of men who have been betrayed by a close and trusted other who is not a romantic partner. It is further acknowledged that all authors of the included papers were women. It is possible that this may have affected the psychological outcomes chosen to investigate, with the focus primarily on self-oriented emotions rather than externalising emotions such as anger.

A reason for the small number of studies found may be that reported prevalence rates for men are likely to be below the actual number (Perryman & Appleton, 2016). Due to societal barriers such as shame making men reluctant to disclose and help-seek, this might explain the consistently smaller proportion of self-identifying betrayed men participating in research (Lysova et al., 2022). A recent guidance paper has been developed looking into these issues that identifies barriers to engagement and suggestions of recommendations for practicing therapy with men (Seager & Barry, 2022).

The qualitative papers add both strengths and limitations. Offering a narrative account that involves a more in-depth focus on the psychological experiences of men, findings suggested enduring difficulties beyond the betrayal event. However, it is possible that methodological differences could explain this where interview questions focused directly on

experiences of disclosure and the impact on views of the self. As such, these factors can make it difficult to draw objective inferences on the psychological impact of betrayal on men.

Review Process

The final search strategy was felt to be both comprehensive and appropriate. By piloting and refining the review question, search results were supplemented by hand searching of the references of included papers. This strategy met the requirements for being systematic, specific, and sensitive to answering the review question and lent confidence in all relevant papers being included and forming a representative sample of available evidence as far as possible. Making the eligibility criteria explicit with the development of an audit trail (of excluded studies with reasons), allowed for a degree of confidence in those papers that were included answering the review question. However, cross-checking by a peer was not performed on the inclusion/exclusion criteria which could limit the review on how rigorous this was applied. Instead, a peer bolstered robustness of the review process independently cross-checking the quality assessment of included studies and demonstrating a substantial strength of agreement for inter-rater reliability. A limitation of using the MMAT was the inability to categorise the overall quality of studies, however this did prevent studies being automatically labelled as poor if not meeting all criteria (Hong et al., 2018). Instead, contrasting the methodological quality of studies with each other allowed for a detailed presentation of the criteria used to rate each study design. Altogether, these points imply confidence in the conclusions put forth in this review based on the narrative synthesis of evidence.

Research Initiatives

Future research should aim to investigate underlying processes such as shame and self-criticism to understand why some men report mild levels of distress while others

experience more enduring difficulties. One statistically powered study currently being conducted by the author of this review is using a quantitative randomised design to assess the efficacy of a brief compassion-focused imagery intervention in betrayed men. Utilising a range of outcome measures at three time-points, a goal is to directly assess the psychological impact of a betrayal faced by men as well as their receptiveness to a brief therapeutic exercise that targets levels of shame.

Recommendations for other targeted research include longitudinal designs that recruit men who represent the diversity of social graces such as age, ethnicity, socioeconomic status, and sexuality to explore the impact these may have on their experiences. To address conceptual limitations of published papers, studies could consider examining the relationship between characteristics of a betrayal and quality of men's interpersonal environments on statistically analysed psychological outcomes. Peer reviewed research that intends to disentangle statistically significant results on quantitative outcome measures from clinically meaningful results from qualitative accounts would also be helpful. This may resolve the difference found in reported levels of distress where standardised diagnostic questionnaires may not always detect and capture underlying processes (Macur, 2013).

Clinical Implications

It is not a new phenomenon that men experience betrayal trauma as well as women. Yet, as this review shows, the psychological outcomes on men's mental health is still under researched. It is important to understand what the impact is as well as how men may express their distress, and whether this is similar or different to women, so that they are less likely to be overlooked (J. Barry, 2020).

The evidence found within this review suggests that men are not as significantly impacted as women following an interpersonal betrayal. However, further understanding of

why this is the case is warranted. Using an approach specific to men, such as the guidelines outlined by the British Psychological Society (Seager & Barry, 2022), may improve understanding on the psychological impact of betrayal and lead to more effective engagement for those men that do experience difficulties.

Conclusions

This is the first systematic review to synthesise the literature on the psychological impact of an interpersonal betrayal in men. The findings provide evidence of men experiencing some degree of distress; however, the nature and severity of this distress is not wholly clear and requires further investigation. Although future research is needed, this review provides a clear starting point on where the evidence is currently lacking and where researchers might choose to best focus their efforts.

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Tables and Figures

Figure 1 *PRISMA Flow Diagram*

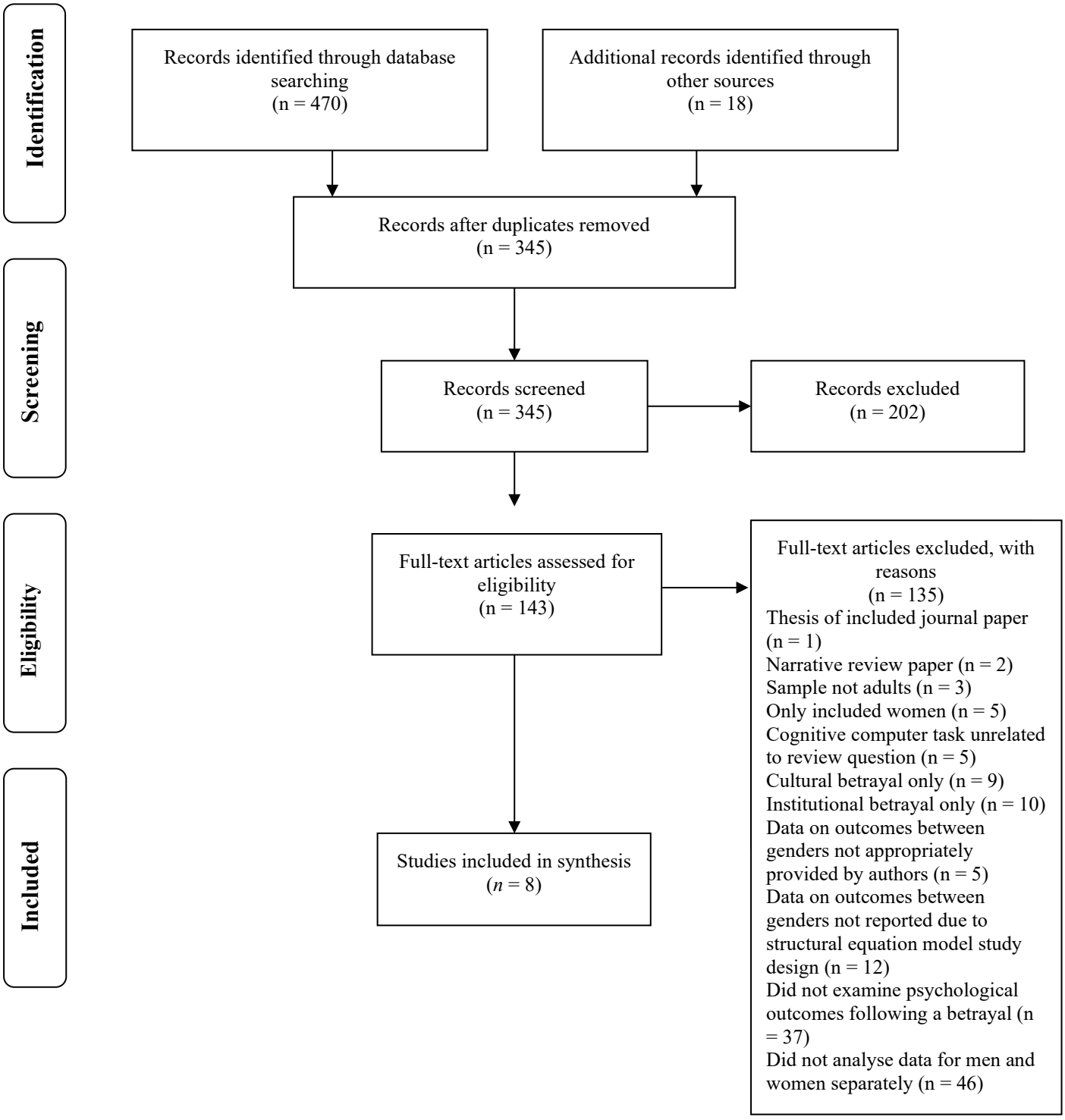

Table 1. 1 *Eligibility Criteria*

	Inclusion Criteria	Exclusion Criteria
Participants / Population	Studies that included men aged 18 and over who had experienced an interpersonal Betrayal (e.g., dishonesty, disloyalty, infidelity, gaslighting, failure to help, harmful disclosure). Studies with women were included providing they analysed data for men and women separately.	Studies that included children and adolescents (under the age of 18), women- only samples, and studies involving adult men who experienced childhood sexual abuse or institutional betrayal that did not meet criteria for interpersonal betrayals (e.g., failure to help during time of need).
Intervention / Exposure	None.	None.
Comparator / Control	This review was not looking specifically at a comparison. Therefore, studies were included whether they had a control group or not as long as they met the inclusion criteria.	None.
Outcome Measures	Studies were eligible if they included any psychological effects that could be considered as emotional and mental health difficulties (e.g., shame, self-blame, self-criticism, depression, anxiety, trauma, guilt, self-doubt, anger, distress, low self-esteem, alienation, avoidance, isolation, and jealousy). It was anticipated that such outcomes would include quantitative data on self-report measures for specific symptoms for trauma, depression, and anxiety, such as the † IES-R, GAD7, PHQ9, HADS. Studies exploring other topics were included if they also explored psychological effects from an interpersonal betrayal.	Papers that did not report specific psychological outcomes following an interpersonal betrayal were excluded.
Context and Study Designs	Studies conducted in any setting were eligible for inclusion. Qualitative, quantitative, cross-sectional, longitudinal, between-subjects, case studies, treatment/intervention studies, studies without a control group, pilot studies, randomised control trials, non-randomised control studies, mixed method interventions, pre-test/post-test, follow-up assessments, case series, cohort studies, and observational studies, if they included self-reported baseline data on psychological outcomes. Grey literature including unpublished dissertations and theses were also eligible for inclusion.	Studies were excluded if the paper was not written up in English and if they used the following methodologies - reviews, commentaries, books, book chapters, narrative papers, and conference/meeting abstracts.

† IES-R: Impact of Events Scale Revised; GAD-7: Generalised Anxiety Disorder; PHQ-9: Patient Health Questionnaire; HADS: Hospital Anxiety and Depression Scale

Table 1. 2 *Key Characteristics of Included Studies*

Author, Date, Location, & Journal	Sample *(n)*	Gender Distribution	Age Range	Betrayal Type	Study Design & Analytic Strategy	Comparator	Outcome Measures	Main Findings (psychological outcomes with descriptive statistics)	Limitations
Goldsmith (2005), Oregon, USA, Thesis	Time 1: 185 (59 Men) Time 2: 96 (25 Men)	Time 1: 31.9% Men 68.1% Women Time 2: 26% Men 74% Women	Time 1: 18 – 32 Time 2: 19 - 34	Physical, sexual, and emotional abuse, childhood neglect	Within samples non-randomised longitudinal quantitative analysis. Chi-Square, Independent *t* Tests, Hierarchical Regressions, and MANOVA.	Pre and post (18 – 28 months, *M* = 20.27)	TAS-20, TSC-40, BBTS, CAT scale	Time 1: HB Trauma (*M* = 2.19); Anxiety (*M* = 3.84), Depression (*M* = 6.08); Dissociation (*M* = 2.02); 24 Men scored high for child abuse trauma on the CAT (above cut-off of 26). TAS-20: Difficulty identifying feelings DIF (*M* = 19.75), Difficulty describing feelings DDF (*M* = 14.04), Externally oriented thinking EOT (*M* = 19.75). Time 2: HB Trauma (*M* = 3.61); Anxiety (*M* = 5.00), Depression (*M* = 6.87); Dissociation (*M* = 2.09); 10 Men scored above 26 on the CAT. TAS-20: DIF (*M* = 17.60), DDF (*M* = 13.80), EOT (*M* = 18.50).	Limited statistical power due to small sample size. SD not reported. Culturally homogenous sample.
Goldsmith et al. (2013), New York, USA, Journal of Traumatic Stress	593 (247 Men)	41.7% Men 58.3% Women	17 – 52 *M* = 21.9 *SD* = 5.7	Physical, sexual, and emotional abuse	Cross sectional non-randomised quantitative analysis. Path Analytic Model.	Interpersonal (high) vs non interpersonal (low) betrayal, and gender	BBTS, DERS, TSC-40, IES	Difficulties with emotion regulation (*M* = 76.20, *SD* = 19.96); Depression (*M* = 6.48, *SD* = 4.21); Anxiety (*M* = 4.91, *SD* = 3.77), Avoidance (*M* = 7.75, *SD* = 5.80), Intrusions (*M* = 7.46, *SD* = 5.51); HB Trauma (*M* = 2.13, *SD* = 2.65), LB Trauma (*M* = 3.07, *SD* = 3.74)	Student sample, not reflective of older populations.
Martin et al. (2013), Oregon, USA, Psychological Trauma: Theory, Research, Practice, and Policy	273 (85 Men)	31% Men 69% Women	*M* = 20.36 *SD* = 3.99	Physical, sexual, and emotional abuse	Cross sectional non-randomised quantitative analysis. Independent *t* Tests, Multiple and Hierarchical Regressions.	Interpersonal (high) vs non interpersonal (low) betrayal, and gender	BBTS, TSC-40, R-CMS	HB Trauma (*M* = 0.72, *SD* = 0.88); Depression (*M* = 6.82, *SD* = 4.92); PTSD (*M* = 52.86, *SD* = 14.20)	Majority White Women student sample that lacked power and generaliz-ability.
Platt & Freyd (2012), Oregon, USA, Psychological Trauma: Theory, Research, Practice, and Policy	306 (104 Men)	34% Men 66% Women	17 – 55 *M* = 20.8	Physical, sexual, and psychological abuse	Cross sectional randomised quantitative analysis. Independent *t* Tests and Chi-Square.	Interpersonal (high) vs non interpersonal (low) betrayal, and gender	BBTS, DAS, SPM	HB Trauma (*n* = 36); Dysfunctional Attitudes (*M* = 135.67, *SD* = 31.19); Shame (*M* = 4.17, *SD* = 5.07)	Age only hypothesised. Inadequate power. Low experimental validity as students could complete at any time without being identified.

Author, Date, Location, & Journal	Sample *(n)*	Gender Distribution	Age Range	Betrayal Type	Study Design & Analytic Strategy	Comparator	Outcome Measures	Main Findings (psychological outcomes with descriptive statistics)	Limitations
Rooney (2016), Wolverhampton, UK, Thesis	5	100% Men	21 - 65	Intimate Partner Violence (IPV), dishonesty, disloyalty, harmful disclosure of confidential information, and failure to offer assistance during time of need.	Qualitative interviews using Interpretative Phenomeno-logical Analysis (IPA).	None	None	For all men, loss of identity, negative self-image, low self-esteem, low self-worth, lack of confidence, and distrust in others was reported; 80% of the men experienced shame and self-blame; and 60% struggled with feelings of isolation.	Small sample size, lack of demographic data for ethnicity.
Sinha (2016), Texas, USA, Thesis	548 (149 Men)	27.2% Men 72.8% Women	18 – 53 *M* = 20.57 *SD* = 3.27	Physical, sexual, and psychological abuse	Cross sectional non-randomised quantitative analysis. Hierarchical Multiple Regressions.	Interpersonal (high) vs non interpersonal (low) betrayal, and gender	BBTS, PCL-S, DES-II	For all men, the total trauma score was *M* = 4.42, and for high betrayal *M* = .99. For the PTSD total score, this resulted in *M* = 35.52, and for dissociation, *M* = 21.03.	Data for PCL subscales for men not provided. SD not reported.
Tang & Freyd (2012), Oregon, USA, Psychological Trauma: Theory, Research, Practice, and Policy	1240 (406 Men)	32.74% Men 67.26% Women	Over 85% of total sample aged 18 - 40	Physical, sexual, and emotional abuse	Between-samples non-randomised cross- sectional quantitative analysis. Mann-Whitney *U* test and MANCOVA.	Interpersonal (high) vs non interpersonal (low) betrayal, and gender	TSC-40, R-CMS, BBTS	32% men experienced traumas high in betrayal. 404 men scored for depression (*M* = .61, *SD* = .43), and anxiety (*M* = .66, *SD* = .46) on the TSC-40. PTSD symptoms for 230 men were reported for arousal (*M* = 2.28, *SD* = .60), avoidance (*M* = 1.92, *SD* = .59), and re-experiencing (*M* = 1.82, *SD* = .67).	Online cross-sectional survey limits any causal conclusions. Insufficient reporting on age of the sample.
Treviranus (2022), California, USA, Thesis	8 (2 Men)	25% Men 62.5% Women	18+	IPV by a partner, gaslighting, physical, emotional, psychological, and sexual abuse	Qualitative interviews using IPA.	None	None	One man cited shame, guilt, and isolation impacted seeking help from an abusive relationship. Loss of confidence was experienced, as well as anxiety and depression. Both men voiced low self-esteem but whereas for one this increased future revictimization, for the other their low self-worth made them hyper aware of future risk. Neglect of self-image was noted by one man's weight gain. Both men struggled with lack of trust in others	Sample only representative of lesbian and gay identifying individuals.

BBTS: Brief Betrayal Trauma Survey (Goldberg & Freyd, 2006); TSC-40: Trauma Symptom Checklist (Elliott & Briere, 1992); R-CMS: Revised Civilian Mississippi Scale (Norris & Perilla, 1996); PCL-S: Post-traumatic Stress-Disorder Checklist Specific (Weathers et al., 1993); IES: Impact of Events Scale (Horowitz et al., 1979); CAT: Child Abuse Trauma Scale (Sanders & Becker-Lausen, 1995); TAS-20: Toronto Alexithymia Scale (Bagby et al., 1986); DERS: Difficulties in Emotion Regulation Scale (Gratz & Roemer, 2004); DAS: Dysfunctional Attitudes Scale (Weissman, 1979); SPM: Shame Posture Measure (Feiring & Taska, 2005); and DES-II: Dissociative Experiences Scale (Carlson & Putnam, 1993).

Table 1. 3 *MMAT Quality Appraisal of Included Studies*

Qualitative Study Design						
Study	**Is the approach appropriate to answer the research question?**	**Are data collection methods adequate?**	**Are the findings adequately derived from the data?**	**Is the interpretation of the results sufficiently substantiated by data?**	**Is there coherence between data sources, collection, analysis, and interpretation?**	**Comments**
Rooney (2016)	Yes	Yes	Yes	Yes	Yes	Terminology defined, methodology of IPA adhered to, themes explore individual narratives.
Treviranus (2022)	Yes	Yes	Yes	Yes	Yes	Clear rationale for IPA with reference to trustworthiness, rigor, and reflexivity.
Quantitative Randomised Study Design						
Study	**Is randomisation appropriately performed?**	**Are the groups comparable at baseline?**	**Are there complete outcome data? (80% minimum)**	**Are outcome assessors blinded to the intervention provided?**	**Did the participants adhere to the assigned intervention?**	**Comments**
Platt & Freyd (2012)	Yes	Can't tell	Yes	Yes	Yes	Computer generated randomisation. 11 participants excluded from analysis. 96.4% completion
Quantitative Non-Randomised Study Design						
Study	**Are the participants representative of the target population?**	**Are measurements appropriate regarding the outcome and intervention?**	**Are there complete outcome data? (80% minimum)**	**Are the confounders accounted for in the design and analysis?**	**During the study period, is the intervention administered as intended?**	**Comments**
Goldsmith (2005)	No	Yes	No	Yes	Yes	Child abuse trauma score controlled for in analysis. Outcome data post intervention 51.9% of sample pre intervention (missing data for 89 cases).
Goldsmith et al. (2013)	Yes	Yes	Yes	Yes	Yes	Online survey. Age and gender included as covariates. Outcome data had a completion of 90.8% (60 excluded).
Martin et al. (2013)	No	Yes	Yes	Yes	Yes	Gender controlled for in the analysis. Outcome data completion rate 96.5% (10 participants excluded).
Tang & Freyd (2012)	Yes	Yes	Yes	Yes	Yes	Online survey. Age was included as a covariate. After excluding some data responses, study completion was 98.2% (23 excluded).
Sinha (2016)	Yes	Yes	Yes	Yes	Yes	Experiential avoidance controlled for in the analysis. Data completion was 80.0% (139 excluded).

Appendix A Guidelines for Authors: Clinical Psychology and Psychotherapy

1. SUBMISSION

Clinical Psychology & Psychotherapy aims to keep clinical psychologists and psychotherapists up to date with new developments in their fields. The Journal will provide an integrative impetus both between theory and practice and between different orientations within clinical psychology and psychotherapy. *Clinical Psychology & Psychotherapy* will be a forum in which practitioners can present their wealth of expertise and innovations in order to make these available to a wider audience. Equally, the Journal will contain reports from researchers who want to address a larger clinical audience with clinically relevant issues and clinically valid research. The journal is primarily focused on clinical studies of clinical populations and therefore no longer normally accepts student-based studies.

This is a journal for those who want to inform and be informed about the challenging field of clinical psychology and psychotherapy. Submissions which fall outside of Aims and Scope, are not clinically relevant and/or are based on studies of student populations will not be considered for publication and will be returned to the author.

2. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Research Article: Substantial articles making a significant theoretical or empirical contribution (submissions should be limited to a maximum of 5,500 words excluding captions and references).

Comprehensive Review: Articles providing comprehensive reviews or meta-analyses with an emphasis on clinically relevant studies (review submissions have no word limit).

Measures Article: Articles reporting useful information and data about new or existing measures (assessment submissions should be limited to a maximum of 3,500 words).

Clinical Report: Shorter articles (a maximum of 2,000 words excluding captions and references) that typically contain interesting clinical material. These should use (validated) quantitative measures and add substantially to the literature (i.e., be innovative).

3. PREPARING THE SUBMISSION

Parts of the Manuscript

The manuscript should be submitted in separate files: main text file; figures. Cover Letters and Conflict of Interest statements may be provided as separate files, included in the manuscript, or provided as free text in the submission system. A statement of funding (including grant numbers, if applicable) should be included in the "Acknowledgements" section of your manuscript.

The text file should be presented in the following order:

1. A short informative title containing the major key words. The title should not contain abbreviations;
2. A short running title of less than 40 characters;
3. The full names of the authors;
4. The authors' complete institutional affiliations where the work was conducted (Institution Name, Country, Department Name, Institution City, and Post Code), with

a footnote for an author's present address if different from where the work was conducted;

5. Conflict of Interest statement;
6. Acknowledgments;
7. Data Availability Statement
8. Abstract, Key Practitioner Message and 5-6 keywords;
9. Main text;
10. References;
11. Tables (each table complete with title and footnotes);
12. Figure legends;

Figures and appendices and other supporting information should be supplied as separate files.

Authorship

On initial submission, the submitting author will be prompted to provide the email address and country for all contributing authors.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned, including the name(s) of any sponsor(s) of the research contained in the paper, along with grant number(s). Thanks to anonymous reviewers are not appropriate.

Conflict of Interest Statement

Authors will be asked to provide a conflict-of-interest statement during the submission process.

Abstract

Enter an abstract of no more than 250 words containing the major keywords. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.

Key Practitioner Message

All articles should include a Key Practitioner Message of 3-5 bullet points summarizing the relevance of the article to practice.

Keywords

Please provide five-six keywords.

Main Text

1. The journal uses US spelling; however, authors may submit using either US or UK English, as spelling of accepted papers is converted during the production process.
2. Footnotes to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.

References

References should be prepared according to the *Publication Manual of the American Psychological Association* (6th edition). This means in-text citations should follow the author-date method whereby the author's last name and the year of publication for the source

should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper. Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page 1, and a DOI should be provided for all references where available.

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figure Legends

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

General Style Points

The following points provide general advice on formatting and style.

1. **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly, and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
2. **Units of measurement:** Measurements should be given in SI or SI-derived units.
3. **Numbers:** numbers under 10 are spelled out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats).
4. **Trade Names:** Chemical substances should be referred to by the generic name only. Trade names should not be used. Drugs should be referred to by their generic names. If proprietary drugs have been used in the study, refer to these by their generic name, mentioning the proprietary name and the name and location of the manufacturer in parentheses.

4. EDITORIAL POLICIES AND ETHICAL CONSIDERATIONS

Conflict of Interest

The journal requires that all authors disclose any potential sources of conflict of interest. Any interest or relationship, financial or otherwise that might be perceived as influencing an author's objectivity is considered a potential source of conflict of interest. These must be disclosed when directly relevant or directly related to the work that the authors describe in their manuscript. Potential sources of conflict of interest include but are not limited to patent or stock ownership, membership of a company board of directors, membership of an advisory board or committee for a company, and consultancy for or receipt of speaker's fees from a company. The existence of a conflict of interest does not preclude publication. **If the authors have no conflict of interest to declare, they must also state this at submission**. It is the

responsibility of the corresponding author to review this policy with all authors and collectively to disclose with the submission ALL pertinent commercial and other relationships.

Funding

Authors should list all funding sources in the Acknowledgments section.

Authorship

The list of authors should accurately illustrate who contributed to the work and how. All those listed as authors should qualify for authorship according to the following criteria:

1. Have made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data;
2. Been involved in drafting the manuscript or revising it critically for important intellectual content;
3. Given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content; and
4. Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in the Acknowledgements statement (e.g., to recognize contributions from people who provided technical help, collation of data, writing assistance, acquisition of funding, or a department chairperson who provided general support). Prior to

submitting the article all authors should agree on the order in which their names will be listed in the manuscript.

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As part of the journal's commitment to supporting authors at every step of the publishing process, the journal requires the submitting author (only) to provide an ORCiD identifier when submitting a manuscript.

University of Southampton

Faculty of Environmental and Life Sciences

School of Psychology

Chapter 2: Efficacy of a brief compassion intervention on psychological outcomes in men following a betrayal.

by

Alexandra Charlotte Clarisse Newman

ORCID ID 0000-0002-3655-4852

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Efficacy of a brief compassion intervention on psychological outcomes in men following a betrayal.

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Short title:

COMPASSIONATE IMAGERY FOR BETRAYED MEN

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Conflict of Interest

None.

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Data availability statement:

The data that support the findings of this study are openly available in [repository name e.g., "figshare"] at http://doi.org/[doi], reference number [reference number].

Author Contributions

Alexandra Newman: Conceptualisation, Methodology, Validation, Formal Analysis, Investigation, Visualisation, Writing – Original Draft **Alison Bennetts:** Conceptualisation, Supervision, Project Administration, Writing – Review and Editing **Lusia Stopa:** Conceptualisation, Supervision, Project Administration, Writing – Review and Editing

Abstract

Compassionate imagery was developed for individuals experiencing high shame who find it difficult to generate compassion toward the self. This study investigated the impact of a brief compassion intervention compared with guided relaxation in men who have experienced an interpersonal betrayal. In total, 52 men participated with 26 randomised into each group. The study employed a 2 x 3 design using two conditions (compassionate-imagery and relaxation-control) tested at three time points (pre, post and one-week follow-up). Results showed reductions in negative affect, and improvements in positive affect and self-compassionate action for both conditions. This suggests that betrayed men may benefit from a single session of compassion or relaxation; however, more research is needed to confirm whether both interventions are effective, and if they are to understand the mechanisms behind their effects. It is important to understand ways in which men may differ from women in response to interpersonal betrayal so that men's mental health needs from a betrayal are not overlooked.

Keywords:

MALE PSYCHOLOGY, BETRAYAL TRAUMA THEORY, INTERPERSONAL BETRAYAL TRAUMA, COMPASSION FOCUSED THERAPY, COMPASSIONATE IMAGERY

Public Significance Statement

This is the first study examining betrayed men's responsiveness to a brief compassion intervention. Findings showed that both brief compassionate imagery and guided relaxation were effective for improving men's positive mood, reducing negative mood, and increasing motivation to act in ways that alleviate suffering. Theories of masculinity are recommended to account for men-specific experiences; however, further research is warranted to understand the mechanisms of change involved so that psychologists can effectively meet men's emotional needs.

Efficacy of a brief compassion intervention on psychological outcomes in men following a betrayal.

Date submitted: Friday 19th May 2023

Introduction

Men face betrayals as well as women, yet the traumatic effects of being betrayed have largely been investigated in women (DePrince & Freyd, 2002). It is beneficial to properly understand the impact of a betrayal on the mental health of men so that men-specific experiences are not overlooked or assumed to be completely the same as women (Farrell et al., 2016). This paper aimed to understand whether a brief compassion exercise might effect change in affect toward the self in a sample of betrayed men, in comparison to a guided relaxation task, and to see whether any benefits were sustained at one-week follow-up. So, what are the psychological outcomes on men's mental health following an interpersonal betrayal? Firstly, it is important to understand what is meant by the term betrayal before considering the experiences of men and what psychologists may be able to offer to meet those needs.

Betrayal Trauma Theory (BTT) and the Role of Shame

An interpersonal betrayal is conceptualised as a breach of trust within a close relationship (Freyd, 1994), and can vary from acts of abuse, to gaslighting, infidelity, failure to help, disclosing confidential information, dishonesty, and disloyalty (Rachman, 2010). Through the lens of Betrayal Trauma Theory, Freyd (1994) proposed that interpersonal betrayals shatter the betrayed individual's beliefs in the safety and security of their attachment to the betrayer (Freyd, 2003). As individuals attempt to make sense of a betrayal trauma by a known trusted other, adverse consequences include symptoms of anxiety and depression (Gagnon et al., 2019). The negative impact of focusing on the self as "betrayed" can lead individuals to self-blame, self-criticise, and experience feelings of shame (Gilbert & Procter, 2006).

Theories on the development of self and the role of shame may offer an understanding of how these difficulties develop from a betrayal (Luke & Stopa, 2009). Sense of self emerges from early childhood experiences of the caregiver/parent being available to notice the child's needs and respond appropriately (Fonagy et al., 1995). When this happens consistently over time, the child builds an internal working model of attachments which incorporates underlying assumptions about how others will behave toward the self, such as whether others are likely to meet their distress with comfort and reassurance (Fonagy, 1999). The child then uses this caregiver-child relationship to form an understanding of themselves and social relations with others that extends into adulthood. As such, core beliefs about the self, world, and others *("I am lovable/the world is safe/others are caring")* shape an individual's impression of how they are viewed by others, for example positively or negatively (Stopa, 2009).

Those individuals with a negative sense of self may be more likely to internalise an act of a betrayal by ruminating on how the violation of trust reflects on their self-image (Santor & Walker, 1999). Individuals may thus make appraisals that focus on themselves to explain why the betrayal occurred, such as *"they must have cheated on me because I am not good enough"* (Freyd, 1996). If they blame themselves for the act rather than the betrayer, individuals may evaluate their self-worth and perceive themselves as existing negatively in the mind of the betraying other (Lewis, 2003). This may be more likely in individuals with pre-existing low self-esteem where a betrayal might be interpreted as confirming negative underlying experiences about the self, for example *"I must be unlovable, inferior, inadequate"* (Leary et al., 1995). This critical sense of self is at odds with the need to be accepted by close and trusted others because the experience of living negatively in other people's minds is associated with the threat of rejection (Andrews et al., 2000). In relationships with close others such as friends, parents, and partners, the felt sense of

rejection threatens the safety and security of that attachment, as well as the individual's own sense of self. This fear of looking bad to others and being rejected can result in feelings of shame as self-identities are tied to people whose approval is regarded as important (Gilbert & Irons, 2009). Crucially, how others relate to the individual has a direct bearing on how the individual views their own worth. As such, the experience of being devalued and shamed by a close trusted other, can influence whether the individual identifies with and embodies this negative image. Taken together, these explanations for the negative impact of a betrayal, which have largely been studied in women, show that betrayal trauma can lead to increased levels of anxiety, guilt, reduced trust in relationships, self-blame, shame, and social isolation (Cromer & Smyth, 2010; Dockler & Mueller, 2017). These studies showed that when women made interpretations about the betrayal that focused negatively on themselves, this severely increased the symptoms of post-traumatic stress and depression (Kucharska, 2017). By ruminating on their traumatic memories, the betrayed women developed maladaptive beliefs surrounding their responsibility for the betrayal of trust (Accortt et al., 2008; Andrews et al., 2000). A key question is whether the same processes and outcomes apply to men?

Links Between Betrayal, Shame, and Men

In order to properly understand the impact of a betrayal on the mental health of men, it is important to recognise the differences in how men may express emotional difficulties compared to women (Farrell et al., 2016). Most research to date has concentrated either on the trauma experiences of women, or investigated men and women collectively, using methods that favour women-specific socialisation such as relying on introspection and emotion-based discussions which runs the risk of assuming men's difficulties to be the same (Whitley, 2021). In considering the experiences of men following a betrayal, a systematic review of the evidence base has found several outcomes including shame, self-criticism, and

self-blame, as well as depression and anxiety (see systematic review paper by same authors). Although shared by both men and women, an understanding of the underlying factors of shame and self-criticism has particular relevance to male psychology (J. A. Barry et al., 2019). Much research in this area has centred on poor help-seeking by men for mental health difficulties with feelings of shame given as a reason (Steinmetz, 1977).

Why are men prone to experiencing shame, and why is shame problematic with regards to mental health? To answer this question, it is necessary to consider theories of masculinity and gender role socialisation (J. A. Barry et al., 2019). Such approaches highlight the differences in managing psychological difficulties between men and women with men more likely to conceal emotional vulnerabilities (Angst et al., 2002). Within Western society, boys are exposed to masculine scripts that stress desirable traits of control, stoicism, strength, and success (J. S. Brown et al., 2019). These ideals may be internalised from a young age and come to be used as ways of men evaluating their self-worth in relation to other men. For example, a man who values strength may judge himself more harshly if he perceives himself as weak. As such, symptoms of anxiety and depression can be in conflict with these masculine norms, and he may fear ridicule from others (J. S. Brown et al., 2019). Associated is the experience of shame that can intensify the emotional difficulties experienced as men work hard to deny these feelings by shutting off and avoiding expressing the vulnerable parts of themselves (Pollack, 1998). This can make it difficult for men to be honest and admit they are struggling due to the fear of being ridiculed by other men (Trivers, 2011).

Closely tied to this fear of ridicule is the threat of rejection. As already discussed, an individual's sense of self is strongly linked to how important others view the self (Gilbert, 2014). For men, standards of invulnerability and independence may be particularly important to gain approval from other men and potential partners (J. S. Brown et al., 2019). Being socially accepted may therefore boost an individual's self-identity by others viewing the self

positively (Gilbert, 2014). On the other hand, not perceiving oneself to live up to the masculine ideals may lead men to fear being viewed negatively by others. The threat of becoming the "undesired self" will drive men's efforts to deny experiences linked to feelings of shame (Gilbert, 2010). This is important for men because they are more likely to turn away from negative feelings and are less tolerant of their vulnerabilities than women (Seager & Wilkins, 2014). The fear of expressing powerlessness that threatens masculine norms can thus be maintained by the shame of appearing weak (J. Smith et al., 2019). As a result, men may feel trapped by the need to avoid the threat of rejection that could confirm low self-worth by concealing their emotions (Pollack, 1998). One therapy that has been developed specifically to explain the underlying processes of shame and self-criticism is Compassion Focused Therapy (CFT; Gilbert, 2009).

Compassion Focused Therapy (CFT) and Compassionate Mind Training (CMT)

Within CFT, Gilbert (2014) describes three interacting emotion-regulation systems that influence people's behaviour: the drive system which is about pursuing goals; the threat and protection system which is concerned with threat-based emotions such as fear, and fight/flight survival responses; and the contentment system that focuses on safeness. Developing from early attachment experiences, these three systems interact and co-regulate each other to achieve different social motives. A baby who relies on the mother for survival will be distressed if the mother disappears, and soothed when the mother reappears and attends to the baby's needs. As such, when threat-based emotions such as fear and anxiety are triggered, resources are diverted towards fight/flight/freeze, meaning goal-based actions and accessing the contentment system are temporarily thwarted or blocked (Gilbert, 2014).

Overreliance on any one system can create imbalance and difficulties in managing emotions. Originally developed for protection, the default state of threat is also triggered in

non-life-threatening situations in which self-criticism and shame may be present. Indeed, both over and under-development of this threat system has been strongly linked to mental health problems (Gilbert, 2009). To protect the self against a detected threat, arousal may either be activated with the fight/flight response, or deactivated with freeze behaviours such as helplessness, trapped defeat, and despair. When the threat system is activated, the contentment system that focuses on affiliation and soothing is deactivated. However, when the threat system is not triggered, the contentment system enables feelings of lower energy emotions such as calmness and safeness. This is usually in response to needs having been met, others being viewed as supportive, kind, and forgiving, and the self viewed as lovable. This inner state soothes threat-based emotions of shame and self-criticism and down-regulates arousal that allows for individuals to reactivate the drive system needed for exploring and growth (Gilbert, 2009). Linked to the contentment system is the development of three flows of compassion.

Compassion is defined as a motivation to engage with suffering experienced within oneself and others, and to act in ways that relieve that suffering (Gilbert, 2009). This intention and motivation to care for other's and one's own wellbeing can flow in three directions: compassion towards others, compassion from others towards ourselves, and compassion directed towards ourselves (self-compassion) (Gilbert, 2014). Turning towards painful experiences with wisdom and courage is associated with all three flows. To be compassionate and alleviate suffering, firstly individuals need to be able to recognise and tolerate distress, and secondly be empathically moved by it (Gilbert, 2014). Unless the individual is able to connect to their own suffering without judgement and self-criticism, psychological difficulties and emotional distress such as shame may be experienced.

CFT theorises that the threat of shame and rejection from others is associated with difficulties in generating compassion toward the self (Gilbert, 2010). This relates back to the

idea that humans are motivated to become the "desired self" by creating positive feelings about the self in other's minds and feeling a sense of safeness (Gilbert, 2009). The threat of becoming "undesired" and rejected will direct efforts to avoid or deny experiences that are linked to feelings of shame (Gilbert, 2010). In addressing processes of shame and self-criticism, CFT teaches the skills of compassion using Compassionate Mind Training (CMT) to promote compassionate resilience (insights, motivation, and action) toward the self, toward others, and from others (Gilbert & Procter, 2006). This encourages the development of compassionate insight using soothing affiliative skills by individuals engaging with pain and distress. Through attributes of courage, strength, and wisdom, these rebalance an over-active threat system triggered by self-criticism and shame and help to alleviate suffering. All of this has relevance to betrayal.

From the CFT perspective, the negative impact of betrayal on sense of self and the fear of rejection, are linked with the threat system. This can create difficulties in down-regulating shame-related emotions and being able to access the contentment system. CFT works to develop this contentment system through skills that help to alleviate suffering. Therefore, CFT should target the negative impact of betrayal by rebalancing the three emotion regulation systems of drive, threat, and contentment. One intervention in CFT used to train these skills in stimulating positive emotions and cultivate compassion is imagery.

Compassionate Imagery for Shame-Based Memories

Imagery as a clinical intervention targets meanings and beliefs about the self (Çili & Stopa, 2021). In interpersonal betrayal, negative meanings attached to images often involve the self in relation to others (Freyd, 1996), and are usually associated with distressing emotions that ultimately impact upon an individual's mood and behaviour (Stopa, 2011). Thus, the ability to create images in the mind that represent desired parts of the self is a great

strength of imagery and has importance for changing an individual's distorted sense of self. By employing imagery to alter meanings attached to betrayals of trust, it is possible to shift this view of self attached to the memory of the interpersonal event (Stopa, 2011).

As a technique, imagery has a substantial evidence base for treating psychological difficulties (Morina et al., 2017). A single brief session has demonstrated positive outcomes in reducing distress and negative experiences about the self connected with difficult memories (Wild et al., 2008). Compassionate imagery used within CMT involves generating compassionate images to promote self-soothing by interrupting the vicious self-critical cycle that maintains feelings of shame (Gilbert, 2010). It is believed that the mechanism of change in compassionate imagery is the targeting of underlying processes of shame and self-criticism. This is achieved by accessing nurturing and affiliative emotional memories and bringing these alternative experiences online in place of the threat and shame-based memories (Wheatley & Hackmann, 2011).

Another benefit to compassionate imagery is that it can integrate knowing something with feeling something. This is particularly helpful for individuals experiencing a head-heart divide between what they think and what they feel, who might say *I know the betrayal wasn't my fault but I still feel that I am to blame"* (Gilbert, 2009). Compassionate imagery works with this divide by building people's capacity in a caring orientation towards the self (Gilbert & Procter, 2006). Compassionate imagery reframes people's self-critical thoughts and shaming experiences, using a supportive inner tone to activate a mentality of safeness and contentment, and create a warm affiliative relationship with oneself. In doing so, with practice individuals are able to soothe threat-based emotions of fear and shame (Gilbert & Procter, 2006).

Rationale and Aims of the Study

Although there is a wealth of evidence on compassionate imagery targeting feelings of shame connected to trauma-based memories, there has been no peer-reviewed study to the authors' knowledge to date looking at the efficacy of this technique with men who have been betrayed. Due to gender social norms, the shame associated with an interpersonal betrayal can drive men's efforts to deny experiences that threaten masculine norms (J. A. Barry et al., 2019). To avoid the threat of shame, men may work hard to conceal these threat-based emotions. Compassionate imagery helps to rebalance and soothe an over-active threat system triggered by self-criticism and shame, so that individuals are able to generate compassion toward the self (Gilbert & Procter, 2006; Morina et al., 2017). As these findings highlight, it is possible that through training, betrayed men may learn to turn towards and tolerate difficult feelings, with a sensitivity and non-judgemental understanding for why they may feel the way they do that could make a difference to the impact of shame experienced. However, this has not yet been investigated empirically. Thus, to address this gap in the literature, this study sought to investigate whether brief compassionate imagery may be a promising intervention for men who have experienced shame from being betrayed.

The primary aim of the current research was to compare the efficacy of a brief compassionate imagery manipulation on state levels of self-compassion, positive and negative affect, self-esteem and relationship-trust compared to a control group of guided progressive muscle relaxation. This control was chosen as relaxation imagery has known benefits on down-regulating stress and indirect positive affect but does not actively target thoughts or feelings. The study also aimed to compare the impact of both conditions on these state-measures after one-week from the imagery task to assess whether any benefits were sustained.

Research Hypotheses

Based on the research aims, the following two hypotheses were tested: 1) A brief compassionate-imagery manipulation will reduce state negative-affect, and increase state self-compassion, state positive-affect, state self-esteem and state relationship-trust compared to the control imagery condition; and 2) A brief compassionate-imagery manipulation will maintain levels of state self-compassion, state affect, state self-esteem and state relationship-trust at one-week follow-up, compared to a control group of guided relaxation.

Method

Design

The study employed a mixed model randomised experimental design with two independent variables. The within-groups factor of time had three levels (pre, post and one-week follow-up) and the between-groups factor of condition had two levels (compassionate-imagery and relaxation-control). Dependent variables involved repeated outcome measures (state levels of self-esteem, self-compassion, positive and negative affect, and degree of trust in relationships with close and trusted others).

Participants and Recruitment

The study recruited a sample size of 52 participants. This was the minimum number needed to be sufficiently powered, as calculated by G* Power version 3.1 (Faul et al., 2007). For a factorial design, a partial eta squared n_p^2 large effect size of .1379 (Cohen's $f = .40$) computed 26 participants per two independent groups, to test a one-directional hypothesis, with 80% power and 5% significance level. The rationale for basing recruitment on a large effect size was supported by a study that found a compassionate manipulation to be superior (Cohen's $d = 1.34$), conferring confidence in the current study's design (Arimitsu &

Hofmann, 2017). Furthermore, expecting recruitment to be challenging, a large effect size was chosen to reduce the total sample needed to a more achievable number, taking into consideration attrition.

Men were recruited over eight months (September 2022 – April 2023) by advertising in social media (e.g., Facebook, Twitter, LinkedIn), word-of-mouth, and charities such as the Mankind Initiative that work with men. The sampling strategy was purposely broad to ensure capturing participants in the public who had experienced an interpersonal betrayal. The term interpersonal betrayal was operationalised as a relationship of trust being broken in adulthood or adolescence by a close other e.g., partner, parent, friend, colleague. Table 2.1 details the eligibility criteria for the study. If participants met exclusion criteria based on symptom scores, they were signposted to a debrief form containing a list of mental health support services. It was anticipated that due to the sensitive nature of experiencing a betrayal, the study would take place online to access a greater number of participants across the UK. Participants were offered the chance to win one of 25 Amazon gift vouchers worth £20 from a prize draw.

[INSERT TABLE 2.1]

A total of 52 men participated in all three stages of the study (26 compassion condition, 26 relaxation condition). Participants that were excluded from the study included 39 men who scored within the clinical range on the screening measures. Of the 52 men included in analyses, the mean age range was 18-61 years (compassion $M = 32.88$, $SD = 9.70$; relaxation $M = 36.54$, $SD = 11.33$). An independent samples t-Test revealed no significant difference between the two groups, $t\ (50) = -1.249$, $p = >.05$). The majority of the sample identified their ethnicity as White (63.5%), followed by 13.5% Black, 9.6% Asian, 9.6% Other, and a minority identifying as Mixed (3.8%). A breakdown of demographic

characteristics can be seen in Table 2.2. The majority of participants identified as heterosexual (88.5%) and 80.8% selected no current mental health difficulties. Scores on screening measures for anxiety (M = 10.83, SD = 2.68) and depression (M = 12.17, SD = 3.22) were within the moderate range of difficulty, and the number of trauma symptoms was reported as between 0-5 (M = 2.35, SD = 2.01).

[INSERT TABLE 2.2]

Measures

Participants completed standardised outcome measures at different time points online using Qualtrics. All participants in the study completed all outcome measures regardless of which study condition they were randomly allocated to. Prior to the study going live, the study procedure was piloted to ensure acceptability with two men (M_{age} = 24.5) and took an average duration of 40 minutes. Cronbach's alphas for all measures at each time point are reported in Table 2.3.

Screening

Demographic data. A brief questionnaire was used to collect demographic information which was used to describe the sample.

Generalised Anxiety Disorder – 7 (GAD-7; Spitzer et al., 2006). The GAD-7 is a brief measure of generalised anxiety disorder symptoms. Scores range from 0-21, where 5-9 indicates *mild impairment;* 10-14 *moderate;* and 15-21 *severe anxiety.* The measure has excellent internal reliability, α = 0.92 (Spitzer et al., 2006).

Patient Health Questionnaire - 9 (PHQ-9; Kroenke et al., 2001). PHQ-9 is the 9-item depression subscale of the full measure and was used in the present study to identify

participants' self-reported psychological mood. Scores range from 0-27, where 5-9 indicates *mild impairment;* 10-14 *moderate;* 15-19 *moderately severe;* and 20-27 *severe depression.* The measure has good internal reliability, α = 0.89 (Kroenke et al., 2001).

Trauma Screening Questionnaire (TSQ; Brewin et al., 2002). The TSQ is a brief 10-item measure used to screen for reexperiencing and arousal symptoms in PTSD where a score of 6 or higher would indicate a possible diagnosis. The predictive value of the TSQ has been found to have 90% overall efficiency (Brewin et al., 2002). The TSQ was slightly adapted by the addition of a question that firstly asks, "Have you been betrayed by a close and trusted other?" and then a free text box and forced multiple choice to indicate what the betrayal trauma was. Permission was granted to slightly adapt the measure from the author.

Baseline

The following measures were completed immediately after screening for participants that met the eligibility criteria to proceed. These questionnaires were used to describe the sample on the different trait-outcomes.

Impact of Events Scale (IES-R; Weiss, 2007). The IES-R is a measure of distress from trauma events and was used in the current research to measure distress from a betrayal. Results are clustered onto three subscales of intrusion, avoidance and hyperarousal. Out of a maximum of 88, a score of 24 indicates symptoms of trauma, and 33 and above representing severe impairment. The scale has excellent internal consistency, α = 0.96 (Creamer et al., 2003).

The Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1965). The RSE has demonstrated good reliability, α = 0.88 (Robins et al., 2001), and was developed to assess

trait self-esteem with scores ranging between 10 – 40. Higher scores indicate higher self-esteem.

The Self-Compassion Subscale of the Compassionate Engagement and Action Scales (CEAS; Gilbert et al., 2017). The CEAS is a measure created to assess compassionate motives and competencies of engagement and action from others, for others, and for self. It was used in the present research to assess participants' trait-based self-compassion level. Engagement items (n = 8) focus on an individual's motivation to engage with their distress with one dimension being *sensitive* to their own suffering and another dimension being *emotionally moved* by their distress. Action items (n = 5) focus on the individual's ability to take action to *alleviate* their distress. All items are rated on a 10-point Likert scale with higher scores indicating greater self-compassion. It has good reliability for Engagement, $\alpha = 0.77$, and excellent reliability for Action $\alpha = 0.90$ (Gilbert et al., 2017).

Trust in Close Relationships Scale (TCRS; Rempel et al., 1985). The TCRS assesses individual's level of trust in close relationships. In this study, participants' level of trust, determined by three subscales of dependency, faith and predictability were used to assess trait beliefs about trust with either a current relationship partner or for future relationships with close and trusted others. 17 items are rated on a 7-point Likert scale with higher scores indicating greater perceived levels of trust in others. The scale has reported a good overall Cronbach $\alpha = 0.81$ (Rempel et al., 1985).

Pre/Post Intervention and One-Week Follow-Up

Participants completed the following state-measures during an arranged Microsoft Team's call (pre-intervention and post-intervention), and then again at one-week follow up. Only the IES-R was included at follow-up with the other four state-measures.

The Positive and Negative Affect Scale (State-PANAS; Watson et al., 1988). The PANAS includes 10 positive and 10 negative affect statements rated on a 5-point Likert scale. Instructions were adjusted slightly to *"in this moment"* to measure participants' situational emotions, with permission granted from the measure's author. The decision to adapt instructions to measure state-levels was justified by published research (Bennetts et al., 2020). The PANAS has conferred good internal consistency for both the positive, $\alpha = 0.89$, and negative scales, $\alpha = 0.85$ (Crawford & Henry, 2004). The negative affect score was used to assess the degree of state-based feelings of shame.

State Self-Esteem Scale (S-SES; Heatherton & Polivy, 1991). Within the S-SES, 20 items are rated on a 5-point scale for how true respondents feel them to be in that moment and produces total scores ranging from 20 to 100 with higher scores indicating greater self-esteem in the situation. It has demonstrated excellent reliability, $\alpha = 0.92$, (Heatherton & Polivy, 1991) and was used in this study to measure participants' state self-esteem directly before and after the experimental intervention and again at follow-up.

State Self-Compassion Subscale of the Compassionate Engagement and Action Scales (State-CEAS; Gilbert et al., 2017). Instructions for this scale were slightly adapted instructing participants to self-report for how they felt about each item in the present moment, both before and after the experimental manipulation, and at one-week follow-up. Scores were used to capture state beliefs about participants' self-compassion. Permission to slightly adapt this subscale of the CEAS was granted from Professor Paul Gilbert.

State-Trust in Close Relationships Scale (State-TCRS; Rempel et al., 1985). Instructions for this scale were slightly adapted instructing participants to self-report for how they felt about the item in the current situation, both before and after the experimental intervention, and at one-week follow-up. Scores were used to capture state beliefs about trust

with either a current relationship partner or for future relationships with close and trusted others. Permission was granted from the outcome measure's author.

Follow-Up Only

Impact of Events Scale (IES-R; Weiss, 2007). The IES-R was used again to measure change in general distress at the one-week follow-up time point to compare against scores at baseline.

[INSERT TABLE 2.3]

Vividness Manipulation Check

Prior to the experimental condition, all participants were read a script asking them to recall the shame-based memory of the betrayal in their mind, focusing on the worst intrusive image, and to then consider what emotions and thoughts came up for them when thinking about this event. This was used to temporarily activate relevant self-defining beliefs encapsulated within the memory that may have exerted an influence on state self-measures. A manipulation check for the betrayal image involved participants using vividness ratings (0 – not vivid; to 100 – extremely vivid).

Compassionate Imagery Script

A compassionate imagery script was created based upon Professor Paul Gilbert's publicly available compassion-focused exercises. This drew on a number of compassionate mind training skills including soothing rhythm breathing, loving kindness, creating a safe place, perfect nurturer, and compassionate ideal self.

Guided Relaxation Script

A guided-imagery relaxation script was developed by the lead researcher and involved individuals engaging in a progressive muscle relaxation practice. Both scripts were of comparative length.

Procedure

Ethical approval for this study was granted for this study (ERGO ID: 72333). The online survey tool Qualtrics XM was used to design the suite of questionnaires for each stage of the study. The study utilised a single blind design where only the researcher had knowledge which group participants were allocated to. During the procedure, the researcher continued to follow key guidance within the Division of Clinical Psychology's resource paper Effective Therapy Via Video: Top Tips (DCP Digital Healthcare Sub-Committee et al., 2020) which details important considerations for managing risks associated with online remote working. Figure 2 depicts a flowchart of the study's procedure.

Data Analysis Strategy

Data were analysed using SPSS Version 28 (IBM Corp., 2023) and screened for normality of distribution using histograms and boxplots. Outliers that were identified were retained and adjusted to the next closest score within two standard deviations of the mean (Field, 2013). Following this, data were found to be normally distributed and assumptions for homogeneity of variance were met.

To examine trait differences between the conditions of compassion and relaxation, independent *t*-tests were completed on baseline measures (distress from a betrayal, self-esteem, self-compassion, and trust in close relationships).

To examine changes in state self-esteem, trust in relationships, positive and negative affect, and self-compassion, a series of repeated-measures MANOVAs were conducted to assess differences with one between-subjects factor (condition – two levels: compassion and relaxation) and one within-subjects factor (time – three levels: pre-intervention, post-intervention, and one-week follow-up). Post hoc analyses were not performed due to fewer than three levels on the grouping factor.

Cohen's guidelines were used to interpret the strength of effect size statistics and magnitude of mean difference (Cohen, 2013). A partial eta squared of .01 to 0.5 is determined to be small, .06 to .137 medium, and .138 and higher is a large effect size.

[INSERT FIGURE 2]

Results

Baseline Measures

Independent Samples *t*-Tests were conducted to examine for differences between the compassion and relaxation groups on the baseline measures. Non-significant results indicated that participants in both groups were not significantly different from each other, suggesting randomisation to have been effective. Means and standard deviations for both groups on measures are shown in Table 2.4.

[INSERT TABLE 2.4]

Impact of Events Scale Revised (IES-R). Participant's scores at baseline and follow-up on the IES-R overall were entered into a repeated-measures MANOVA, shown in Table 5. There was a statistically significant main effect of time (p = <.001), but no significant interaction (p = >.05) or effect of condition (p = >.05). Follow up analyses revealed a reduction in distress related to the betrayal from baseline to follow-up, $F(3, 48) = 7.870$, p =

<.001. Univariate ANOVAs were run on the three subscales of the IES-R and results showed a statistically significant main effect of time on the avoidance subscale (p = <.05), but no significant interaction (p = >.05) or effect of condition (p = >.05). Follow up analyses revealed that from baseline to follow-up avoidance scores reduced, $F(1, 50) = 7.12$, $p = .010$, $\eta_p^2 = .125$ (medium). No other contrast analyses were significant (p = >.05).

State Measures

An independent samples *t*-Test was conducted to compare vividness ratings for the two conditions. There was no significant difference for compassion ($M = 80.69$, $SD = 13.49$) and relaxation ($M = 76.88$, $SD = 13.89$; $t(50) = 1.02$, p = >.05).

Repeated-measures MANOVAs were conducted to explore the effects of time and condition on state measures, with descriptive and MANOVA statistics displayed in Table 2.5.

State self-esteem (S-SES). There was no statistically significant main effect of condition (p = >.05) or time (p = >.05). The interaction between time and condition was also non-significant (p = >.05).

State trust in close relationships (TCRS). There was no statistically significant main effect of condition (p = >.05) or time (p = >.05). The interaction between time and condition was also non-significant (p = >.05).

Positive and Negative Affect Scale (PANAS). There was a statistically significant main effect of time (p = <.001), but no effect of condition (p = >.05). Follow up analyses revealed that from pre-intervention to post-intervention positive affect scores increased and negative affect scores decreased (Positive: $F(1, 50) = 19.674$, p = <.001, $\eta_p^2 = .282$ (large); Negative: $F(1, 50) = 12.463$, p = <.001, $\eta_p^2 = .200$ (large)). This was also found for pre-intervention to follow-up where positive affect scores increased and negative affect scores

decreased (Positive: $F(1, 50) = 9.667$, $p = .003$, $\eta_p^2 = .162$ (large); Negative: $F(1, 50) = 13.411$, $p = <.001$, $\eta_p^2 = .211$ (large)). The interaction between time and condition did not reach significance ($p = 0.64$), though examination of means showed that the compassion group trended towards greater increases in positive affect and reductions in negative affect. Table 5 shows the mean differences across time for both conditions. No other contrast analyses were significant ($p = >.05$).

State self-compassion (S-CEAS). There was a statistically significant main effect of time ($p = .029$), but no significant interaction ($p = >.05$) or effect of condition ($p = >.05$). Follow up analyses revealed that from pre-intervention to post-intervention self-compassionate action scores increased, $F(1, 50) = 8.422$, $p = .006$, $\eta_p^2 = .144$ (large). It was also found that from pre-intervention to follow-up self-compassionate action scores increased, $F(1, 50) = 7.737$, $p = .008$, $\eta_p^2 = .134$ (large). No other contrast analyses were significant ($p = >.05$).

[INSERT TABLE 2.5]

Discussion

This study aimed to explore the efficacy of a brief compassion imagery exercise in a sample of betrayed men, in comparison to a guided progressive muscle relaxation task, and to see whether any benefits were sustained at one-week follow-up. In particular, the study examined the effect of each condition on factors including state-levels of self-compassion, positive and negative affect, self-esteem, and relationship-trust. The main findings indicated that both interventions were equally effective at improving state self-compassionate action and positive affect and reducing negative affect. However, neither intervention found significant differences for state levels of self-esteem, trust in close relationships, or compassionate engagement.

These findings are inconsistent with previous research that has shown compassionate imagery is effective for shame-based memories (Gilbert & Procter, 2006). Due to the shame associated with an interpersonal betrayal and masculine norms driving men's efforts to deny feelings of shame (J. A. Barry et al., 2019), the current study had predicted that compassionate imagery could be an effective intervention for a sample of betrayed men. Based on previous research, this focus on self-compassion can soothe distressing emotions and rebalance an over-active threat system by down-regulating physiological arousal (Morina et al., 2017). In compassionate imagery, this is achieved by generating an impression of compassionate images to promote self-soothing and activate feelings of safeness. It was therefore expected that the internalisation of such images flowing into the self, and imagining how it feels to be fully compassionate toward the self, would have resulted in greater self-compassion than from engaging in a relaxation intervention (Gilbert, 2014). Although guided relaxation has benefits on reducing stress and indirectly improving positive affect (Toussaint et al., 2021), it does not directly target negative meanings and beliefs about the self. As a single session of compassionate imagery has in previous research demonstrated a reduction in negative affect about the self from difficult experiences (Wild et al., 2008), it is unclear why no differential effects between conditions was observed at the statistical significance level. Instead, levels of positive affect and self-compassionate action were found to increase and negative affect decrease over time regardless of condition. However, there are a number of considerations that may offer an explanation for the equivalent effect being found in relaxation.

One explanation for these preliminary results could be that by consistently cueing men in the relaxation condition to notice the relaxed sensation, this refocusing of attention may have interrupted the cycle of self-critical thoughts about the betrayal (Toussaint et al., 2021). As with the men in the compassion condition, this diverted focus may have indirectly

soothed negative feelings including shame, and enabled lower energy positive emotions such as calmness (Gilbert, 2009). Through different mechanisms, both conditions may have achieved access to feelings of contentment by rebalancing and soothing an over-active threat system, whether by enhancing relaxation states or psychological safeness. Furthermore, these states of increased positive affect and reduced negative affect were maintained over one-week and implies that even a brief session of either intervention confers sustained benefits on emotions and mood (Wheatley & Hackmann, 2011). However, when looking at the actual scores over time, these could still be considered as only modest changes in affect and so more research is needed to understand these preliminary results. Since it is believed that the mechanism of change in compassionate imagery involves targeting shame and promoting self-soothing (Gilbert & Procter, 2006), it would be helpful for a more sufficiently powered study to explore whether the content and focus of the compassion and relaxation scripts contribute to a statistically significant difference.

Contrary to the hypothesis, the present study found that state levels of self-compassionate action increased significantly over time across both conditions, unlike self-compassionate engagement. While this suggests that the betrayed men in this study were more able to act in ways that relieved their suffering, they were not more able to engage and tolerate pain and distress (Gilbert, 2010). This pattern is consistent with theoretical accounts in the male psychology literature. Research in this area has identified the differences between men and women in expressing and managing emotions with men less likely to engage in introspection, and more likely to avoid emotional vulnerabilities (Whitley, 2021). In fact, it has been reported that men prefer action-oriented therapeutic approaches compared to emotional exploration, and that an acknowledgement of this communication style for coping with stress can increase acceptability towards help-seeking (Seager & Barry, 2022). The finding then that self-compassionate action improved fits with men in general preferring

active intervention as opposed to tolerating the distress and may go some way as to explaining why no significant differences between groups was found on state affect.

An additional explanation that may account for the lack of difference between the groups concerns the gentle approach modelled by the researcher. It is possible that the experience of a therapeutic woman's voice that embodied qualities of compassion may have resulted in the other-to-self flow of compassion being activated in men in both conditions, regardless of the intervention. Alternatively, effects may have been mediated by different mechanisms of action. Unlike compassion operating within the compassion condition, the effects observed within the relaxation condition may have been the result of lowering physiological arousal that enabled the men to take a metacognitive stance and allow for cognitive flexibility. These hypotheses would need to be tested in future research but could tentatively offer another explanation for no differential effects being found.

Of note, there was no change on levels of self-esteem or trust in close relationships over time or by condition. Given that neither intervention directly targeted these outcomes within the content of the scripts, it was anticipated that these may be secondary effects. Instead, this indicates the procedure to have been ineffective at increasing these variables. Unlike self-compassion that focuses on the relationship with the self, self-esteem is contingent on comparisons with others and positive evaluations of self-worth which were not uniquely targeted within either intervention (Neff, 2003). Similarly, although instructions were adapted on the measure of trust in close relationships, as items referred to trust in a partner, this may have lacked a degree of validity for men who experienced a betrayal from a close other that was not a romantic partner (Rempel et al., 1985).

Finally, analyses on the measure IES-R found distress from the betrayal to have reduced and in particular decreased levels of avoidance. This suggests that regardless of the

script, exposure to the betrayal memory may have resulted in lower avoidance without the need for directly targeting meanings and beliefs. While not a hypothesis, it is possible that due to the focus of the study being betrayal, men were prevented from avoiding thinking about the memory. In turn, this may have enabled them to benefit from increased positive affect, decreased negative affect, and improved self-compassionate action to alleviate suffering by the activation of the contentment system in place of threat (Gilbert & Procter, 2006).

Strengths and Limitations

Noteworthy strengths of the present study included the successful achievement of increased nationwide accessibility due to using remote delivery, an adequately powered sample, inclusion of a control condition, lack of attrition, and a single blind design so that participants were unaware of the condition they were assigned. Randomisation controlled for experimenter bias so that participants scoring low on self-compassion at screening were not deliberately allocated to the compassionate imagery condition. Furthermore, participants comprised a wide array of demographics from age, ethnicity, and sexuality, increasing the generalisability of the results. Anecdotally, men shared positive reflections on both interventions post-script.

The current study results should also be considered in light of several limitations. Firstly, the self-selected sample were recruited by advertising the survey online using social media. This strategy was biased in favour of those volunteers who may have had access to such platforms and was not entirely representative of those members of the target population who do not engage with online sources. It is further acknowledged that all three members of the research team were women and as noted, this may have influenced the research towards self-oriented emotions at the expense of other emotions such as anger. While it is possible

that this may have had an effect, constructs were selected based on the Betrayal Trauma Theory and the psychological outcomes generally found to be experienced following a betrayal trauma, regardless of gender. Nevertheless, although not identified within the evidence-base supporting the theory, it may still be of interest for future research to investigate men-specific experiences such as anger and externalising behaviours in response to being betrayed.

An additional limitation concerns the brevity and chosen platform of a singular imagery exercise. Although this was the aim of this study, it remains unclear how outcomes from a single session delivered online may have compared with repeated practice face to face, in this population of betrayed men. As such, further research may explore the efficacy of practicing brief compassionate imagery exercises across more than one time point. Furthermore, although the compassion group's scores moved in the anticipated direction, a larger sample of men based on a medium effect size may have guaranteed greater statistical power to detect differences between the compassion and relaxation groups.

While it is unclear why the brief compassion imagery intervention was not more effective than relaxation on the outcomes measured, it is possible that rehearsal may have been required to generate differential effects. Indeed, due to men engaging in the intervention at one time point only, it is unknown whether outcomes would have increased further had there been opportunities for more sessions or rehearsal. In turn, the short timeframe of a one-week follow-up may also have accounted for a lack of difference being found. Given that the effects in both conditions may have been mediated by different underlying mechanisms, it is reasonable to hypothesise that the compassion condition may have sustained psychological benefits over a longer time period compared to relaxation. As the present study design did not allow measurement beyond a week, future research would need to test this.

The lack of a shame measure is a weakness and would have strengthened the current study. Not wanting to overburden participants more than necessary, this limitation meant that differential effects in levels of shame between the groups could not be tested. Had this been possible, it would be expected that men in the compassion condition would report the greatest reduction in shame. As follows, rather than grouping all negative emotions on the negative affect subscale of the PANAS, differential effects in negative emotions could have been explored. As a result, this could have tested whether either intervention had a significant effect on betrayed men's levels of shame over time.

Additionally, psychometric properties and validity could have been examined for the adapted state-versions of the CEAS and TCRS to ensure factor structures cross-validated with the original trait-measures. Where wording was adapted slightly to include "in this moment", trait-measures consequently became state-measures. As differences in outcomes were only hypothesised for state-levels, it would be favourable for future research to use validated adapted state-based measures to assess momentary changes.

A further area that was not explored in the current study includes the other flows of compassion. Since the view of the self develops in response to how important others view the self, such as positively or negatively, the capacity to care and receive care from others is important (Gilbert, 2014). These three flows interact as compassion directed towards the self is impacted by compassion from others and impacts compassion towards others. In this way, it would be of interest to understand how these two other flows of compassion influence psychological outcomes in men who have been betrayed.

Research Initiatives

To overcome these limitations, there is a need for more targeted research before the possibility of informing evidence-based recommendations. Future studies could utilise The

State Shame and Guilt Scale (Marschall et al., 1994) to determine whether a relaxation or compassion intervention impacts levels of shame in betrayed men. Validated adapted measures should also be used in future where Confirmatory Factor Analyses could be performed on state versions of the CEAS and TCRS to ensure convergent validity.

Such research could also investigate whether the type of betrayal as well as the gender/sexuality and relationship of the betrayer may impact men's symptoms and their responsiveness to interventions differentially. As the interventions were delivered online, it will be important to understand whether these same effects would be observed face to face and whether the efficacy of this brief intervention translates well into different contexts including clinical populations. Furthermore, the delivery of these interventions should be facilitated by other researchers including men to determine whether significant changes were a result of the intervention and not experimenter variables such as reading style. This may allow firmer conclusions to be drawn on replicability and mechanisms of change involved in efficacy.

Clinical Implications

Of note, this study made an original contribution by being the first to explore the efficacy of a brief compassionate imagery exercise in a sample of betrayed men, on self-compassion, positive and negative affect, self-esteem, and relationship-trust. As such, this study sought to extend existing knowledge in this area and demonstrate the applicability and benefits of compassionate imagery techniques.

The evidence found from trait and state measures within this study suggests that in this sample of betrayed men, their mental health following an interpersonal betrayal was moderately impacted, on outcomes including anxiety and depression. This study suggests preliminary evidence of efficacy with both brief compassionate imagery and guided

relaxation for improving positive mood, reducing negative mood, and increasing betrayed men's motivation to act in ways that alleviate suffering. Further evaluation of why guided relaxation was found to have comparable benefits to compassionate imagery is warranted to understand the mechanisms of change involved.

Conclusions

To summarise, this paper aimed to understand whether a brief compassion exercise might effect change in affect toward the self in a sample of betrayed men, in comparison to a guided relaxation task, and to see whether any benefits were sustained at one-week follow-up. Specifically, this study's findings demonstrated preliminary support for the efficacy of both compassion and relaxation interventions for a reduction in negative affect, and improvements in positive affect and self-compassionate action. Given that interpersonal betrayal impacts the mental health of both men and women, and that in general men express and manage emotional difficulties in ways that are different to women, it is important to continue to design and evaluate research interventions so that psychologists can effectively meet men's emotional needs.

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Tables and Figures

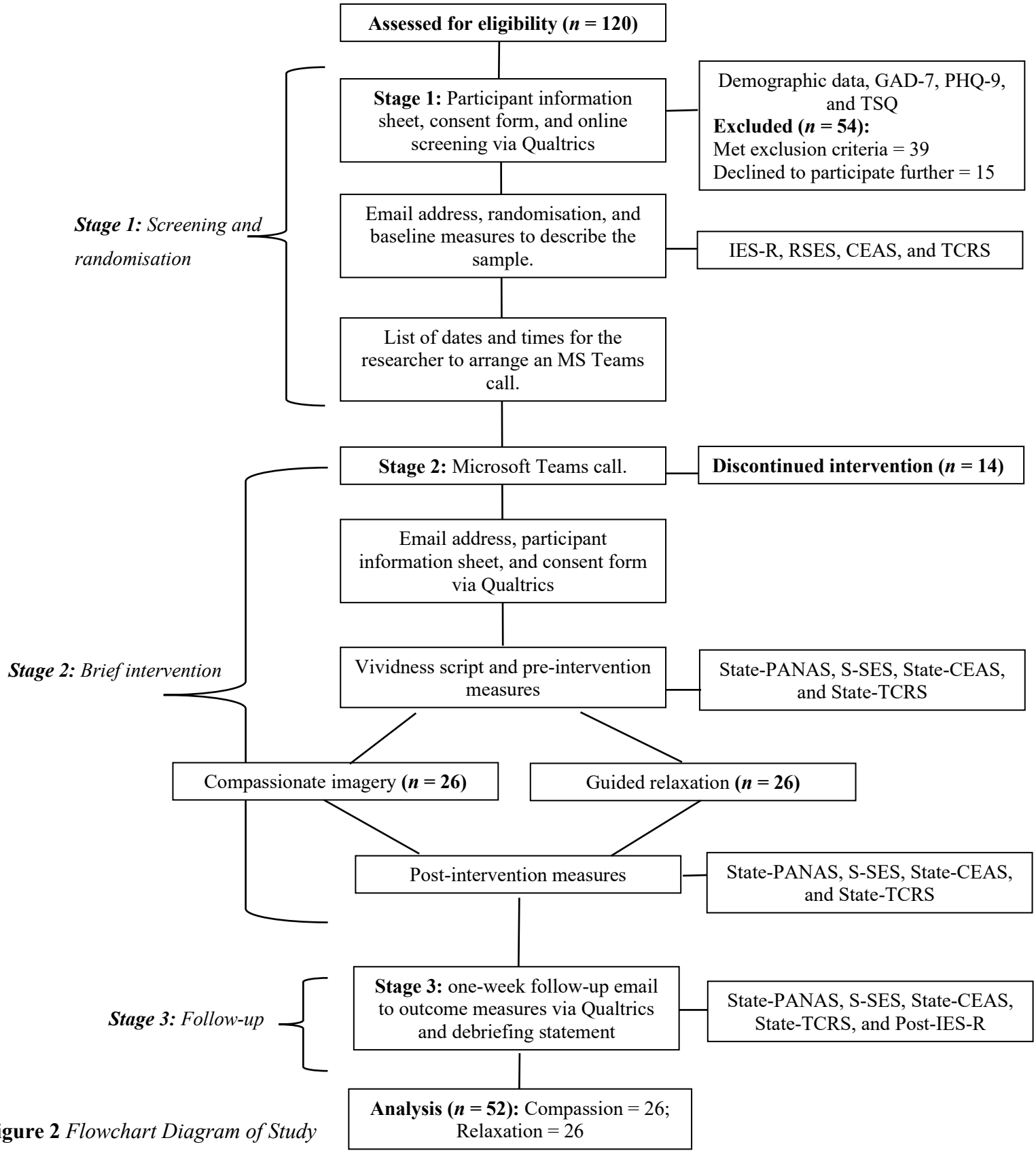


Figure 2 *Flowchart Diagram of Study*

Table 2. 1. *Eligibility criteria*

Inclusion criteria	• Male sex (born male at birth, as transgender males may have been exposed to female gender stereotypes during childhood (Dietert & Dentice, 2013); • Aged 18 and older; • Be able to read and write English; • To have experienced a type of betrayal by a close and trusted other as evidenced by the Trauma Screening Questionnaire (TSQ; Brewin, 2002). This was adapted by the addition of a question that firstly asked, "Have you been betrayed by a close and trusted other?" followed by a multiple choice and free-text box to indicate what the betrayal trauma was. Participants needed to score below 6 on the original scale items, as this is below the score for clinical symptomology (Brewin, 2002).This meant that the inclusion criteria involved men that were affected by an interpersonal betrayal but not to the extent of experiencing significant PTSD.
Exclusion criteria	• Individuals already receiving therapy for mood-related difficulties from a betrayal event; • If currently still facing a betrayal situation by screening for the length of time since the betrayal to avoid exposure to further psychological risk (less than 3 months); • A diagnosis of PTSD or Autism Spectrum Disorder (ASD) due to associated difficulties with Theory of Mind; • Not able to remember the memory of the betrayal; • If scores on the GAD-7 totalled 15 or more; if scores on the PHQ-9 totalled 20 or more or scoring 1 or above on the question regarding suicidal thoughts.

Table 2. 2. *Sociodemographic Characteristics of Participants*

Included Men (n = 52)				
		M	*SD*	*N*
Age		34.71	10.60	
Ethnicity	White (British / English / Welsh / Scottish / Irish / Traveller)			33 (63.5%)
	Black / Black British (African / Caribbean)			7 (13.5%)
	Asian / British Asian (Bengali / Indian / Pakistani)			5 (9.6%)
	Mixed (White / Asian / Black African / Black Caribbean)			2 (3.8%)
	Other not listed			5 (9.6%)
Sexuality	Heterosexual			46 (88.5%)
	Homosexual			3 (5.8%)
	Bisexual			3 (5.8%)
Mental Health	None			42 (80.8%)
	Depression			4 (7.7%)
	Comorbid Anxiety and Depression			4 (7.7%)
	Anxiety			2 (3.8%)
	GAD-7 (Anxiety)	10.83	2.68	
	PHQ-9 (Depression)	12.17	3.22	
	TSQ (Trauma)	2.35	2.01	
Type of betrayal	Dishonesty			10 (19.2%)
	Disloyalty			4 (7.7%)
	Failure to help during time of need			1 (1.9%)
	Harmful disclosure of information			4 (7.7%)
	Infidelity			8 (15.4%)
	Other			2 (3.8%)
	Multiple			23 (44.2%)
Betrayer	Partner			22 (42.3%)
	Parent/Caregiver			4 (7.7%)
	Friend			12 (23.1%)
	Colleague			2 (3.8%)
	Sibling/Family			2 (3.8%)
	Multiple			10 (19.2%)
Length of time	3-6 months			9 (17.3%)
	1 year			9 (17.3%)
	2-5 years			14 (26.9%)
	6-10 years			6 (11.5%)

	More than 10 years			14 (26.9%)
Degree of betrayal felt at the time	0-100	82.10	20.77	
Degree of betrayal felt now	0-100	48.92	33.68	
Impact on trust in others	0-100	52.81	30.36	

Note. M, SD, and *n* represent mean, standard deviation, and number of participants, respectively.

Table 2. 3. *Cronbach's alphas (α) for all measures at each time point*

Measure	Subscale	Baseline	Pre	Post	Follow Up
GAD-7		.68			
PHQ9		.75			
TSQ		.65			
IES-R	Total	.94			.96
	Intrusions	.88			.91
	Avoidance	.89			.92
	Hyperarousal	.79			.82
RSE	Positive	.85			
	Negative	.86			
PANAS	Positive		.93	.93	.95
	Negative		.90	.89	.90
SSES	Positive		.90	.93	.92
	Negative		.93	.94	.94
CEAS	Action	.81	.75	.84	.82
	Engagement (6 items)	.66	.51*	.74	.71
	Engagement (4 items)		.60*		
	Sensitivity (2 items)		.57*		
TCRS		.85	.90	.95	.94

Note. α between .51 to .60 poor, .61 to .70 acceptable, .71 to .80 satisfactory, .81 to .90 good, .91 to 1.0 excellent (Cronbach, 1951). *As α for the CEAS Engagement subscale at pre-intervention was poor, this was re-run excluding the two sensitivity items to achieve an acceptable coefficient.

Table 2. 4. *Descriptive statistics and p values for measures at baseline by condition*

	Compassion (n = 26)		Relaxation (n = 26)		
	M	*SD*	*M*	*SD*	*p*
IES-R	35.62	15.17	42.00	15.40	.138
Intrusions	13.19	6.34	15.50	5.10	.155
Avoidance	14.23	5.89	17.54	7.25	.077
Hyperarousal	8.19	3.97	8.96	4.37	.509
RSE	22.12	2.73	23.54	2.58	.059
CEAS Engagement	37.00	10.76	34.50	8.50	.357
CEAS Action	24.15	8.09	26.04	7.68	.393
TCRS	27.38	8.91	30.42	8.04	.203

Table 2. 5. *Descriptive statistics and MANOVA statistics for each state measure*

Measure	Compassion (n = 26)			Relaxation (n = 26)			MANOVA		
	Pre-*M* *(SD)*	Post *M* *(SD)*	Follow Up *M (SD)*	Pre-*M* *(SD)*	Post *M* *(SD)*	Follow Up *M (SD)*	Interaction	Time	Condition
IES-R	Baseline: 35.62 (15.17)		32.50 (13.09)	Baseline: 42.00 (15.40)		41.15 (15.36)	$F(3, 48) = 1.481$, $p = .232$, $\eta_p^2 = .085$ (Medium)	$F(3, 48) = 7.870$, $p = <.001$**, $\eta_p^2 = .330$ (Large)	$F(3, 48) = 1.720$, $p = .175$, $\eta_p^2 = .097$ (Medium)
S-SES	50.62 (9.92)	49.73 (7.56)	49.35 (7.55)	50.58 (6.63)	50.35 (6.17)	49.19 (7.79)	$F(2, 49) = .131$, $p = .878$, $\eta_p^2 = .005$ (Small)	$F(2, 49) = .706$, $p = .499$, $\eta_p^2 = .028$ (Small)	$F(1, 50) = .006$, $p = .939$, $\eta_p^2 = .000$ (Small)
TCRS	25.27 (13.04)	25.54 (13.62)	27.50 (12.18)	28.12 (13.85)	27.04 (14.36)	25.77 (13.56)	$F(2, 49) = 2.242$, $p = .117$, $\eta_p^2 = .084$ (Medium)	$F(2, 49) = .074$, $p = .929$, $\eta_p^2 = .003$ (Small)	$F(2, 49) = .063$, $p = .802$, $\eta_p^2 = .001$ (Small)

PANAS Positive	28.15 (7.48)	35.81 (7.97)	34.54 (9.16)	32.46 (8.77)	33.96 (7.11)	33.04 (7.53)	$F(4, 47) = 2.387$, $p = .064$, $\eta_p^2 = .169$ (Large)	$F(4, 47) = 6.542$, $p = <.001$**, $\eta_p^2 = .358$ (Large)	$F(2, 49) = .904$, $p = .412$, $\eta_p^2 = .036$ (Small)
PANAS Negative	19.23 (8.46)	14.92 (5.25)	15.15 (5.46)	19.69 (7.43)	17.50 (6.59)	17.04 (5.97)			
CEAS Engagement	37.04 (7.80)	40.62 (10.61)	39.46 (8.56)	35.73 (7.41)	34.65 (6.91)	36.12 (8.48)	$F(4, 47) = 1.778$, $p = .149$, $\eta_p^2 = .131$ (Medium)	$F(4, 47) = 2.958$, $p = .029$*, $\eta_p^2 = .201$ (Large)	$F(2, 49) = 2.013$, $p = .144$, $\eta_p^2 = .076$ (Medium)
CEAS Action	24.73 (6.02)	28.31 (6.52)	27.88 (6.73)	23.85 (7.21)	24.08 (7.12)	25.38 (7.23)			

*p <.05 **p <.001

Appendix B Guidelines for Authors: Psychology of Men and Masculinities

Journal scope statement

Psychology of Men & Masculinities is devoted to the dissemination of scholarship that advances the psychology of men and masculinities. This discipline is defined broadly as the study of how boys' and men's lives are connected to both gender and sex as well as the cultural and individual meanings associated with boys and men. The field encompasses the social construction of gender, sex differences and similarities, and biological processes.

We are interested in work that arises from both applied specialties (e.g., clinical, counselling, school, health, and I/O psychology) and foundational areas (e.g., social, personality, developmental, cognitive, and biological psychology). We also welcome manuscripts from other social science disciplines, such as social work, sociology, public health, and media science.

We accept empirical (quantitative, qualitative, and mixed methods), conceptual, and review manuscripts. We are particularly interested in meta-analyses, review manuscripts that synthesize and critically evaluates a body of literature, and conceptual manuscripts that propose new theories, constructs, or ideas.

Examples of relevant topics include, but are not limited to:

- biological factors influencing men.
- masculine norms and ideologies
- gender role strain, stress, discrepancy, and conflict
- fathering

- men’s sexism
- applications of intersectionality
- boys and men of colour
- gay and bisexual men
- boys’ experiences of and perpetration of bullying
- assessment and measurement issues
- mental and physical health
- violence and sexual aggression
- body image and muscularity
- sexual development, health, and dysfunction
- addictive behaviours
- boys' / men's relationships with girls / women and with each other

Masked Review Policy

Psychology of Men & Masculinities uses a masked review process. Each copy of a manuscript should include a separate title page with author names and affiliations, and these should not appear anywhere else on the manuscript. The first page of the manuscript should include only the title of the manuscript and the date it is submitted. Footnotes containing information pertaining to the authors' identity or affiliations should be removed. Every effort should be made to see that the manuscript itself contains no clues to the authors' identity.

Manuscript Preparation

Prepare manuscripts according to the *Publication Manual of the American Psychological Association* using the 7th edition. Manuscripts for *Psychology of Men & Masculinities* may be regular-length submissions (7,500 words, not including references, tables, or figures) or brief

reports (2,500 words, not including references, tables, or figures). Please include your submission's word count on the title page.

Participant description

Authors are encouraged to include a description of the study participants in the Method section of each empirical report, including (but not limited to) the following:

- Sex/Gender
- Race/Ethnicity
- Age
- Nativity or immigration history
- Socioeconomic status
- Any other relevant demographics (e.g., disability status; sexuality)

In the discussion section of the manuscript, authors are encouraged to discuss the diversity of their study samples and the generalizability of their findings.

Abstract and Keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

Public Significance Statements

Authors submitting manuscripts to *Psychology of Men & Masculinities* are required to provide 2–3 brief sentences regarding the public significance of the study or meta-analysis described in their paper. This description should be included within the manuscript on the

abstract/keywords page, but in a separate paragraph from the abstract and keywords. It should be written in language that is easily understood by both professionals and members of the lay public.

When an accepted paper is published, these sentences will be boxed beneath the abstract for easy accessibility. All such descriptions will also be published as part of the Table of Contents, as well as on the journal's web page. This new policy is in keeping with efforts to increase dissemination and usage by larger and diverse audiences.

To be maximally useful, these statements of public health significance should not simply be sentences lifted directly from the manuscript. They are meant to be informative and useful to any reader. They should provide a bottom-line, take-home message that is accurate and easily understood. In addition, they should be able to be translated into media-appropriate statements for use in press releases and on social media.

Prior to final acceptance and publication, all public health significance statements will be carefully reviewed to make sure they meet these standards. Authors will be expected to revise statements, as necessary.

Appendix C Measures

Demographic Characteristics Questionnaire

ERGO ID: 72333 Version 1 14.04.2022

Thank you for consenting to participate in this research study. You will firstly be asked a few questions about yourself before moving onto a few questionnaires. [* participants selecting these responses will be excluded from further participation]

1. Please indicate your age in years.*excluded if under 18.

2. Please select your gender.
   - Male
   - Female*
   - Transgender*

3. Please select the ethnicity that you most identify with.
   - White: British / English / Welsh / Scottish / Northern Irish
   - White: Irish
   - White: Gypsy / Irish Traveller
   - White: Other not listed here
   - Mixed: White and Black Caribbean
   - Mixed: White and Black African
   - Mixed: White and Asian
   - Mixed: Other not listed here

- Asian / British Asian: Bangladeshi
- Asian / British Asian: Indian
- Asian / British Asian: Pakistani
- Asian / British Asian: Other not listed here.
- Black / Black British: African
- Black / Black British: Caribbean
- Black / Black British: Other not listed here.
- Arab
- Chinese
- Prefer not to say.
- Other not listed: please use the space provided.

4. Please select the sexual orientation that best describes you.
    - Heterosexual
    - Lesbian*
    - Gay
    - Bisexual
    - Transgender*

5. Please indicate if you have been diagnosed with any of the following and if you have a current diagnosis.
    - Anxiety
    - Depression
    - PTSD*

- Autism*
- N/A

6. Please indicate if you are currently under a mental health service or awaiting an appointment if you have or are being referred.
    - Yes*
    - No
7. Please indicate the type of interpersonal betrayal you have experienced. If you have experienced more than one trauma, please select the one that you found the most distressing.
    - Dishonesty
    - Disloyalty
    - Infidelity
    - Harmful disclosure of confidential information
    - Failure to offer assistance during time of need.
    - Other not listed: please detail your response in the space below.
8. Please indicate the relationship of the person / persons that betrayed you.
    - Partner
    - Parent / Caregiver
    - Friend
    - Colleague
    - Other:
9. How long ago did the betrayal occur?

    [Drop down box for years]

    [Drop down box for months; e.g., less than one month, 1, 2, 3, etc.]

10. Please use the scale below to show the degree to which you felt betrayed at the time.

0 1 2 3 4 5 6 7 8 9 10

No harm Significantly betrayed.

11. Please use the scale below to show the degree to which you feel betrayed now.

0 1 2 3 4 5 6 7 8 9 10

No harm Significantly betrayed.

12. Has the betrayal impacted your trust in others?

0 1 2 3 4 5 6 7 8 9 10

Completely trusting Significantly distrusting

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at rls8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

The Traumatic Screening Questionnaire (TSQ)

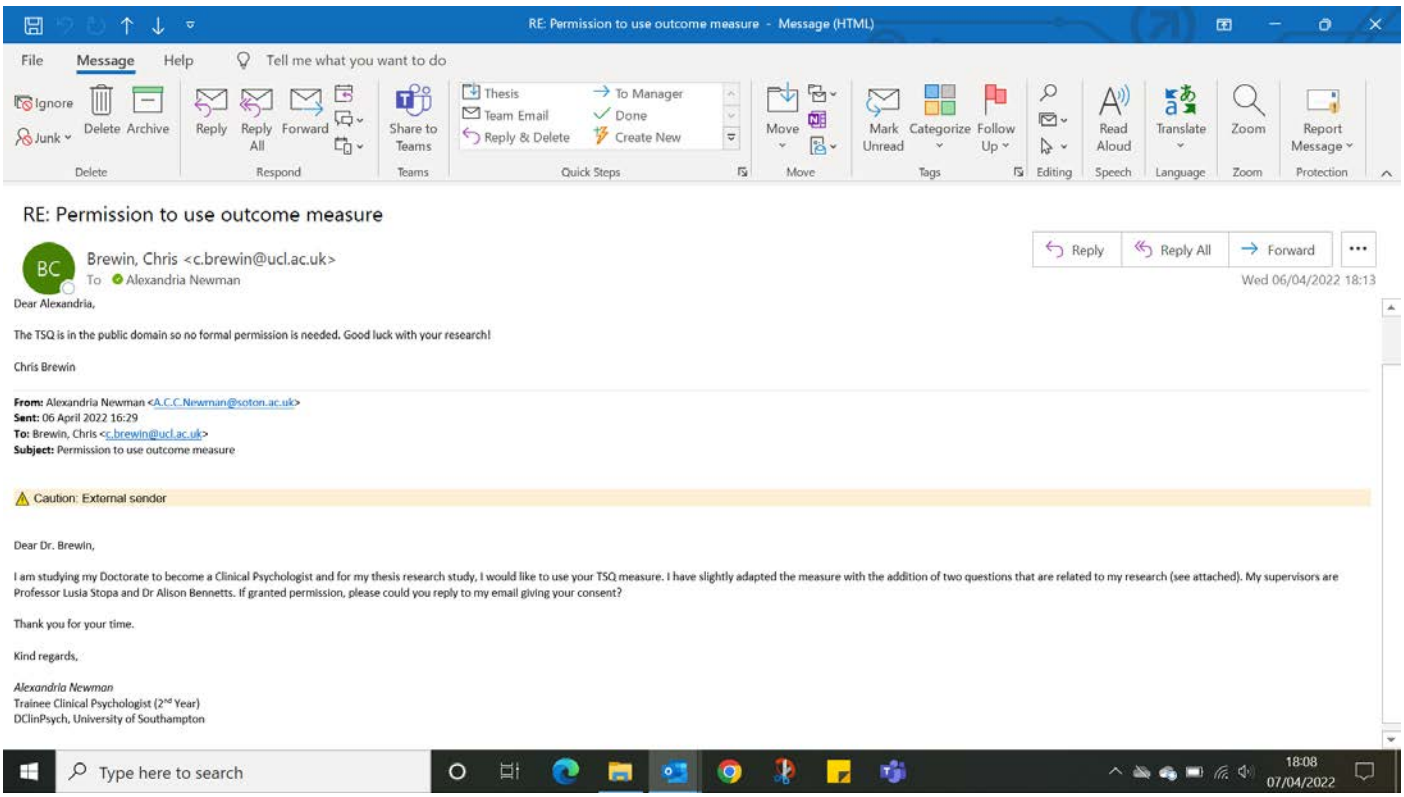
ERGO ID: 72333 Version 1 14.04.2022

Your Own Reactions Now to the Traumatic Event

Please consider the following reactions which sometimes occur after a traumatic event. This questionnaire is concerned with your personal reactions to the traumatic event which happened. Please indicate whether or not you have experienced any of the following AT LEAST TWICE IN THE PAST WEEK:

i) Have you been betrayed by a close and trusted other?	YES	NO
ii) Please indicate in the space what the betrayal was.		
	YES, AT LEAST TWICE IN THE PAST WEEK	NO
1. Upsetting thoughts or memories about the event that have come into you mind against your will		
2. Upsetting dreams about the event		
3. Acting or feeling as though the event were happening again		

4. Feeling upset by reminders of the event		
5. Bodily reactions (such as fast heartbeat, stomach churning, sweatiness, dizziness) when reminded of the event		
6. Difficulty falling or staying asleep		
7. Irritability or outbursts of anger		
8. Difficulty concentrating		
9. Heightened awareness of potential dangers to yourself and others		
10. Being jumpy or being startled at something unexpected		



RE: Permission to use outcome measure - Message (HTML)

File Message Help Tell me what you want to do

Ignore Junk Delete Archive Reply Reply All Forward Share to Teams Thesis Team Email Reply & Delete To Manager Done Create New Move Mark Unread Categorize Follow Up Read Aloud Translate Zoom Report Message

Delete Respond Teams Quick Steps Move Tags Editing Speech Language Zoom Protection

RE: Permission to use outcome measure

BC Brewin, Chris <c.brewin@ucl.ac.uk>
To Alexandria Newman

Reply Reply All Forward

Wed 06/04/2022 18:13

Dear Alexandria,

The TSQ is in the public domain so no formal permission is needed. Good luck with your research!

Chris Brewin

From: Alexandria Newman <A.C.C.Newman@soton.ac.uk>
Sent: 06 April 2022 16:29
To: Brewin, Chris <c.brewin@ucl.ac.uk>
Subject: Permission to use outcome measure

⚠ Caution: External sender

Dear Dr. Brewin,

I am studying my Doctorate to become a Clinical Psychologist and for my thesis research study, I would like to use your TSQ measure. I have slightly adapted the measure with the addition of two questions that are related to my research (see attached). My supervisors are Professor Lusia Stopa and Dr Alison Bennetts. If granted permission, please could you reply to my email giving your consent?

Thank you for your time.

Kind regards,

Alexandria Newman
Trainee Clinical Psychologist (2nd Year)
DClinPsych, University of Southampton

Type here to search 18:08 07/04/2022

IMPACT OF EVENTS SCALE-Revised (IES-R)

INSTRUCTIONS: Below is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you DURING THE PAST SEVEN DAYS with respect to _____ _____(event) that occurred on _____(date). How much have you been distressed or bothered by these difficulties?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Any reminder brought back feelings about it	0	1	2	3	4
2. I had trouble staying asleep	0	1	2	3	4
3. Other things kept making me think about it.	0	1	2	3	4
4. I felt irritable and angry	0	1	2	3	4
5. I avoided letting myself get upset when I thought about it or was reminded of it	0	1	2	3	4
6. I thought about it when I didn't mean to	0	1	2	3	4
7. I felt as if it hadn't happened or wasn't real.	0	1	2	3	4
8. I stayed away from reminders of it.	0	1	2	3	4
9. Pictures about it popped into my mind.	0	1	2	3	4
10. I was jumpy and easily startled.	0	1	2	3	4
11. I tried not to think about it.	0	1	2	3	4
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.	0	1	2	3	4
13. My feelings about it were kind of numb.	0	1	2	3	4
14. I found myself acting or feeling like I was back at that time.	0	1	2	3	4
15. I had trouble falling asleep.	0	1	2	3	4
16. I had waves of strong feelings about it.	0	1	2	3	4
17. I tried to remove it from my memory.	0	1	2	3	4
18. I had trouble concentrating.	0	1	2	3	4
19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.	0	1	2	3	4
20. I had dreams about it.	0	1	2	3	4
21. I felt watchful and on-guard.	0	1	2	3	4
22. I tried not to talk about it.	0	1	2	3	4

Total IES-R Score:_____

INT: 1, 2, 3, 6, 9, 14, 16, 20
AVD: 5, 7, 8, 11, 12, 13, 17, 22
HYP: 4, 10, 15, 18, 19, 21

Weiss, D.S. (2007). The Impact of Event Scale-Revised. In J.P. Wilson, & T.M. Keane (Eds.) *Assessing psychological trauma and PTSD: a practitioner's handbook* (2nd ed., pp. 168-189). New York: Guilford Press.

AETR2N 22 1/13/2012

Using the Impact of Event Scale-Revised (IES-R): Permissions and Costs. The IES-R is available for use without cost, and the author will grant permission to use the measure to anyone with the appropriate training and context to administer the measure. For graduate students and their advisors, this document is the permission to use the measure in dissertation or another program requirement research.

RSE

Please record the appropriate answer for each item, depending on whether you Strongly agree, agree, disagree, or strongly disagree with it.

1 = Strongly agree
2 = Agree
3 = Disagree
4 = Strongly disagree

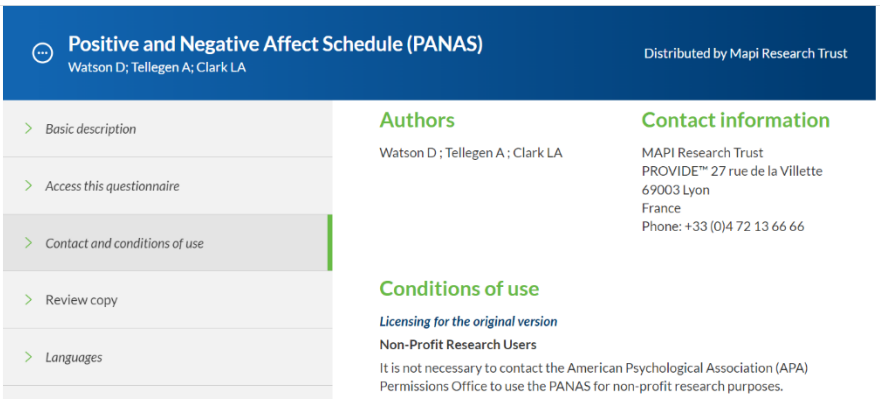
_____ 1. On the whole, I am satisfied with myself.
_____ 2. At times I think I am no good at all.
_____ 3. I feel that I have a number of good qualities.
_____ 4. I am able to do things as well as most other people.
_____ 5. I feel 1do not have much to be proud of.
_____ 6. I certainly feel useless at times.
_____ 7. I feel that I'm a person of worth.
_____ 8. I wish I could have more respect for myself.
_____ 9. All in all, I am inclined to think that I am a failure.
_____ 10. I take a positive attitude toward myself.

The Rosenberg Self-Esteem Scale is perhaps the most widely-used self-esteem measure in social science research. Dr. Rosenberg was a Professor of Sociology at the University of Maryland from 1975 until his death in 1992. He received his Ph.D. from Columbia University in 1953, and held a variety of positions, including at Cornell University and the National Institute of Mental Health, prior to coming to Maryland. Dr. Rosenberg is the author or editor of numerous books and articles, and his work on the self-concept, particularly the dimension of self-esteem, is world-renowned.

The Rosenberg Self-Esteem Scale is now in the public domain, meaning you may use it without charge and without notifying the Sociology Department. This permission extends to making translations or adaptations as you see fit, consistent with traditional scholarly attribution practices. The department does not maintain any information on the scale beyond what is linked below, and cannot advise on its use.

Positive and Negative Affect Schedule (PANAS-SF)

Indicate the extent you have felt this way over the past week.		Very slightly or not at all	A little	Moderately	Quite a bit	Extremely
PANAS 1	Interested	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PANAS 2	Distressed	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PANAS 3	Excited	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PANAS 4	Upset	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PANAS 5	Strong	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PANAS 6	Guilty	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PANAS 7	Scared	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PANAS 8	Hostile	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PANAS 9	Enthusiastic	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PANAS 10	Proud	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PANAS 11	Irritable	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PANAS 12	Alert	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PANAS 13	Ashamed	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PANAS 14	Inspired	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PANAS 15	Nervous	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PANAS 16	Determined	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PANAS 17	Attentive	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PANAS 18	Jittery	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PANAS 19	Active	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PANAS 20	Afraid	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5



Positive and Negative Affect Schedule (PANAS)
Watson D; Tellegen A; Clark LA

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- Basic description
- Access this questionnaire
- Contact and conditions of use
- Review copy
- Languages

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Watson D ; Tellegen A ; Clark LA

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Non-Profit Research Users

It is not necessary to contact the American Psychological Association (APA) Permissions Office to use the PANAS for non-profit research purposes.

STATE SELF-ESTEEM SCALE

This is a questionnaire designed to measure what you are thinking at this moment. There is of course, no right answer for any statement. The best answer is what you feel is true of yourself at the moment. Be sure to answer all of the items, even if you are not certain of the best answer. Again, answer these questions as they are true for you **RIGHT NOW.**

1. I feel confident about my abilities.

1	2	3	4	5
Not At All	A Little Bit	Somewhat	Very Much	Extremely

2. I am worried about whether I am regarded as a success or failure.

1	2	3	4	5
Not At All	A Little Bit	Somewhat	Very Much	Extremely

3. I feel satisfied with the way my body looks right now.

1	2	3	4	5
Not At All	A Little Bit	Somewhat	Very Much	Extremely

4. I feel frustrated or rattled about my performance .

1	2	3	4	5
Not At All	A Little Bit	Somewhat	Very Much	Extremely

5. I feel that I am having trouble understanding things that I read.

1	2	3	4	5
Not At All	A Little Bit	Somewhat	Very Much	Extremely

6. I feel that others respect and admire me.

1	2	3	4	5
Not At All	A Little Bit	Somewhat	Very Much	Extremely

7. I am dissatisfied with my weight.

1	2	3	4	5
Not At All	A Little Bit	Somewhat	Very Much	Extremely

8. I feel self-conscious.

1	2	3	4	5
Not At All	A Little Bit	Somewhat	Very Much	Extremely

9. I feel as smart as others.

1	2	3	4	5
Not At All	A Little Bit	Somewhat	Very Much	Extremely

10. I feel displeased with myself.

1	2	3	4	5
Not At All	A Little Bit	Somewhat	Very Much	Extremely

11. I feel good about myself.

1	2	3	4	5
Not At All	A Little Bit	Somewhat	Very Much	Extremely

12. I am pleased with my appearance right now.

1	2	3	4	5
Not At All	A Little Bit	Somewhat	Very Much	Extremely

13. I am worried about what other people think of me.

1	2	3	4	5
Not At All	A Little Bit	Somewhat	Very Much	Extremely

14. I feel confident that I understand things.

1	2	3	4	5
Not At All	A Little Bit	Somewhat	Very Much	Extremely

15. I feel inferior to others at this moment.

1	2	3	4	5
Not At All	A Little Bit	Somewhat	Very Much	Extremely

16. I feel unattractive.

1	2	3	4	5
Not At All	A Little Bit	Somewhat	Very Much	Extremely

17. I feel concerned about the impression I am making.

1	2	3	4	5
Not At All	A Little Bit	Somewhat	Very Much	Extremely

18. I feel that I have less scholastic ability right now than others.

1	2	3	4	5
Not At All	A Little Bit	Somewhat	Very Much	Extremely

19. I feel like I'm not doing well.

1	2	3	4	5
Not At All	A Little Bit	Somewhat	Very Much	Extremely

20. I am worried about looking foolish.

1	2	3	4	5
Not At All	A Little Bit	Somewhat	Very Much	Extremely

STATE - TRUST IN CLOSE RELATIONSHIPS SCALE

ERGO ID: 7233 Version 1 14.04.2022

This is a questionnaire designed to measure what you are thinking at this moment. There is of course, no right answer for any statement. The best answer is what you feel is true of yourself at the moment. Be sure to answer all of the items, even if you are not certain of the best answer. Again, answer these questions as they are true for you RIGHT NOW.

Instructions:

Using the 7-point scale shown below, indicate the extent to which you agree or disagree with the following statements as they relate to someone with whom you have a close interpersonal relationship. Place your rating in the box to the right of the statement.

Strongly Disagree			Neutral			Strongly Agree
-3	-2	-1	0	1	2	3

1. My partner has proven to be trustworthy, and I am willing to let D him/her engage in activities which other partners find too. threatening. ☐
2. Even when I don't know how my partner will react, I feel ☐ F

comfortable telling him/her anything about myself, even those things of which I am ashamed.

3. Though times may change, and the future is uncertain, I know my partner will always be ready and willing to offer me strength and support. ☐ F

4. I am never certain that my partner won't do something that I dislike or will embarrass me. ☐ P

5. My partner is very unpredictable. I never know how he/she is going to act from one day to the next. ☐ P

6. I feel very uncomfortable when my partner has to make decisions which will affect me personally. ☐ P

7. I have found that my partner is unusually dependable, especially D when it comes to things which are important to me. ☐

8. My partner behaves in a very consistent manner. ☐ P

9. Whenever we have to make an important decision in a situation, we have never encountered before, I know my partner will be concerned about my welfare. ☐ F

10. Even if I have no reason to expect my partner to share things with me, I still feel certain that he/she will. ☐ F

11. I can rely on my partner to react in a positive way when I expose my weaknesses to him/her. ☐ F

12. When I share my problems with my partner, I know he/she will ☐ F

respond in a loving way even before I say anything.

13. I am certain that my partner would not cheat on me, even if ☐
the
D opportunity arose and there was no chance that he/she would get
caught.

14. I sometimes avoid my partner because he/she is unpredictable and I ☐ P
fear saying or doing something which might create conflict.

15. I can rely on my partner to keep the promises he/she makes to me. ☐
D

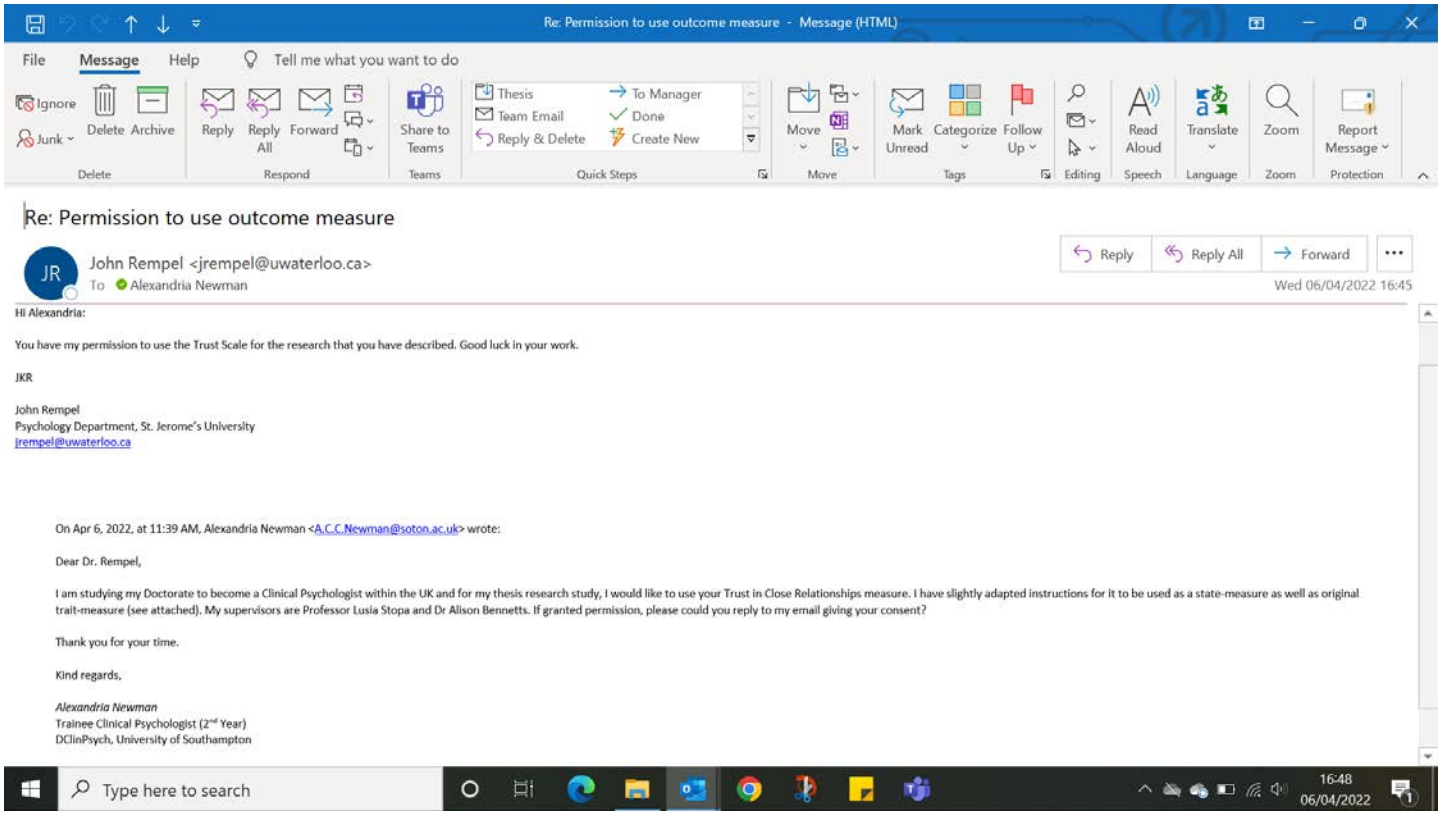
16. When I am with my partner, I feel secure in facing unknown new ☐ F
situations.

17. Even when my partner makes excuses which sound rather ☐
unlikely,
D I am confident that he/she is telling the truth.

Scoring

The items marked with a D are the Dependency items. Items marked with an F are the Faith items, and Items marked with a P are the Predictability items.

One can score the questionnaire based on the 3 subscales separately or combine the subscales to create an overall trust in close relationships score.



Re: Permission to use outcome measure - Message (HTML)

File Message Help Tell me what you want to do

Ignore Junk Delete Archive Reply Reply All Forward Share to Teams Thesis Team Email Reply & Delete To Manager Done Create New Move Mark Unread Categorize Follow Up Read Aloud Translate Zoom Report Message

Delete Respond Teams Quick Steps Move Tags Editing Speech Language Zoom Protection

Re: Permission to use outcome measure

JR John Rempel <jrempel@uwaterloo.ca>

To Alexandria Newman

Reply Reply All Forward

Wed 06/04/2022 16:45

Hi Alexandria:

You have my permission to use the Trust Scale for the research that you have described. Good luck in your work.

JKR

John Rempel
Psychology Department, St. Jerome's University
jrempel@uwaterloo.ca

On Apr 6, 2022, at 11:39 AM, Alexandria Newman <A.C.C.Newman@soton.ac.uk> wrote:

Dear Dr. Rempel,

I am studying my Doctorate to become a Clinical Psychologist within the UK and for my thesis research study, I would like to use your Trust in Close Relationships measure. I have slightly adapted instructions for it to be used as a state-measure as well as original trait-measure (see attached). My supervisors are Professor Lusia Stopa and Dr Alison Bennetts. If granted permission, please could you reply to my email giving your consent?

Thank you for your time.

Kind regards,

Alexandria Newman
Trainee Clinical Psychologist (2nd Year)
DClinPsych, University of Southampton

Type here to search 16:48 06/04/2022

THE COMPASSIONATE ENGAGEMENT AND ACTION SCALES

ERGO ID: 72333 Version 1 14.04.2022

State - Self-compassion

When things go wrong for us and we become distressed by setbacks, failures, disappointments or losses, we may cope with these in different ways. We are interested in the degree to which people can be compassionate with themselves. We define compassion as "a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it." This means there are two aspects to compassion. The *first* is the ability to be motivated to engage with things/feelings that are difficult as opposed to trying to avoid or supress them. The *second* aspect of compassion is the ability to focus on what is helpful to us. Just like a doctor with his/her patient. The first is to be motivated and able to pay attention to the pain and (learn how to) make sense of it. The second is to be able to take the action that will be helpful. Below is a series of questions that ask you about these two aspects of compassion. Therefore, read each statement carefully and think about how it applies to you if you become distressed. Please rate the items using the following rating scale:

Never Always

1 2 3 4 5 6 7 8 9 10

Section 1 – These are questions that ask you about how motivated you are, and able to engage with distress when you experience it. There is of course, no right answer for any statement. The best answer is what you feel is true of yourself *at the moment*. Be sure to answer all of the items, even if you are not certain of the best answer. Again, answer these questions as they are true for you RIGHT NOW. So:

When I'm distressed or upset by things…

I am *motivated* to engage and work with my distress when it arises.

Never Always

1 2 3 4 5 6 7 8 9 10

I *notice and* am *sensitive* to my distressed feelings when they arise in me.

Never Always

1 2 3 4 5 6 7 8 9 10

(r)3. I avoid thinking about my distress and try to distract myself and put it out of my mind.

Never Always

1 2 3 4 5 6 7 8 9 10

I am *emotionally moved* by my distressed feelings or situations.

Never Always

1 2 3 4 5 6 7 8 9 10

I *tolerate* the various feelings that are part of my distress.

Never Always

1 2 3 4 5 6 7 8 9 10

I *reflect on* and *make sense* of my feelings of distress.

Never Always

1 2 3 4 5 6 7 8 9 10

(r)7 I do not tolerate being distressed.

Never Always

1 2 3 4 5 6 7 8 9 10

8. I am *accepting, non-critical and non-judgemental* of my feelings of distress.

Never Always

1 2 3 4 5 6 7 8 9 10

Section 2 – These questions relate to how you actively cope in compassionate ways with emotions, thoughts and situations that distress you. There is of course, no right answer for any statement. The best answer is what you feel is true of yourself *at the moment*. Be sure to answer all of the items, even if you are not certain of the best answer. Again, answer these questions as they are true for you RIGHT NOW. So:

When I'm distressed or upset by things…

I direct my *attention* to what is likely to be helpful to me.

Never Always

1 2 3 4 5 6 7 8 9 10

I *think* about and come up with helpful ways to cope with my distress.

Never Always

1 2 3 4 5 6 7 8 9 10

(r)3. I don't know how to help myself.

Never Always

1 2 3 4 5 6 7 8 9 10

I take the *actions* and do the things that will be helpful to me.

Never Always

1 2 3 4 5 6 7 8 9 10

I create inner feelings of *support, helpfulness and encouragement*.

Never Always

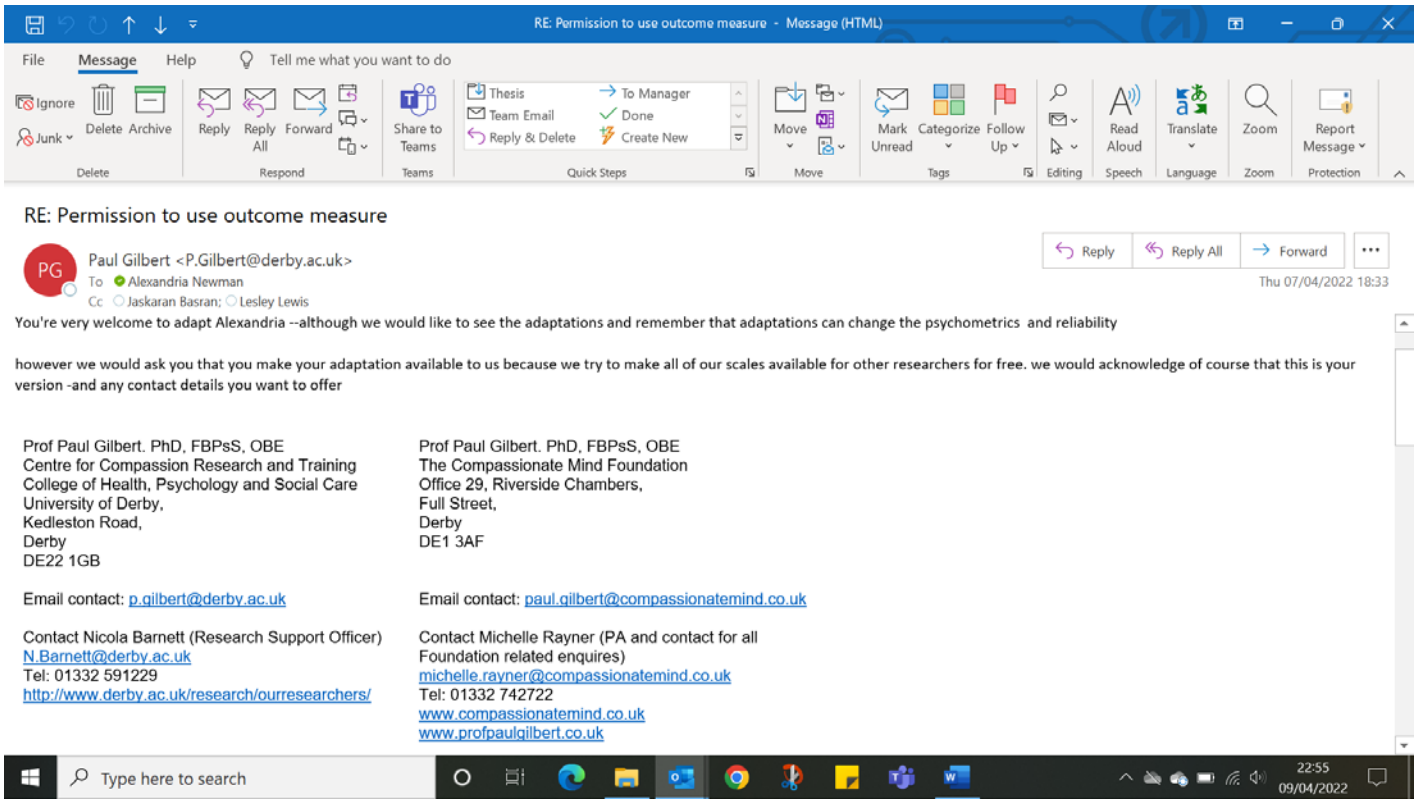
1 2 3 4 5 6 7 8 9 10

NOTE FOR USERS: REVERSE ITEMS (r) ARE NOT INCLUDED IN THE SCORING

SCORING

The three scales – *Compassion for others*, *compassion from others*, *compassion for self* are scored separately. For each scale two subscales can be calculated: Engagement (items 1, 2, 4, 5, 6, 8) and Actions (1, 2, 4, 5). For the *Compassion for self* scale, two dimensions may be analysed in the Engagement subscale (sum of items 2 and 4, and sum of items 1, 5, 6, and 8). A total score can be calculated (sum of items of the Engagement and Actions subscales) for each scale – *Compassion for others*, *compassion from others*, *compassion for self*.

Please note that reverse items (r) are not included in the scoring.


RE: Permission to use outcome measure - Message (HTML)
File
Message
Help
Tell me what you want to do
Ignore
Junk
Delete
Archive
Reply
Reply All
Forward
Share to Teams
Thesis
Team Email
Reply & Delete
To Manager
Done
Create New
Move
Mark Unread
Categorize
Follow Up
Read Aloud
Translate
Zoom
Report Message
Delete
Respond
Teams
Quick Steps
Move
Tags
Editing
Speech
Language
Zoom
Protection
RE: Permission to use outcome measure
PG
Paul Gilbert <P.Gilbert@derby.ac.uk>
To Alexandria Newman
Cc Jaskaran Basran; Lesley Lewis
Reply
Reply All
Forward
Thu 07/04/2022 18:33
You're very welcome to adapt Alexandria --although we would like to see the adaptations and remember that adaptations can change the psychometrics and reliability
however we would ask you that you make your adaptation available to us because we try to make all of our scales available for other researchers for free. we would acknowledge of course that this is your version -and any contact details you want to offer
Prof Paul Gilbert. PhD, FBPsS, OBE
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Email contact: paul.gilbert@compassionatemind.co.uk
Contact Michelle Rayner (PA and contact for all Foundation related enquires)
michelle.rayner@compassionatemind.co.uk
Tel: 01332 742722
www.compassionatemind.co.uk
www.profpaulgilbert.co.uk
Type here to search
22:55
09/04/2022

Appendix D Scripts

Vividness Manipulation Check of Betrayal Image (Script)

ERGO ID: 72333 Version 1 14.04.2022

Thank you for taking part in this study. Please only proceed if you can spend the next few minutes alone, in a quiet place, focusing on this task. I will be asking you to remember a time when you were betrayed by a close and trusted other and to imagine this memory as clearly as possible.

I would like you to think of the worst part of this memory.

As best as you can, focus on this memory, and consider what emotions and thoughts come up for you when thinking about this event.

As best you can, picture yourself in this situation. Picture the image of yourself as clearly as possible in your mind's eye.

Notice what you are doing. Notice who you are with.

Notice what you can see and hear.

Continue to picture this memory as clearly as possible, just noticing how clear and vivid this image is.

As you continue to hold this memory in mind, now please return to the Qualtrics survey and use the sliding scale to rate how vivid the image of the betrayal was for you.

Compassionate Loving Kindness Imagery Script (adapted from Gilbert, 2010)

ERGO ID: 72333 Version 1 14.04.2022

Find a comfortable sitting position and take a few moments to find a relaxed posture, just move the head around the shoulders slowly to find a relaxed position. Use this time to feel into your body allowing any tension to be released. Place both feet flat on the floor about shoulder's width apart and rest your hands on your legs, allowing your attention to rest on your experience of the body sitting in the chair. Allow your feet to really feel the support of the earth underneath you and then allow your gaze to fall naturally just ahead to an invisible spot in front of you. You can close your eyes or look down at the floor if you prefer. Allow yourself to have a gentle facial expression, maybe a slight smile or natural appearance.

Pause

Now just gently focus on your breathing. Notice how the in-breath begins. Notice how at the end of the in-breath the breath naturally starts to descend; follow the breath down with your attention until it reaches the depths of your stomach. There is a moment here when it appears that there is no breath: a point of stillness and space. Then, of its own accord, without our having to do anything, the breath rises once again on the in-breath and the cycle begins once more.

As you breathe try to allow the air to come down into your diaphragm. Feel your stomach move as you breathe in and out. Breathe a little faster or a little slower until you find a breathing pattern that, for you, seems to be your own soothing, comforting rhythm. Try to really connect with this rhythm of the in-breath and the out-breath, allowing this rhythm to help relaxation in the body.

It is like you are checking in, linking up with the rhythm within your body that is soothing and calming to you. Just gradually allowing the breath to lengthen and slow down.

Pause

Now turn your attention to your body. Sense the weight of your body resting on the chair and the floor underneath you…. allow yourself to feel held and supported…..coming to rest in the present moment…. If you notice your mind wandering, simply notice it happening with curiosity, and then gently guide your attention back to an awareness of your body as best as you can.….just gently observing….no need to change anything…..just allowing things to be as they are.

Now place your attention on your feet, and then on the earth beneath your feet. Just feel the earth. Notice the areas of contact between your body and the chair. Notice the support the chair is offering to you right now. Allow this to happen, allow a comfortable sense of heaviness to spread through your body, supported and carried by the chair. Notice the rise and fall of the breath. Notice any tension you are holding within your body, the neck, shoulders, down the arms, the weight of the head. Each time you notice any tightness or difficulty in these different parts of your body allow it to drain into your chair, be absorbed by your chair. You could place your hands over your heart to remind yourself that you are bringing not only attention, but loving attention, to your experience. Feel the warmth of your hands, the gentle pressure of your hands, and feel how your chest rises and falls beneath your hands with every breath.

Pause

When you're ready, try to create a place in your mind that could give you the feeling of safeness and calmness….Imagine looking around you, what can you see? It might be a

beautiful wood where the leaves of the trees dance gently in the breeze, powerful shafts of light caress the ground with brightness. Or it may be a beautiful beach with a crystal blue sea stretching out to the horizon where it meets the ice blue sky…. Or relaxing next to an open fire….take some time to visualise your space……Now focus on what you can feel, like the sensation of the sun on your face or a breeze caressing your hair…. Or can you feel soft, white sand underfoot…… Next think about what you can hear. Can you hear the rustle of the leaves on the trees, or birds, or the gentle hushing of waves on the sand?..... Now think about whether you can smell anything, such as the salty smell of the sea or the smell of wood smoke or a sweetness of the air….. Take a few moments to immerse yourself in your own place of calmness and safety……..

When you bring your safe place to mind allow your body to relax. Think about your facial expression; allow it to have a soft smile of pleasure at being there…. Imagine that the place itself takes joy in you being there…. Explore your feelings when you imagine this place is happy with you being there…. Even if it is just a fleeting sense of where the image might be, try to create an emotional connection to this place.

And sitting across from you in this place just a small distance, you can see a version of yourself that is an embodiment of compassion and warmth……and in observing this compassionate version of yourself, notice how it is sitting with a strong posture and presence, that shows a strength and resilience that is able to tolerate great difficulty and discomfort……. observe how your compassionate self also appears very wise…it shows a calmness and can see things clearly… it understands how we've evolved over hundreds of millions of years, knowing that our brains, our bodies and our minds on all sorts of dimensions we didn't choose, we didn't ask for…so much that we have learned is not what we would choose, and so much that pains us and troubles us in life is really not our

fault…and in observing your compassionate self, you can see that it is fully committed…there is nothing in the world as important as the alleviation and prevention of your suffering…. your compassionate self is completely committed to your wellbeing… …and resting for a moment, you are allowing your eyes to meet the eyes of this compassionate version of you…noticing the health, vitality and wellbeing present in the skin and the eyes…just noticing a warm, smiling expression…. seeing the deep care and connectedness that is there…the warmth, and real presence…whenever your mind wanders away from this practice just breathe in and bringing your attention back to this connection with this compassionate self…

And imagining that you can bring the awareness of this compassionate self into you, just as you might pour cool clear water from a jug into a clear glass…just from the top of your head as you inhale, breathing in the presence of this compassionate self…and feeling yourself being filled by this presence up from the soles of your feet, through the legs and lower body…with each cycle of the breath becoming this compassionate body…all the way to the top of the head…letting go of any wondering or worrying about if we really are this compassionate self…just imagining what it would be like…how we would want our face to have the expression of this compassionate being

Now imagining in a friendly tone of voice, in a caring tone of voice, a strong and authoritative tone of voice…imagining in your mind seeing and hearing your compassionate self say these words…

may I be filled with love and kindness and compassion…

may I be peaceful and at ease…

may I be well…

may I be happy…

may I be filled with love and kindness and compassion…

may the conditions that have caused my suffering to be let go, and may I be well…

may even the parts in me that resist compassion, the parts in me that cling to suffering, may even those parts come to be at ease, at rest….

may I be present and aware…

may I be awake and wise.. …

Pause

Taking this time just to rest in the breath, in the presence of this compassionate self…just imagining what it would look like if you were moving through your day as this compassionate self, imagining taking action to care for, look after specific people you might meet…imagine caring for yourself, promoting your own wellbeing… …And gradually with each exhalation just letting go of the images and resting of the breath, feeling your feet on the ground. And bringing a part of your attention to the top of your head…and breathing awareness into your body, awareness of your presence in the room…and as you breath in noticing the sounds around you in the room… remembering your motivation to be aware of the suffering you notice in yourself and others and move towards the alleviation and prevention of that suffering so that you may wake up, be present, and in peace.

Pause

This is the end of the practice. Thank you.

References

Gilbert, P. (2010). *Training our minds in, with, and for compassion: An introduction to concepts and compassion-focused exercises*. Retrieved from https://www.getselfhelp.co.uk/docs/GILBERT-COMPASSION-HANDOUT.pdf

Guided Relaxation Script

ERGO ID: 72333 Version 1 14.04.2022

Find a comfortable sitting position and take a few moments to find a relaxed posture, just move the head around the shoulders slowly to find a relaxed position. Use this time to feel into your body allowing any tension to be released. Place both feet flat on the floor about shoulder's width apart and rest your hands on your legs, allowing your attention to rest on your experience of the body sitting in the chair. Allow your gaze to fall naturally just ahead to an invisible spot in front of you. You can close your eyes or look down at the floor if you prefer.

Pause

Let any outside sounds around you be in the background of your awareness and begin to notice any tension you are holding within your body, the neck, shoulders, down the arms, the weight of the head. Take a few deep breaths, filling your chest with air and just give yourself permission to relax.

Pause

When you are ready to begin, tense your right hand by stretching your fingers as far as you can, as though they are trying to touch something out of reach. Make sure that you can feel the tension, but not so much that you feel pain. Keep tensing for a few moments. *[5 seconds pause]* Feel the tension, notice this tension, and then relax your hand and keep it relaxed for a few moments. [*5 seconds pause]* Notice the difference between tensing and relaxing.

Now, tense your right forearm by making a fist with your right hand. Make sure that you can feel the tension, but not so much that you feel discomfort. Keep tensing for a few moments.

[5 seconds pause] Feel the tension, notice this tension, and then relax your hand and keep it relaxed for a few moments. [*5 seconds pause]* Notice the difference between tensing and relaxing.

Now, bring your right arm up to your shoulder and begin to flex your bicep muscle making sure that you can feel that tension. If you notice any pain or discomfort, stop immediately. Keep tensing for a few moments. *[5 seconds pause]* Feel the tension, notice this tension, and then relax your arm, bringing it to rest down by your side and keep it relaxed for a few moments. [*5 seconds pause]* Notice the difference between tensing and relaxing.

Now, begin tensing your left hand by stretching your fingers as far as you can, as though they are trying to touch something out of reach. Make sure that you can feel the tension, but not so much that you feel pain. Keep tensing for a few moments. *[5 seconds pause]* Feel the tension, notice this tension, and then relax your hand and keep it relaxed for a few moments. [*5 seconds pause]* Notice the difference between tensing and relaxing.

Now, tense your left forearm by making a fist with your left hand. Make sure that you can feel the tension, but not so much that you feel discomfort. Keep tensing for a few moments. *[5 seconds pause]* Feel the tension, notice this tension, and then relax your hand and keep it relaxed for a few moments. [*5 seconds pause]* Notice the difference between tensing and relaxing.

Now, bring your left arm up to your shoulder and begin to flex your bicep muscle making sure that you can feel that tension. If you notice any pain or discomfort, stop immediately. Keep tensing for a few moments. *[5 seconds pause]* Feel the tension, notice this tension, and then relax your arm, bringing it to rest down by your side and keep it relaxed for a few

moments. [*5 seconds pause]* Notice the difference between tensing and relaxing. Take a few moments longer to really feel your body relax [*5 seconds pause]*.

Now, moving towards the feet, curl the toes on your right foot downwards, as though you are gripping onto sand underneath them. If you notice any cramping, stop, and then try to find the most comfortable approach of tensing for you. Try this for a few moments. *[2 seconds pause]* Feel the tension, notice this tension, and now relax your toes and stay relaxed for a few moments [*5 seconds pause]*. Notice the difference between tensing and relaxing.

Now, gently tense your right leg's calf muscle by squeezing. You can do this by squeezing your toes into your right foot and pointing the tip of your foot downwards, similar to how you might imagine a ballerina pivoting. If you begin to notice any cramping, stop immediately, and then try to find the most comfortable approach of tensing this muscle for you. Try this for a few moments. *[2 seconds pause]* Feel the tension, notice this tension, and now relax your leg and stay relaxed for a few moments. [*5 seconds pause]* Notice the difference between tensing and relaxing.

Now, moving towards the left foot, curl the toes on your left foot downwards, as though you are gripping onto sand underneath them. If you notice any cramping, stop, and then try to find the most comfortable approach of tensing for you. Try this for a few moments. *[2 seconds pause]* Feel the tension, notice this tension, and now relax your toes and stay relaxed for a few moments [*5 seconds pause]*. Notice the difference between tensing and relaxing.

Now, gently tense your left leg's calf muscle by squeezing. You can do this by squeezing your toes into your left foot and pointing the tip of your foot downwards, similar to how you might imagine a ballerina pivoting. If you begin to notice any cramping, stop immediately, and then try to find the most comfortable approach of tensing this muscle for you. Try this for

a few moments. *[2 seconds pause]* Feel the tension, notice this tension, and now relax your leg and stay relaxed for a few moments. [*5 seconds pause]* Notice the difference between tensing and relaxing. Take a few moments longer to really feel your body relax [*5 seconds pause]*.

Moving to the muscles in your face, start by trying to open your mouth as wide as you can. Try holding this position for a few moments. *[5 seconds pause]* Then relax your jaw and stay relaxed for a few moments [*5 seconds pause].*

Now, scrunch up your nose as tight as you can, really holding this tension there for a few moments *[5 seconds pause]* Feel the tension and now relax your nose and stay relaxed for a few moments [*5 seconds pause].*

Now, squeeze your eyes tight shut and keep them like this for a few moments *[5 seconds pause]* Feel the tension, notice this tension, and then relax your eyes and stay relaxed for a few moments [*5 seconds pause]*

Now, raise your eyebrows as high as they will go, as though you are surprised. Make sure that you can feel the tension spreading across your forehead and keep tensing for a few moments. *[5 seconds pause]* Feel the tension in these muscles, notice this tension, and now relax your eyebrows and stay relaxed for a few moments [*5 seconds pause]*. Notice the difference between tensing and relaxing.

Now, facing forward carefully and slowly move your head back to rest on the back of your neck, as though you are looking up to the sky. If you begin to notice any pain, stop immediately, and then try to find the most comfortable approach of tensing this muscle for you. Try this for a few moments. *[5 seconds pause]* Then relax your neck, perhaps rolling your head around a little, and stay relaxed for a few moments. [*5 seconds pause]*

Now, raising your shoulders up in line with your ears, as though your neck is shrinking, begin to tense these muscles. If you begin to notice any discomfort, you can try to find the most comfortable approach of tensing these muscles for you. Try this for a few moments. *[5 seconds pause]* Feel the tension, notice this tension, and now relax your shoulders for a few moments [*5 seconds pause]*

Now, try to push your shoulder blades back, as though you were trying to squeeze a pen in-between them, and push your chest out. If you notice any cramping, try to find the most comfortable approach of tensing this area for you. Try this for a few moments. *[5 seconds pause]* Then relax your shoulder blades and stay relaxed for a few moments. [*5 seconds pause]* Notice the difference between tensing and relaxing.

Take a few moments longer to really feel your body relax [*5 seconds pause]*. Begin to notice any tension you are holding within your body and trying to let go of this tension, just relaxing the weight of the head, the neck, shoulders, and back, down the arms, all the way to the fingers, your legs and down to the feet and toes, just allowing yourself to relax and just noticing this difference between tensing and relaxing… [*5 seconds pause]* Finally, just moving the head around the shoulders slowly, take a few moments to remain seated, then open your eyes, be alert, and come back to the here and now. This is the end of the practice. Thank you.

Appendix E Study Advert

University of Southampton

Have you been betrayed by someone you trusted?

The Psychologist, British Psychological Society

I am looking for male volunteers to take part in an online research study investigating the impact of being betrayed by someone you trust. The study aims to look at a number of different dimensions about how the betrayal made you feel.

To take part you must:

- Be an adult male (aged 18+ and born male at birth)
- Have been betrayed by someone you trusted in adolescence or adulthood

What is involved?

- Complete some questionnaires at different time-points
- You may be invited to a brief exercise with the lead researcher
- Chance to enter a **prize draw to win one of twenty-five £20 Amazon gift vouchers**

If you would like to find out more about the study, you can contact the lead researcher, *Miss Alexandria Newman (Trainee Clinical Psychologist)* at an3n20@soton.ac.uk.

Version 2. Date: 01.11.2022 ERGO: 72333

Appendix F ERGO II Ethics application form – Psychology Committee

ERGO ID: 72333

Version 4

01.11.2022

1. Applicant Details

1.1 Applicant name	**Alexandria Newman**
1.2 Supervisor	**Dr Ali Bennetts**
1.3 Other researchers / collaborators (if applicable):	**Professor Lusia Stopa**

2. Study Details

2.1 Title of study	**Efficacy of a Brief Compassion Intervention on Psychological Outcomes in Males Following a Betrayal.**
2.2 Type of project (e.g., undergraduate, Masters, Doctorate, staff)	**Doctorate**

2.3 Briefly describe the rationale for carrying out this project and its specific aims and objectives.

The aim of this project is to investigate whether exposure to a compassionate mental image has an impact on mood, and levels of self-esteem, self-compassion, and relationship trust in male participants who have experienced an interpersonal betrayal. This is a largely under-researched area within male psychology as the majority of literature focuses on masculine toxicity in which males are stereotyped to conceal emotions, or on relational trauma in the context of childhood sexual abuse. This study intends to contribute to current understandings of relational trauma in males and extend this further by researching the influence of a mental imagery exercise on self-compassion in males recalling a betrayal memory. This research will therefore draw on the two key theoretical frameworks of Betrayal Trauma Theory (Freyd, 1994) and Compassionate Mind Training (Gilbert, 2009).

Betrayal Trauma Theory. Freyd (1994) first described the term betrayal trauma within the development of Betrayal Trauma Theory (BTT) as a social dimension of relational trauma in which there is a violation of trust. The theory focused on the assertion that interpersonal betrayals shatter beliefs in the safety and security of the relationship with a close other. Proposing links between a betrayal, alterations in relationship schemas, and post-betrayal appraisals, Freyd (1994) linked the emotion of shame and the cognitive appraisal of self-blame. To illustrate the role of these cognitive-affective appraisals (Andrews et al., 2000), individuals may develop maladaptive cognitions about a betrayal that place the focus on themselves (self-blame e.g., ”I was responsible for causing it to happen”) that either lead to feelings of shame or focus attention on the most shaming-part of the experience (distress-appraisals; DePrince et al., (2011) e.g., social embarrassment or perceived humiliation by others). Where individuals may need to preserve or maintain a relationship, they may avoid focusing on the betrayer’s actions through these misappraisals of self-blame and shame

(Gagnon et al., 2017). However, by focusing on the self, victims can experience secondary distress such as feelings of isolation and alienation. In this way, the risk of negative psychological outcomes like depression following a betrayal may be increased by appraisals that involve a high degree of shame. One therapy that has been developed specifically to tackle shame is compassion focused therapy (Gilbert, 2009).

Compassionate Mind Training. Compassionate-Mind Training (CMT) comprises the skills and techniques which are a part of Compassion-Focused Therapy (CFT). CFT theorises that experiences of shame create a vulnerability to self-criticism, self-attack and threats of rejection from others (Gilbert, 2009), and can be associated with difficulties in generating positive affect, warmth and compassion toward the self. A key tenet of CFT is to help clients develop a compassionate kind relationship to themselves to replace self-blame and criticism. This can be where CMT and compassionate-imagery as a technique can facilitate a caring orientation with oneself by encouraging individuals to practice using a supportive inner tone and activate feelings of safety and contentment (Gilbert, 2014).

Links between Males, BTT, and CMT. Males may be more prone to shame due to gender stereotypes within society where the stigma to conform to a masculine identity means concealing emotional vulnerabilities (Hine et al., 2020) As CMT targets self-criticism and shame and the experience of shame is a key feature of betrayal trauma, it is expected that betrayed men may experience high levels of shame and self-criticism. Researching this sample may provide important insights into the betrayal experiences of males and their responsiveness to an experimental compassionate-imagery intervention.

This proposed empirical study would offer an important contribution to existing knowledge by testing whether experimental manipulations of compassion can temporarily decrease

feelings of shame. In turn, this may act as a catalyst for further research interventions investigating the efficacy of CMT for betrayal in male populations. Studying this largely under-researched population could offer insights into the rate of males who may benefit from accessing services and systems of support. If males are able to engage and benefit, even temporarily, from brief-CMT that targets feelings of shame and self-criticism from a betrayal, this may encourage earlier mental-health intervention (Bates et al., 2019).

2.4 Provide a brief outline of the basic study design. Outline what approach is being used and why.

The aim of this experimental study is to explore whether exposure to a compassionate mental image has an impact on mood, self-esteem, self-compassion, and relationship trust in male participants who have experienced a betrayal. A mixed model design will explore the within-groups factor of time (pre, post and 1 week follow-up) and between-groups factor of condition (compassionate-imagery and a control imagery condition). Dependent variables will involve repeated administration of the outcome measures (state levels of self-esteem, self-compassion, positive and negative affect, and degree of trust in relationships with close and trusted others) to evaluate the two groups at pre-intervention, post-intervention and follow-up.

Since the study is interested specifically in the role of a compassionate image on levels of self-compassion, an alternative imagery exercise will provide a control condition. Instead of focusing on compassion, the control imagery condition will use a guided relaxation task. Guided relaxation imagery has known benefits on stress and on positive affect but does not

actively target thoughts, feelings or sensations. This will allow the experimental manipulation of a brief compassion image to be tested through active engagement with the exercise.

2.5 What are the key research question(s)? Specify hypotheses if applicable.

Research questions and corresponding hypotheses:

RQ1 What is the impact of a brief compassionate-imagery manipulation on state levels of self-compassion, positive and negative affect, self-esteem and relationship-trust compared to a control group of guided relaxation imagery?

H1 A brief compassionate-imagery manipulation will reduce state negative-affect, and increase state self-compassion, state positive-affect, state self-esteem and state relationship-trust compared to the control imagery condition.

RQ2 What is the impact of a brief compassionate-imagery manipulation on state levels of self-compassion, positive and negative affect, self-esteem and relationship-trust at one-week follow-up, compared to the impact of a control group of guided relaxation imagery?

H2 A brief compassionate-imagery manipulation will maintain levels of state self-compassion, state affect, state self-esteem and state relationship-trust at one-week follow-up, compared to a control group of guided relaxation imagery.

3. Sample and setting

3.1 Who are the proposed participants and where are they from (e.g., fellow students, club members)? List inclusion / exclusion criteria if applicable.

Power was calculated using G* Power version 3.1 (Faul et al., 2007). Assuming results will achieve an eta squared n2 medium effect size of 0.09, an a-priori power analysis identified a total sample size needed of 82 participants for 2 independent groups, to test a one-tailed hypothesis, with 80% power and 5% significance level.

Inclusion criteria: Participants must be of the male sex (born male at birth, as transgender males may have been exposed to female gender stereotypes during childhood (Dietert & Dentice, 2013), aged 18 and older, be able to read and write English, give consent, complete psychometric measures, have no hearing impairments, and to have been impacted by the experience of a betrayal by a close and trusted other as evidenced by an adapted version of the Trauma Screening Questionnaire (TSQ; Brewin, 2002). This would be adapted by the addition of a question that firstly asks, "Have you been betrayed by a close and trusted other?" and then a free text box or forced multiple choice to indicate what the betrayal trauma was. Participants must score below 6 on the original scale items, as this is below the score for clinical symptomology (Brewin, 2002).This will mean that the inclusion criteria involves males that have been affected by an interpersonal betrayal but not to the extent of experiencing significant clinical symptomology.

Exclusion criteria: Individuals will be excluded if already receiving therapy for mood-related difficulties from a betrayal event; if they are currently still facing a betrayal situation by screening for the length of time since the betrayal in the clinical characteristics screening questionnaire, to avoid exposure to further psychological risk; if they report a diagnosis of

PTSD or Autism Spectrum Disorder (ASD) due to associated difficulties with Theory of Mind; if they are not able to remember the memory of the betrayal; if scores on the Patient Health Questionnaire-9 (PHQ-9) total 20 or more, indicating severe depression, or 1 or above on the question regarding suicidal thoughts; and score 15 or more indicating severe anxiety on the Generalised Anxiety Disorder-7 (GAD-7) – such individuals will be signposted to access mental health support services and will not be eligible to participate. Where a response to the question about suicidal ideation may have been left blank, these individuals will also be excluded as part of the study's risk assessment. All individuals looking to participate will need to complete screening measures of the TSQ, PHQ-9, and GAD-7 to assess eligibility.

3.2. How will the participants be identified and approached? Provide an indication of your sample size. If participants are under the responsibility of others (e.g., parents/carers, teachers) state if you have permission or how you will obtain permission from the third party).
Male participants will be identified and approached by advertising through social media (e.g., Facebook), charities such as the Mankind Initiative that work with male victims, and the university student population surrounding Southampton. The sampling strategy will initially be broad to ensure capturing participants who may have experienced an interpersonal betrayal but not meet criteria for a formal trauma-diagnosis by using the TSQ to screen for this. All participants will be directed to complete a brief betrayal screening questionnaire to determine if they have experienced a betrayal and are eligible to take part in the study. It is anticipated that due to the sensitive nature of experiencing a betrayal and the stigmatisation of males as

victims, recruitment may be challenging. As a result, it is expected that the study procedure will take place online to access a greater number of participants across the UK. It is intended to recruit a minimum total of 80 males, so that there is an equal distribution of participants in both conditions, whilst still retaining power needed for a medium effect size.

3.3 Describe the relationship between researcher and sample. Describe any relationship e.g., teacher, friend, boss, clinician, etc.
There will be no relationship between the researching Trainee Clinical Psychologist and the sample. However, there may be a risk if sharing via personal social media accounts. Upon reaching the experimental stage, if someone in the sample is identified as having a close personal relationship with the researcher then they will need to be excluded from the study but thanked for their interest in participation.

3.4 How will you obtain the consent of participants? (*please upload a copy of the consent form if obtaining written consent***) NB A separate consent form is not needed for online surveys where consent can be indicated by ticking/checking a consent box (normally at the end of the PIS). Other online study designs may still require a consent form or alternative procedure (for example, recorded verbal consent for online interviews).**
At the stage when potential participants access the link to the online survey, they will be required to have read and understood the participant information sheet (PIS). After reading

the PIS, they will be directed to the digital consent form which will require them to check a box included on the form as indication of their consent. They will not be able to continue past this stage without providing consent.

3.5 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.

4. Research procedures, interventions, and measurements

4.1 Give a brief account of the procedure as experienced by the participant. Make it clear who does what, how many times and in what order. Make clear the role of all assistants and collaborators. Make clear the total demands made on participants, including time and travel. *Upload copies of questionnaires and interview schedules to ERGO.*
Screening. A digital link directing potential participants to the participant information sheet and digital consent form will be attached to study adverts posted on social media, online platforms and a variety of organisations which will be contacted by email and asked if they would be willing to share within their organisation (see draft version of study advert attached). If individuals choose to provide digital consent to take part, they will be invited to complete initial screening questionnaires on the Qualtrics survey link. Questionnaires will be designed so that if participants meet eligibility criteria on the screening measures, they will

then be directed to provide an email address and once being randomised into one of the two groups, they can be contacted again to complete further measures and the task. Individuals who do not meet inclusion criteria will be directed to a screen thanking them for their participation with links for external sources of support, as well as the researcher's details should they wish for a further debrief.

Description of the sample. Trait outcome measures will be administered once with data collected being used to describe the sample. A pre and post study design will be used to assess state-levels of compassion to self, self-esteem, positive and negative affect (negative affect score will be used to assess degree of state-based feelings of shame) and trust in close relationships by administering the following outcome measures.

Study Phase	Measure	Description
Screening	**Demographic and clinical characteristics questionnaire.**	A brief questionnaire will be used to collect demographic information on age, ethnicity, sexual orientation, marital status, mental health diagnoses and any contact with mental health services. Information will also be collected on the type of betrayal, relationship significance to the participant (e.g., partner, friend, colleague), length of time since the betrayal, degree to which the person feels betrayed, and how much the participant now trusts others. This

	information will be used to screen for level of harm caused and depth of a trusting bond.
Patient Health Questionnaire - 9 (PHQ-9; Kroenke et al., 2001).	PHQ-9 is the 9-item depression subscale of the full measure. This will be used to identify participants' self-reported psychological mood. Scores range from 0-27, where 5 indicates *mild impairment;* 10 *moderate;* 15 *moderately severe;* and 20 *severe depression.* The measure has good internal reliability, $\alpha = 0.89$ (Kroenke et al., 2001).
Generalised Anxiety Disorder – 7 (GAD-7; Spitzer et al., 2006).	This will be used as a brief measure of generalised anxiety disorder symptoms. Scores range from 0-21, where 5 indicates *mild impairment;* 10 *moderate;* and 15 *severe anxiety.* The measure has excellent internal reliability, $\alpha = 0.92$ (Spitzer et al., 2006).
Trauma Screening Questionnaire (TSQ; Brewin et al., 2002).	This brief 10-item measure will be used to screen for reexperiencing and arousal symptoms in PTSD where a score of 6 or higher would indicate a possible diagnosis. The predictive value of the TSQ has been found to have 90% overall efficiency (Brewin et al., 2002). The TSQ would be slightly adapted by the addition of a question that firstly asks, "Have you been

		betrayed by a close and trusted other?" and then a free text box or forced multiple choice to indicate what the betrayal trauma was.
	Impact of Events Scale (IES-R; Weiss, 2007).	This will be used to measure distress from betrayal trauma events. Results are clustered onto 3 subscales of intrusion, avoidance and hyperarousal. Out of a maximum of 88, a score of 24 indicates symptoms of trauma, and 33 and above representing cut-off for a diagnosis of PTSD. The scale has been found to have excellent internal consistency, $\alpha = 0.96$ (Creamer et al., 2003).
Baseline (Trait measures to describe the sample)	**The Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1965).**	This has demonstrated good reliability, $\alpha = 0.88$ (Robins et al., 2001), and will be used to assess trait self-esteem with scores ranging between 10 – 40. Higher scores indicate *higher self-esteem*.
	The Self-Compassion Subscale of the Compassionate Engagement and	This will assess participant's trait-based self-compassion level. 8 Engagement items focus on an individual's motivation to engage with their distress with one dimension being sensitive to suffering in oneself and another dimension being emotionally

	Action Scales (CEAS; Gilbert et al., 2017)	moved by one's distress. 8 Action items focus on the individual's ability to take action to alleviate their distress. All items are rated on a 10-point Likert scale with higher scores indicating greater self-compassion. It has been found to have good reliability for Engagement, α = 0.77, and excellent reliability for Action α = 0.90 (Gilbert et al., 2017).
	Trust in Close Relationships Scale (TCRS; Rempel et al., 1985).	Participant's level of trust, determined by three subscales of dependency, faith and predictability will be used to assess trait beliefs about trust with either a current relationship partner or for future relationships with close and trusted others. Seventeen items are rated on a 7-point Likert scale with higher scores indicating greater perceived levels of trust in others. The scale has reported a good overall Cronbach α = 0.81 (Rempel et al., 1985).
Pre/Post-intervention and 1 week follow-up	**The Positive and Negative Affect Scale (State-PANAS; Watson et al., 1988).**	10 positive and 10 negative affect statements are rated on a 5-point Likert scale with instructions adjusted slightly to *"in this moment"* to measure participant's situational emotions. The PANAS has conferred good internal consistency for both the positive, α = 0.89, and negative scales, α = 0.85 (Crawford & Henry,

	2004). The negative affect score will be used to assess the degree of state-based feelings of shame.
State Self-Esteem Scale (S-SES; Heatherton & Polivy, 1991).	20 items are rated on a 5-point scale for how true they feel in that moment and produces total scores ranging from 20 to 100 with higher scores indicating greater self-esteem in the situation. It has demonstrated excellent reliability, $\alpha = 0.92$, (Heatherton & Polivy, 1991) and will be used in this study to measure participant's state self-esteem directly before and after the experimental intervention and again at follow-up.
State Self-Compassion Subscale of the Compassionate Engagement and Action Scales (State-CEAS; Gilbert et al., 2017)	Instructions for this scale will be slightly adapted instructing participants to self-report for how they feel about each item in the present moment, both before and after the experimental manipulation, and at one week follow-up. Scores will be used to capture state beliefs about participant's self-compassion.
State-Trust in Close Relationships	Instructions for this scale will be slightly adapted instructing participants to self-report for how they feel about the item in the current situation, both before and

	Scale (State-TCRS; Rempel et al., 1985).	after the experimental intervention, and at one week follow-up. Scores will be used to capture state beliefs about trust with either a current relationship partner or for future relationships with close and trusted others.
	Follow-Up Only: Impact of Events Scale (IES-R; Weiss, 2007).	This will be used to measure change in general trauma symptoms at pre and 1 week follow up time points and comparing the two groups.

Randomisation. Participants will be randomised using Qualtrics and will be assigned to either the experimental or control group. This will be a single blind design where only the research team will have knowledge which groups participants are allocated to. Half of participants recruited will be randomly allocated to the experimental condition (compassionate mental imagery exercise) and the other half of participants will be guided through a relaxation task.

Experimental stage. Those participants that meet eligibility criteria will be contacted by email that they provided in the screening stage. This email will include a direct link to a Microsoft Office Form listing the possible dates and times that the researcher can do an individual video call with them over MS Teams. Participants will be asked to select slots that they would be available and would be reminded in the email and on the form that this stage of the study is not anonymous as responses will need to identify email addresses and participants for the video call, and the researcher would be able to visually identify them. Participants will then be emailed with confirmation of their slot and provided with a link to the Teams call. A reminder email will also be sent one week beforehand.

On the date and time of their slot, once joining their individual video call and prior to the exercise, participants in both conditions will be asked to recall the shame-based memory of the betrayal in their mind, focusing on the worst intrusive image, and to then consider what emotions and thoughts came up for them when thinking about this event. A manipulation check for the betrayal image will involve participants using vividness ratings (0 – not vivid; to 100 – extremely vivid). Participants will only then be directed to the specific task they have been allocated to if they have at least a vividness rating of 60, otherwise they will continue to be primed by focusing longer on the memory and asked prompting questions to elicit further details in the image. Afterwards, males will be asked to complete state-based measures using the link provided in the email. They will then complete the intervention imagery exercise (compassion vs guided imagery) and immediately after complete the state-measures again by a further email from the researcher with the links to the post-intervention Qualtrics surveys. Each intervention including outcome measures is expected to last around 60 minutes to allow for differences in cognitive processing. Finally, all individuals will be contacted at one-week follow-up by email from the experimental intervention to complete the state-measures for a final time to evaluate whether any benefits are sustained. Those that participate in the experimental stage will also be offered the opportunity to be entered into a prize-draw to win an Amazon voucher and emailed a debriefing form thanking them for their participation.

Compassionate-imagery. The researcher will facilitate reading the imagery script in the video-call session so that the intervention is conducted in real-time. Participants will be asked to bring to mind a soothing and compassionate image, in line with the Perfect Nurturer (Lee, 2005) and Gilbert and Procter (2006) and to consider what that compassionate image would

say, feel and act towards them. This is chosen to test the experimental hypothesis of compassionate-imagery targeting specific psychological state-based outcomes of shame and self-criticism where the script will be piloted with 2 males (see attachments for the compassionate imagery script and the guided relaxation script which may be adjusted for comparative time length.)

Guided relaxation. The researcher will facilitate reading the script in the video-call session so that the intervention is conducted in real-time. A matched distraction task of guided-imagery relaxation will involve individuals engaging in a progressive muscle relaxation imagery practice. Both conditions will involve a physiological component of either soothing rhythmic breathing (compassion group) or muscle relaxation (guided relaxation) that use visualisation techniques. The manipulation will be whether this involves compassion or not.

4.2 Will the procedure involve deception of any sort? If yes, what is your justification?

No, the project will not use any deception.

4.3. Detail any possible (psychological or physical) discomfort, inconvenience, or distress that participants may experience, including after the study, and what precautions will be taken to minimise these risks.

Strain from participation – potentially psychologically demanding to concentrate on completing multiple outcome measures and an intervention. Although taking place online due to the risks associated with spreading Covid-19, it is anticipated that there will be occasions

where the scheduling of the session and the length may be inconvenient for participants. Risk: LOW.

Psychological distress – participants will be made aware both verbally and within the PIS that the intervention may evoke distressing emotions. It is possible that the researcher will need to manage sensitive conversations and emotional distress. There is a chance that participants may experience emotional discomfort as a result of taking part in the proposed study as asking them to focus on a betrayal may cause distress. However, in order to manage this risk each participant will be effectively signposted to relevant support organisations via the PIS and debrief sheet. A review of evidence has shown that people are resilient when asked questions about betrayal, and in fact researchers may actually overemphasise individuals' vulnerability to distress (Becker-Blease & Freyd, 2006). A debrief will be conducted on all participants, with contact details provided for any further questions. To ensure wellbeing of participants, the debrief sheet will provide details of support organisations. Risk: LOW.

4.4 Detail any possible (psychological or physical) discomfort, inconvenience, or distress that YOU as a researcher may experience, including after the study, and what precautions will be taken to minimise these risks. If the study involves lone working please state the risks and the procedures put in place to minimise these risks (please refer to the lone working policy**).**

Lone working – The researcher will facilitate the intervention sessions online with participants and so there will be no risk of face-to-face lone working. It is likely that the researcher may conduct sessions online from their home and be exposed to managing difficult conversations and emotions without the immediate aid of their supervisor. Digital technologies such as

group video conference calls like MS Teams will reduce the risk of contracting the Corona Virus. If online sessions are conducted from the researcher's home, this will be in a room against a plain background with no personally identifiable possessions visible such as photographs. University procedures, policy and guidance will be adhered to by completing the University of Southampton Doctorate in Clinical Psychology Risk Assessment for remote working and delivering telepsychology (APA, 2020). Furthermore, the researcher will continue to follow key guidance within the BPS Code of Ethical Conduct (2018) and the Division of Clinical Psychology's resource paper Effective Therapy Via Video: Top Tips. The latter resource details important considerations for managing risks associated with online remote working. Finally, regular research supervision will be agreed to discuss any difficulties, regular meetings between the researcher and their personal clinical and academic tutor will be held throughout the recruitment period, and check-in phone calls with one of the research supervisors can be offered at the end of any difficult sessions. As much as possible, communication with participants will be arranged within working hours and diaries within the research team coordinated so a supervisor may be available if needed. If this is not possible for any reason, then the researcher will contact the University Student Support Hub which operates 24/7. Risk: LOW.

Psychological distress – it is possible that topics covered could evoke sensitive conversations and emotional distress that the researcher will need to manage. As well as agreed check-in phone calls between the researcher and the supervisor, participants will be encouraged to reflect on sensitive topics and the impact this may have on them. This will help the researcher to offer a debrief at the end of the experiment that should increase rapport with participants. The researcher will have regular supervision and informal contact with the research supervisor as required, in addition to regular meetings with their PCT throughout the recruiting period.

4.5 Explain how you will care for any participants in 'special groups' e.g., those in a dependent relationship, are vulnerable or are lacking mental capacity), if applicable:
Not applicable.

4.6 Please give details of any payments or incentives being used to recruit participants, if applicable:
Individuals that participate in either the experimental manipulation or control group will be offered the opportunity to be entered into a prize-draw to win an Amazon voucher (25 x £20) and emailed a debriefing form thanking them for their participation. Participants will be invited to enter their email address so that they can be contacted if they are selected for a prize.

5. Access and storage of data

5.1 How will participant confidentiality be maintained? Confidentiality is defined as non-disclosure of research information except to another authorised person. Confidential information can be shared with those already party to it and may also be disclosed where the person providing the information provides explicit consent. Consider whether it is truly possible to maintain a participant's involvement in the study confidential, e.g., can people observe the participant taking part in the study? How will data be anonymised to ensure participants' confidentiality?

Participants will each be allocated a pseudo-anonymised identification number, with contact details stored separately. This study will comply with the Data Protection Act and University of Southampton data protection policies. Data collected from questionnaires will be treated with confidentiality where participants' contact details will be stored on the university network repository on a password-protected computer, in an encrypted individual folder. Pseudo-anonymity of the data will be ensured by assigning participants an identification number. Research findings made available in any reports or publications will not include information that can directly identify participants. Only members of the research team and responsible members of the University of Southampton may be given access to data for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. All of these people have a duty to keep information, as a research participant, strictly confidential. Participation in this study will be kept confidential, unless information is shared that indicates participants or others may be at risk of harm. If this arises during the intervention sessions, Alexandria Newman will discuss with the participant about how and why this information may need to be shared with an appropriate third party.

Only the principal investigator and research supervisors will have access to demographic information and questionnaire data. Participants will be offered to enter their personal email address to be entered into a prize draw and will be informed that they should only provide their name and email address in this specific box if they consent to entering the prize draw. This will be via a separate link provided at the end of the survey to ensure that this data remains separate from the main survey responses. Only the research team will have access to the data for this draw. All data collected will be treated as confidential and participants will

not be identifiable in any dissemination (reports, presentations or publications). The pseudo-anonymised data set will be made available to the research supervisors by sharing with them the password to an encrypted USB that the data is stored on and can be transferred.

5.2 How will personal data and study results be stored securely during and after the study. Who will have access to these data?

Ensuring confidentiality, information will be stored on a password-protected USB, in an encrypted individual folder that only the Trainee Clinical Psychologist and their research supervisors will have authorised permission to access by knowing the password. This will safeguard data from being accessed by others and being able to be identified and will remain the intellectual property of the university. Data will be firstly entered from Qualtrics onto an Excel spreadsheet and then transferred to SPSS for analysis. In accordance with the University Open Access Policy that requires all research output to be deposited, data collated as part of the study will be made publicly available within the university institutional repository. As part of data protection, any personal information identifying research participants will be destroyed. Identifying data (e.g., email addresses) provided for the prize draw will be destroyed once the draw has taken place.

5.3 How will it be made clear to participants that they may withdraw consent to participate? Please note that anonymous data (e.g., anonymous questionnaires) cannot

be withdrawn after they have been submitted. If there is a point up to which data can be withdrawn/destroyed e.g., up to interview data being transcribed please state this here.
Participants will be free to withdraw from the study at any time without giving reason by simply closing the online survey. If they choose to do this, their responses will not be stored and will be deleted. However, once they have completed the survey and submitted their responses, the researcher will be unable to delete their responses. As stated earlier, data will be pseudo-anonymised by allocating an identification number to each participant, so that responses may be cross-referenced to the relevant imagery intervention and to an email address so that they can be contacted for the experimental stage. This information will be treated with confidentiality. Participants will be able to withdraw at any time without penalty and this will be documented on the PIS and consent form. Should they decide they do not wish to continue, the researcher will inform them that any completed questionnaires will not be included in the analysis. If they do decide to withdraw after the experimental or control intervention, (they will be reminded before the session) they should notify the researcher to ensure their data is dealt with appropriately.

6. Additional Ethical considerations

6.1 Are there any additional ethical considerations or other information you feel may be relevant to this study?
No further considerations.

Participant Information Sheet: Stage I

Study Title: Efficacy of a Brief Compassion Intervention on Psychological Outcomes in Males Following a Betrayal.

Researcher: Alexandra Newman

ERGO number: 72333

Version 2 20.05.2022

My name is Alexandra Newman. I am a Trainee Clinical Psychologist doing my Doctorate with the University of Southampton. I would like to invite you to take part in my research study. However, before making your decision, you need to understand why the study is being done and what it would involve. Please take time to read the following information carefully. You do not have to make the decision right away and if you have any doubts or feel unsure please take some time to think it over. If you have any questions about taking part, please email me (an3n20@soton.ac.uk).

What is the research about?

The aim of this project is to investigate the impact of interpersonal betrayal in men. The research will investigate the relationship between mental imagery and a number of different dimensions of how you feel about yourself.

Why have I been asked to participate?

I would like to recruit males, aged eighteen or older, who have experienced a betrayal by a close and trusted other. The research is in two stages. First of all, a screening stage where you will be asked to complete some questionnaires. Based on your answers, you may be invited to

take part in the second stage where we will ask you to do some relaxing imagery exercises and complete some more questionnaires.

What will happen to me if I take part?

If you do decide to take part, you can follow the Qualtrics survey link. This will re- direct you to the online surveys. You will be asked to complete some basic demographic information. You will be asked if you have experienced a betrayal and some further questions about this. You will then be asked to complete two brief questionnaires. I expect that the surveys will take between ten to thirty minutes to complete (this range is to allow for those of you who may need more time to process the questions and consider your responses) but should certainly take no longer than thirty minutes in total.

Based on your responses, you might then be asked to complete a further three brief questionnaires (an average of fifteen questions for each survey). I expect that these will take no longer than twenty minutes to complete. You will then be asked to provide an email address to be contacted later on.

Are there any benefits in my taking part?

I hope that you may find your involvement a worthwhile opportunity to take part in research which aims to help develop current understandings of and possible intervention for experiences of betrayal.

Are there any risks involved?

Given the nature of the research asking about betrayal, it is possible that you may find the experience of completing questionnaires distressing in some way. With this in mind, I have included a list of relevant support organisations that you may wish to contact if you feel distressed, either upon completion of the following surveys or in the future (see resources at the end of this document).

What data will be collected?

Data will be collected on demographic information including your ethnicity and sexual orientation, the betrayal experience, and a brief questionnaire on your wellbeing. This data is classified as special category as responses to questions about depression and anxiety will be used to identify your wellbeing, and demographic data will identify your ethnicity and sexual orientation. Topics of data collected will be self-reported scores on your mood and attitudes toward yourself and others.

Will my participation be confidential?

If you are eligible for further participation and asked to provide an email address, your answers will be linked to it so that you can be contacted regarding the next stage. If you attend the later stages, your answers will be entered into a database where you are identifiable by participant number only. No email addresses or names will be included in the final database. It is completely your decision whether you participate or not. If you would like to be contacted via email with a summary of the study's findings upon its completion, then you will be required to provide your email address. However, this will be kept separately from your responses to the surveys and contact details will be deleted once the study has been completed.

Your participation and the information we collect about you during the course of the research will be kept strictly confidential. Only members of my research team and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.

This project will comply with the Data Protection Act and University of Southampton data protection policies. The research proposal has been submitted through Ergo II and will be conducted in accordance with the University of Southampton School of Psychology Ethics Code of Practice Committee, in line with the British Psychological Society (BPS) Code of Human Research Ethics. It is likely that the data collected will be stored for a minimum of ten years before it is destroyed.

Do I have to take part?

No. It is completely up to you to decide whether or not to take part. Participation in the study is entirely voluntary and you would be able to withdraw at any time. You do not have to give any reasons if you decide not to take part or if you decide to discontinue after beginning the online survey.

What happens if I change my mind?

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Where can I get more information?

If you would like additional information about this study, you can contact either myself at an3n20@soton.ac.uk or Dr Alison Bennetts (University Supervisor) through the Clinical Psychology Department at the University of Southampton:

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Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it. Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for ten years after the study has finished after which time any link between you and your information will be removed. To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information - may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page)

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a directory of local service (called the Oak Book) which support male victims, so please visit this section to find the service in your community. The helpline is a listening service which provides emotional support, practical information and signposting. We receive calls from male victims of domestic abuse across all age ranges and professions. The helpline also welcomes calls from friends, family members, neighbours, colleagues and employers of male victims seeking information.

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Participant Information Sheet: Stage II

Study Title: Efficacy of a Brief Compassion Intervention on Psychological Outcomes in Males Following a Betrayal.

Researcher: Alexandra Newman

ERGO number: 72333

Version 2 20.05.2022

Welcome to Stage II of the research study. My name is Alexandra Newman. I am a Trainee Clinical Psychologist doing my Doctorate with the University of Southampton. I would like to invite you to take part in my research study. However, before making your decision, you need to understand why the study is being done and what it would involve. Please take time to read the following information carefully. You do not have to make the decision right away and if you have any doubts or feel unsure please take some time to think it over. If you have any questions about taking part, please email me (an3n20@soton.ac.uk).

What is the research about?

The aim of this project is to investigate the impact of interpersonal betrayal in men. The research will investigate the relationship between mental imagery and a number of different dimensions of how you feel about yourself.

Why have I been asked to participate?

You have been asked to participate in the second stage of the study based on your responses to the questions in stage one.

What will happen to me if I take part?

Firstly, you will receive an email that will include a direct link to a Microsoft Office Form listing the possible dates and times that I can do an individual video call with you over MS Teams. This stage of the study is not anonymous as by joining a video-call, I would be able to visually identify you. A reminder email will be sent one week beforehand to you with confirmation of your slot and a link to the Teams call.

You will also be randomly allocated to one of two conditions and once joining the video call you will be given a brief memory task. You will then be asked to complete a set of four questionnaires before being guided through an imagery exercise. Immediately after you will be asked to complete a set of four questionnaires again. In total, the intervention including outcome measures is expected to last between 45 minutes and an hour.

Finally, you will be contacted in a week's time from the experimental intervention to complete the four measures for a final time using the Qualtrics survey link. This stage is not expected to take any longer than thirty minutes. At the end of the study, I will email you a debriefing form that provides more details about the study and thank you for your participation.

Are there any benefits in my taking part?

You will be offered the opportunity to be entered into a prize draw for the chance to win an Amazon gift voucher worth £20. I also hope that you may find your involvement a worthwhile opportunity to take part in research which aims to help develop current understandings of and possible intervention for experiences of betrayal.

Are there any risks involved?

Whilst there are no foreseen risks, given the nature of the research asking about betrayal, it is possible that you may find the experience distressing in some way. With this in mind, I have included a list of relevant support organisations that you may wish to contact if you feel

distressed, either upon completion of the study or in the future. If experiencing any adverse effects from participating, you are encouraged to contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

What data will be collected?

Data will be collected on the betrayal experience with various questionnaires on wellbeing. Topics of data collected will be self-reported scores on your mood and attitudes toward yourself and others. Demographic information that was collected from you in the screening stage included your ethnicity and sexual orientation. This data is classified as special category by identifying personal characteristics and the responses to questions about depression and anxiety will be used to identify your wellbeing.

Will my participation be confidential?

Your participation and the information we collect about you during the course of the research will be kept strictly confidential. Your answers will be entered into a database where you are identifiable by participant number only. No email addresses or names will be included in the final database. It is completely your decision whether you participate or not. If you would like to be contacted via email with a summary of the study's findings upon its completion, then you will be required to provide your email address. However, this will be kept separately from your responses to the surveys and contact details will be deleted once the study has been completed. Your participation and the information we collect about you during the course of the research will be kept strictly confidential. Only members of my research team and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are

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signposting service to men suffering from domestic abuse from their current or former wife, partner (including same-sex partner) or husband. This can range from physical violence or object throwing to abuse such as constant bullying or insults. We have also produced a directory of local service (called the Oak Book) which support male victims, so please visit this section to find the service in your community. The helpline is a listening service which provides emotional support, practical information and signposting. We receive calls from male victims of domestic abuse across all age ranges and professions. The helpline also welcomes calls from friends, family members, neighbours, colleagues and employers of male victims seeking information. **Enabling Services.** For students at The University of Southampton, please visit, call +44(0)23 8059 7488 or email firstsupport@soton.ac.uk

CONSENT FORM – Stage I

Study title: Efficacy of a Brief Compassion Intervention on Psychological Outcomes in Males Following a Betrayal.

Researcher name: Alexandra Newman

ERGO number: 72333 Version 2 20.05.2022

Please tick the boxes if you agree with the statements:

I have read and understood the participant information sheet screening stage (20.05.2022, Version 2) and have had the opportunity to ask questions about this study.	
I agree to take part in this project and agree for my data to be used for the purpose of this project.	
I understand that my data will be combined with that from other participants and will be analysed as a whole dataset, the findings from which may be published as part of the research dissemination strategy. I understand that I will not be directly identified in any reports of the research.	
I understand that data collected from questionnaires and surveys with any identifying information will be treated with confidentiality when being analysed.	

I understand my participation is voluntary and I may withdraw at any time for any reason without my rights being affected. I understand that should I withdraw from the study then the information collected about me up to this point may still be used for the purposes of achieving the objectives of the study only.	

Consent will be taken online, so consent form statements will be presented as a series of mandatory tick boxes and signatures will not be collected.

CONSENT FORM – Stage II

Study title: Efficacy of a Brief Compassion Intervention on Psychological Outcomes in Males Following a Betrayal.

Researcher name: Alexandra Newman

ERGO number: 72333 Version 3 01.11.2022

Please tick the boxes if you agree with the statements:

I have read and understood the participant information sheet screening stage (20.05.2022, Version 2) and have had the opportunity to ask questions about this study.	
I agree to take part in this project and agree for my data to be used for the purpose of this project.	
I understand that my data will be combined with that from other participants and will be analysed as a whole dataset, the findings from which may be published as part of the research dissemination strategy. I understand that I will not be directly identified in any reports of the research.	
I understand that data collected from questionnaires and surveys with any identifying information will be treated with confidentiality when being analysed.	

I understand my participation is voluntary and I may withdraw at any time for any reason without my rights being affected. I understand that should I withdraw from the study then the information collected about me up to this point may still be used for the purposes of achieving the objectives of the study only.	
I understand that by providing my email address to be entered into the prize draw or contacted by the research team that my participation will not be confidential. However, I also understand that my responses to the survey questions will remain anonymous as these will be kept separately to my email address.	
Please tick the box if you would like to be entered into the prize draw for the chance to win one of twenty-five £20 Amazon vouchers.	

Consent will be taken online, so consent form statements will be presented as a series of mandatory tick boxes and signatures will not be collected.

Participants will be directed to a separate survey link to enter an email address after completing the post-session questionnaires (to be sent 1 week follow up reminder, and for the prize draw).

UNIVERSITY OF Southampton

Efficacy of a Brief Compassion Intervention on Psychological Outcomes in Males Following a Betrayal: Stage I

Debriefing Statement (V2, 20.05.2022)

ERGO ID: 72333

Thank you for taking part in this study. In this study, we were particularly interested in whether individuals that have experienced a betrayal have lower self-esteem, feel less compassionate towards themselves, and have lost trust in others.

In the online screening, we were selecting people whose scores on the questionnaires fell within a certain range. Your scores were not within a certain range which meant that you were no longer eligible to take part. Your data will only be included to report on how many people met criteria, and participated, in each stage of the study. The results of this study will not include your name or any other identifying characteristics.

If you are interested in learning more about this area of research, I have provided a reading list below. If you have any further questions, please contact me, Alexandra Newman, at an3n20@soton.ac.uk. Thank you for your participation in this research.

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the University of Southampton Head of Research Integrity and Governance (023 8059 5058, rgoinfo@soton.ac.uk).

If you have experienced any distress during the course of this project you are encouraged to make contact with Alexandra Newman at an3n20@soton.ac.uk. However, if you would prefer to contact a support service external to the project you could contact:

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Reading List

Freyd, J. J. (1994). Betrayal trauma: Traumatic amnesia as an adaptive response to childhood abuse. *Ethics & Behaviour*, *4*(4), 307–329. https://doi.org/10.1207/s15327019eb0404_1

Gagnon, K. L., Lee, M. S., & DePrince, A. P. (2017). Victim–perpetrator dynamics through the lens of betrayal trauma theory. *Journal of Trauma & Dissociation*, *18*(3), 373–382. https://doi.org/10.1080/15299732.2017.1295421

Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment, 15*(3), 199-208. https://doi:10.1192/apt.bp.107.005264

Gilbert, P. (2014). The origins and nature of compassion focused therapy. *British Journal of Clinical Psychology*, *53*(1), 6–41. https://doi.org/10.1111/bjc.12043

UNIVERSITY OF Southampton

Efficacy of a Brief Compassion Intervention on Psychological Outcomes in Males Following a Betrayal: Stage II (Compassion)

Debriefing Statement (V1, 14.04.2022)

ERGO ID: 72333

Thank you for taking part in this study. The experience of betrayal can have a negative impact on a person's mood and self-esteem, and for some people these effects can continue for long periods of time. In this study, we were particularly interested in whether individuals that have experienced a betrayal have lower self-esteem, and self-compassion towards themselves, and reduced trust in others. Specifically, we wondered how a brief compassionate-imagery exercise (designed to stimulate self-compassion) would compare with guided relaxation imagery (designed to bring about a relaxed state without necessarily improving self-compassion). We also wanted to explore whether any effects of these exercises would persist after one week. It is important to say that the experience of a betrayal and feelings of low self-esteem, low mood, low self-compassion, and reduced trust in others do not necessarily indicate mental health difficulties. However, that is not to dismiss the fact that they can be distressing.

You were invited to participate in the experimental stage of the research due to your scores on the screening questionnaires falling within a certain range which meant that you were eligible to take part. The first three initial questionnaires screened for anxiety, depression, and trauma symptoms, with the second set of three questionnaires assessing levels of self-esteem, self-compassion, and trust in close others. You were then randomly allocated to the compassionate imagery intervention in which you were asked to bring to mind a soothing and compassionate

image and to consider what that compassionate image would say, feel and act towards you. The results of this study will not include your name or any other identifying characteristics.

It is expected that the experimental conditions will differ on measures of mood, self-esteem, self-compassion, and trust in close others. It is also expected that there will be a difference between the two conditions on levels of mood, self-esteem, self-compassion, and trust in close others at one-week follow-up. Experiences of shame are a key feature of betrayal trauma and can be associated with difficulties in generating positive emotions, warmth and compassion toward the self. We expected compassionate-imagery to be more beneficial than relaxation alone as self-compassion techniques can facilitate a caring orientation with oneself by encouraging you to practice using a supportive inner tone and activate feelings of safety and contentment. Your participation will help our understanding of how compassionate imagery impacts mood, self-esteem, self-compassion, and trust, in males who have experienced a betrayal. This understanding will help to inform theories of interpersonal betrayal, and of how compassionate-focused mental imagery may be utilised in the treatment of shame-based betrayal memories.

If you are interested in learning more about this area of research, I have provided a few references below on the topic of self-compassion. If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the University of Southampton Head of Research Integrity and Governance (023 8059 5058, rgoinfo@soton.ac.uk). If you have experienced any distress during the course of this project you are encouraged to make contact with Alexandra Newman at an3n20@soton.ac.uk. However, if you would prefer to contact a support service external to the project you could contact:

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Enabling Services. For students at The University of Southampton, please visit, call +44(0)23 8059 7488 or email firstsupport@soton.ac.uk

Reading List

Freyd, J. J. (1994). Betrayal trauma: Traumatic amnesia as an adaptive response to childhood abuse. *Ethics & Behaviour*, *4*(4), 307–329. https://doi.org/10.1207/s15327019eb0404_1

Gagnon, K. L., Lee, M. S., & DePrince, A. P. (2017). Victim–perpetrator dynamics through the lens of betrayal trauma theory. *Journal of Trauma & Dissociation*, *18*(3), 373–382. https://doi.org/10.1080/15299732.2017.1295421

Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment, 15*(3), 199-208. https://doi:10.1192/apt.bp.107.005264

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UNIVERSITY OF Southampton

Efficacy of a Brief Compassion Intervention on Psychological Outcomes in Males Following a Betrayal: Stage II (Relaxation)

Debriefing Statement (V1, 14.04.2022)

ERGO ID: 72333

Thank you for taking part in this study. The experience of betrayal can have a negative impact on a person's mood and self-esteem, and for some people these effects can continue for long periods of time. In this study, we were particularly interested in whether individuals that have experienced a betrayal have lower self-esteem, and self-compassion towards themselves, and reduced trust in others. Specifically, we wondered how a brief compassionate-imagery exercise (designed to stimulate self-compassion) would compare with guided relaxation imagery (designed to bring about a relaxed state without necessarily improving self-compassion). We also wanted to explore whether any effects of these exercises would persist after one week. It is important to say that the experience of a betrayal and feelings of low self-esteem, low mood, low self-compassion, and reduced trust in others do not necessarily indicate mental health difficulties. However, that is not to dismiss the fact that they can be distressing.

You were invited to participate in the experimental stage of the research due to your scores on the screening questionnaires falling within a certain range which meant that you were eligible to take part. The first three initial questionnaires screened for anxiety, depression, and trauma symptoms, with the second set of three questionnaires assessing levels of self-esteem, self-compassion, and trust in close others. You were then randomly allocated to the guided

relaxation intervention which involved you engaging in a progressive muscle relaxation practice. The results of this study will not include your name or any other identifying characteristics.

It is expected that the experimental conditions will differ on measures of mood, self-esteem, self-compassion, and trust in close others. It is also expected that there will be a difference between the two conditions on levels of mood, self-esteem, self-compassion, and trust in close others at one-week follow-up. Experiences of shame are a key feature of betrayal trauma and can be associated with difficulties in generating positive emotions, warmth and compassion toward the self. We expected compassionate-imagery to be more beneficial than relaxation alone as self-compassion techniques can facilitate a caring orientation with oneself by encouraging individuals to practice using a supportive inner tone and activate feelings of safety and contentment. Your participation will help our understanding of how compassionate imagery impacts mood, self-esteem, self-compassion, and trust, in males who have experienced a betrayal. This understanding will help to inform theories of interpersonal betrayal, and of how compassionate-focused mental imagery may be utilised in the treatment of shame-based betrayal memories.

If you are interested in learning more about this area of research, I have provided a few references below on the topic of self-compassion. If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the University of Southampton Head of Research Integrity and Governance (023 8059 5058, rgoinfo@soton.ac.uk). If you have experienced any distress during the course of this project you are encouraged to make contact with Alexandra Newman at an3n20@soton.ac.uk. However, if you would prefer to contact a support service external to the project you could contact:

Mind. Mental health charity offering information on a range of topics including types of mental health problem, where to get help, medication and alternative treatments, advocacy. They will look for details of help and support in your own area. Contact details: 0300 123 3393 info@mind.org.uk Text: 86463. Lines are open 9am to 6pm, Monday to Friday (except for bank holidays).

Samaritans. Samaritans are open 24 hours a day, 365 days a year, to listen to anything that is upsetting you, including intrusive and difficult thoughts of suicide and self-harm. Their national free-phone number is 116 123, or you can email jo@samaritans.org You can also visit the website: www.samaritans.org

Victim Support. If you've been a victim of any crime or have been affected by a crime committed against someone you know, we can help you find the strength to deal with what you've been through. Our services are free and available to everyone, whether or not the crime has been reported and regardless of when it happened. See more at: www.victimsupport.org.uk or call: 0845 303 0900. Available weekdays 9am to 8pm, weekends 9am to 7pm, bank holidays 9am to 5pm.

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Gilbert, P. (2014). The origins and nature of compassion focused therapy. *British Journal of Clinical Psychology*, *53*(1), 6–41. https://doi.org/10.1111/bjc.12043