Shame and Working Alliance in Healthcare Relationships

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CITATION LIST

The following publication has been included in the body of the thesis. It is presented with all relevant tables, figures, and appendices as Chapter 3 of this document:

Carabellese, D. J., Proeve, M. J., & Roberts, R. M. (2019). Relationship of patient shame to working alliance and satisfaction: a preliminary investigation. *The Journal of Mental Health Training, Education and Practice*, *14*(4), 251-263. doi:10.1108/jmhtep-10-2017-0059

In addition, the manuscript of paper one, *Working Alliance and Shame: A Scoping Review*, had been submitted for publication at the time of PhD submission. It is presented with all relevant tables, figures, and appendices as Chapter 2 of this document.

AUSTRALIAN HIGHER EDUCATION GRADUATION STATEMENT (AHEGS)

The Australian Higher Education Graduation Statement (AHEGS) is a Commonwealth initiative that has been introduced to assist in both national and international recognition of Australian qualifications and to promote international mobility and professional recognition of graduates. The Graduation Statement is additional to other documentation such as degree certificates and academic transcripts and is based on nationally agreed specifications approved by The Government.

The Graduation Statement provides a description of the award, the awarding institution, a list of the student's academic achievements relevant to the degree and details of the Australian Higher Education System. For Higher Degree by Research students, the AHEGS includes an abstract of **no more than 100 words** which describes the research undertaken. It is intended to provide potential employers and other institutions with a greater understanding of the achievements of the graduate.

AHEGS Abstract

The collaborative, purpose-driven aspects of the relationship between healthcare provider and consumer (the working alliance) is an important predictor of successful and effective healthcare treatments. Healthcare settings are often seen as environments in which the experience of shame is commonplace. This research investigated hypothesised links between dispositional shame and working alliance.

The research program included a scoping review, pilot and follow-up studies with community members, and a clinical sample. A consistently small, negative relationship between dispositional shame and alliance was identified. The results suggest that those with a greater tendency to experience shame may report somewhat weaker alliances.

ABSTRACT

Working alliance – the collaborative, purpose-driven elements of the relationship between healthcare provider and consumer – is a well-evidenced predictor of successful and effective healthcare treatments in a variety of settings, both medical and allied health. It is therefore important to identify and understand which characteristics of consumers, clinicians and environments contribute to the development and maintenance of a robust alliance. Healthcare interactions have long been seen as environments in which the experience of shame is commonplace, requiring the revelation of private information and the body, and discussion of one's own behaviour and its impacts on health and wellbeing. Research also suggests that shame is an aversive and unpleasant experience which frequently motivates avoidance, withdrawal, defensiveness, and anger. It is reasonable to suppose that a tendency to experience intense shame may be related to a weaker working alliance, with flow-on effects on the efficacy and tolerability of treatment. Limited research exists in this area. The aim of this research was to develop an improved understanding of shame's role in working alliance in a variety of healthcare settings.

Study one was a scoping review which examined literature on shame and alliance. Studies were included if they pertained to healthcare relationships, were quantitative in nature, written in English, and included empirical measures of shame and working alliance (or proxies). The scoping review identified 13 studies which met inclusion criteria. The synthesis suggested a small, negative relationship between shame and alliance. Methodological limitations were also identified in past research. It was determined that additional research was needed to understand the hypothesised shame-alliance relationship.

Study two was a pilot study conducted with community members (N=127) who had regularly seen a GP over the past year. Participants were asked to reflect on their relationship with their GP, and completed instruments assessing shame, as well as working alliance and satisfaction. Small, negative correlations were found between shame measures

and working alliance, as well as patient satisfaction. One specific subtype of shame (external shame) had an indirect effect on patient satisfaction through working alliance. The findings from this study suggested that shame was an important factor to consider in the provision of medical care to maximise the quality of patient experience and working alliance.

Study three replicated and expanded upon the methodology of the pilot study, including additional measures to explore potential mechanisms to explain the shame-alliance relationship, such as items assessing generalised and specific tendencies to disclose distressing information. A similar set of measures to the pilot was included for this sample (N=177 community members), with the addition of a secret-specific shame measure. Participants with past psychotherapy experience (n=104) were also asked to retrospectively rate their working alliance with their therapist. Contrary to the hypotheses and to the findings of the pilot study, there were no statistically significant correlations between shame measures and working alliance. Those correlations that were evident were typically small and negative. It was determined that the sample was underpowered to detect an effect of the predicted size.

Study four was concurrent with study three and aimed to investigate the shame/alliance relationship in a clinical sample. Participants were current psychotherapy clients (N=18) as well as their treating psychologists (N=6). This study included both bidirectional ratings of working alliance (client and therapist) as well as ratings over time, with participants providing data across 1-10 treatment sessions. Hierarchical linear modelling was used to assess for a shame/alliance relationship. The hypothesised relationship was not detected in the sample. As with study three, the lack of statistically significant findings was attributed to the low power of the study.

This series of studies represents a preliminary investigation of the hypothesised shame/alliance relationship in healthcare. It identified a small, negative relationship; however, the evidence was modest and sometimes did not reach statistical significance. Overall, the results suggest that those with a greater tendency to experience shame may report somewhat

weaker alliances – as such, clinicians may benefit from remaining alert for signs of high dispositional shame or including brief assessments of shame as part of an intake questionnaire, to better serve highly shame-prone individuals.

DECLARATION

I, Daniel Carabellese, certify that this work contains no material which has been accepted for the award of any other degree or diploma in my name, in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. In addition, I certify that no part of this work will, in the future, be used in a submission in my name, for any other degree or diploma in any university or other tertiary institution without the prior approval of the University of Adelaide and where applicable, any partner institution responsible for the joint-award of this degree.

I acknowledge that copyright of published works contained within this thesis resides with the copyright holder(s) of those works. I also give permission for the digital version of my thesis to be made available on the web, via the University's digital research repository, the Library Search and also through web search engines, unless permission has been granted by the University to restrict access for a period of time.

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2021-03-01

Daniel J. Carabellese
PhD Candidate

Date

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I would also like to thank the School of Psychology at the University of Adelaide, whose professional and academic staff provided administrative and financial support. Particular acknowledgement is due to Research Librarian Maureen Bell, whose patient advice and guidance was absolutely invaluable in conceptualising and conducting my scoping review.

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Although it had its twists and turns, I feel privileged that I was able to be part of this program. So, to everyone who helped to make this possible, I say thank you.

OUTLINE OF THESIS

This research aimed to explore the relationship between dispositional shame (or shame-proneness) and working alliance within healthcare relationships. Although healthcare relationships have long been identified as venues for intense and aversive experiences of shame and humiliation (Lazare, 1987), there had been very limited past research examining the impact of these emotional experiences on the therapeutic relationship. It was therefore decided to approach this research in an exploratory fashion –with a comprehensive review of the literature, piloting in community settings, and finally transferring the piloted methodology to a clinical psychology setting.

Within this framework, the first study was a scoping review which examined published and unpublished research dating from the beginning of electronic records to April 2020. This study was partially concurrent with a pilot study which tested a battery of measures assessing dispositional shame and working alliance, which in this case was rated retrospectively for patients of general practitioners (GPs). The results of this pilot then informed the methodology of the third study, which was conducted with a sample of university staff, students, and visitors, of whom the majority had previously attended psychotherapy and were able to provide retrospective alliance ratings. Finally, the same methodology was expanded to include contemporaneous ratings of alliance by both clients and therapists across a period of time and transferred to a clinical setting at an outpatient clinic.

This research provides an original empirical investigation of the hypothesised relationship between dispositional shame and the collaborative, purposive elements of the therapeutic relationship (i.e., working alliance). It includes a phased research approach which attempts to explore this relatively under-researched area and contains data for both clinical and non-clinical populations which can be compared. It also includes a variety of measures of defined dispositional shame constructs (e.g., internal shame, external shame) at each step, such that their unique contributions can be better understood.

This research took place entirely within the city of Adelaide, South Australia, and its surrounds. As such, the healthcare systems and practitioners referenced within the research are assumed to be part of the South Australian healthcare system unless otherwise noted. For example, the term ‘GP’ is used to denote General Practitioners, who may otherwise be referred to as ‘primary care physicians’, ‘family doctors’ or by other terms in other parts of the world. Similarly, the practice standards described in the first and the final study refer to the Australian Health Practitioner Regulation Agency (AHPRA), the body which governs registered healthcare practitioners in Australia. Care has been taken to identify and elaborate on the relevant organisations and structures where this may be necessary for the understanding of the reader.

The structure of this thesis is consistent with the outline of research provided above. Specifically, Chapter 1 provides an introduction and literature review of both working alliance and shame, as well as identifying the research aims. Chapter 2 contains the manuscript for the scoping review of existing literature. Chapter 3 contains the manuscript for the pilot study. Chapter 4 contains the combined (unpublished) manuscript for study 3 (second community sample) and study 4 (clinical psychology sample). Chapter 5 provides a detailed synthesis of all major findings, as well as a description of the practical and theoretical implications, strengths and limitations, future research directions, and concluding comments. All references – including those for each manuscript – are provided in a combined reference list at the end of the thesis immediately preceding the appendices. The appendices (numbered A to C) provide copies of ethical approvals for the studies contained within the thesis, with the exception of the scoping review (study 1) which required no ethical review.

Tables and figures are provided within manuscripts and are individually numbered for each study (i.e., the numbering re-starts at Table 1, Figure 1, etc. for each study) as they appeared in manuscripts submitted for publication where applicable. Additional supplementary material or appendices attached to each manuscript are included at the end of each manuscript chapter and numbered individually according to the relevant chapter (i.e., re-

starting at Appendix A for each study). A PRISMA-ScR checklist and diagram are provided for the scoping review, as these were also submitted with the journal manuscript as supplementary material. For the purposes of this thesis document, page number references within appendices and elsewhere within the thesis have been updated to reflect the relevant page within the current document. In all chapters, Australian English is used.

This thesis was completed primarily between 2016 and 2020, and as such the majority of the material included pre-dates the seventh edition of the American Psychological Association's (APA) publication manual (American Psychological Association, 2020), which was announced in October 2019 for use beginning in 2020. The majority of academic journals for which the manuscripts contained herein were prepared had not yet transitioned to APA 7th Edition at the time of submission. As such, this thesis adheres to the previous set of style and referencing directions provided in the APA 6th Edition Publication Manual (American Psychological Association, 2010).

OUTLINE OF CANDIDATURE

This thesis was completed in partial fulfilment of a combined Doctor of Philosophy/Master of Psychology (Clinical) at the University of Adelaide. This is a program which offers candidates the opportunity to complete a PhD (equivalent to three years full-time) concurrent with the coursework and professional placements of a master's degree in Clinical Psychology (two years full-time). It is required that the PhD research be of specific relevance to clinical psychology in this program.

The combined program provides graduates with the opportunity to register and practice as a Psychologist in Australia, and subsequently to seek an area of practice endorsement as a Clinical Psychologist. Once the coursework and clinical placement elements of the Master program are completed, candidates are eligible to apply for early registration if they wish to do so, and begin practicing immediately, prior to conferral of the degree.

The research detailed within this thesis, as well as six coursework subjects and three clinical placements (equivalent to over 1000 hours of clinical practice) were completed within just over five years equivalent of full-time study. The final 18 months of research was completed concurrent with part-time clinical work as a registered psychologist in a private practice setting.

Funding for this research was provided by the University of Adelaide School of Psychology, which also provided funding for specific training and professional memberships relevant to the research program. From 2016-2019 a stipend was also provided by the University, as part of an Australian Postgraduate Award Scholarship (later renamed Research Training Program Scholarship).

LIST OF ABBREVIATIONS

Presented in Alphabetical Order

Abbreviation	Full Description
ACT	Acceptance and Commitment Therapy
AHPRA	Australian Health Practitioner Regulation Agency
AIDS	Acquired Immunodeficiency Syndrome
ANS	Alliance Negotiation Scale
API	Autonomy Preference Index
CALPAS	California Psychotherapy Alliance Scale
CALTARS	California Therapeutic Alliance Rating Scales
CBT	Cognitive Behavioural Therapy
CFT	Compassion-Focussed Therapy
CoCo	Communication Competence Questionnaire (German)
DASS-21	Depression Anxiety Stress Scales - Short 21 Item Version
DDI	Distress Disclosure Index
ESS	Experience of Shame Scale
GASP	Guilt and Shame Proneness Scale
GP	General Practitioner (Primary Care Physician)
GPAQ	General Practice Assessment Questionnaire
GPAQ-R	General Practice Assessment Questionnaire - Revised
HAcs	Helping Alliance Counting Signs
HAq	Helping Alliance Questionnaire
HAq-1	Helping Alliance Questionnaire (V1)
HAq-2	Helping Alliance Questionnaire (V2)
HAr	Helping Alliance Rating Scale
HIV	Human Immunodeficiency Virus
HLM	Hierarchical Linear Modelling
IGRS-15s	Interpersonal Guilt Rating Scale-15 Self Report
ISS	Internalised Shame Scale
MSC	Mindful Self-Compassion
NBE	Negative Behaviour Evaluation
NHS	United Kingdom National Health Service
NSE	Negative Self-Evaluation
OAS	Other As Shamer Scale

PDSIQ	Patient Dental Staff Interaction Questionnaire
PPWA	Physician-Patient Working Alliance
PPWAI	Physician-Patient Working Alliance Inventory
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PRISMA-ScR	PRISMA Extension for Scoping Reviews
PsyBA	Psychology Board of Australia
PTSD	Post-traumatic Stress Disorder
RCT	Randomised Controlled Trial
SCAAI	Self-Conscious Affect and Attribution Inventory
SDM	Shared Decision Making
SSGS	State Shame and Guilt Scale
TOSCA	Test of Self-Conscious Affect
TOSCA-3	Test of Self-Conscious Affect - Version 3
TOSCA-4	Test of Self-Conscious Affect – Version 4
TPQ	Treatment Perceptions Questionnaire
VPPS	Vanderbilt Psychotherapy Process Scale
VTAS	Vanderbilt Therapeutic Alliance Scale
VTAS-R	Vanderbilt Therapeutic Alliance Scale - Revised
WAI	Working Alliance Inventory
WAI-C	Working Alliance Inventory, Client Form
WAI-O	Working Alliance Inventory, Observer Form
WAI-S	Working Alliance Inventory, Short Version
WAI-SR	Working Alliance Inventory - Short Revised Version
WAI-SR-C	Working Alliance Inventory - Short Revised Version, Client Form
WAI-SR-T	Working Alliance Inventory - Short Revised Version, Therapist Form
WAI-T	Working Alliance Inventory, Therapist Form
WEB-SG	Weight, Eating, and Body-Related Shame and Guilt Scale
WSC	Working Strategy Consensus

CHAPTER 1. INTRODUCTION AND LITERATURE REVIEW

1.1 Preamble

The first section of this chapter provides an overview of the literature related to the concept of the 'working alliance' in healthcare. A definition and clarification of terminology is first presented, which helps to focus the subsequent sections. The historical study of healthcare relationships is briefly summarised, followed by conceptual review of working alliance. Empirical research into working alliance is then presented, including how it has been measured, key research findings, and their clinical applicability – both in psychotherapy and other healthcare settings. Some limitations of past research, as well as future directions, are discussed.

The second section reviews the research pertaining to shame as a psychological construct. The competing views of the social-adaptive and functionalist theorists on shame are explored and contrasted, and shame subtypes such as internal and external shame are reviewed. Shame is also distinguished from stigma in this section. This is followed by a brief review of a variety of empirically validated instruments designed to assess shame. Finally, potential mechanisms of the proposed relationship between shame and working alliance are elaborated.

1.2 Notes on Terminology

Throughout this thesis, frequent reference is made to the collaborative, purposeful aspects of healthcare relationships between treatment providers and individuals accessing healthcare services. Throughout history, the terms used to refer to this aspect of the therapeutic relationship have varied substantially, as have its conceptualisations and understandings (Muran & Barber, 2011). The most common terms which have been used are helping alliance (Luborsky, 1976), therapeutic alliance (Zetzel, 1977), treatment alliance

(Sandler, Holder, & Dare, 1970), and working alliance (Bordin, 1979; Greenson, 1965). In the interests of simplicity, this thesis will primarily use the terms 'working alliance' or simply 'alliance'. Despite this, it is important to acknowledge the differing theoretical orientations, histories and controversies associated with each of the above terms, which will be explored to some degree in subsequent sections.

Similarly, sections of this document necessarily pertain to individuals who access healthcare services of various kinds for the purposes of treatment. The terms 'client', 'patient', 'user', 'customer' and 'consumer' are used more-or-less interchangeably. This is partly reflective of the broad range of literature drawn on in this document, which comprises diverse fields of practice such as medical care, psychological treatment, criminal justice, and clinical supervision. It is however important to understand that the choice of label for a person taking part in treatment is a complex issue with considerable philosophical and phenomenological implications (Deber, Kraetschmer, Urowitz, & Sharpe, 2005). Chief among these is the idea that 'patient' (the most common historical term to denote such an individual) can be read as implying a passive recipient of care in an unequal power relationship, whereas 'client', 'customer' and other similar terms may imply more active participation and partnership (Neuberger & Tallis, 1999). A thorough exploration of this debate is outside the scope of this project, however it is worth noting that there is some evidence to suggest that the general preference among people accessing physical and mental health care is still to use the term 'patient' (Deber et al., 2005; Simmons, Hawley, Gale, & Sivakumaran, 2010).

1.3 Healthcare Relationships

1.3.1 The Relational Element of Healthcare

The importance of relationships as part of healthcare has been recognised since antiquity (Malatesta, 2015), with considerable academic interest being directed to their power dynamics, ethical considerations, duties of care, and legitimacy. Of particular interest is the

manner in which opinions of the importance of the therapeutic relationship have varied over time, ranging from the concept of a relationship as inconsequential, to facilitative (Conrad, Neve, Nutton, Porter, & Wear, 1995), to important (Zetzel, 1977), to essential (Lambert & Barley, 2001).

Although it is outside the scope of this thesis to examine in detail the historical study of healthcare relationships, it is noteworthy that the advent of the scientific revolution and technological medicine has been argued to have been related to a decreased focus on the therapeutic relationship (Malatesta, 2015). By contrast, in the 21st century, healthcare has come to be viewed as an area in which healthcare professionals and patients form a multi-disciplinary team arrayed in opposition against illness, with the goal of promoting wellbeing (Kitson, Marshall, Bassett, & Zeitz, 2013). It is particularly noteworthy that patient-centred care has increasingly become a measurable outcome in provision of healthcare, and one which is formally recognised in the form of practice requirements (Caesar, 2016). This is made explicit in instruments such as the *General Practice Assessment Questionnaire (GPAQ)* (Roland, Roberts, Rhenius, & Campbell, 2013), which is completed by patients, and specifically invites them to rate the extent to which they felt involved in their care as well as the quality of communication they received from their doctor and the medical practice.

Within the broader discussion of healthcare relationships, there is a key element which has received a significant amount of research interest: the working alliance. Generally understood to refer to the collaborative, purpose-driven aspects of a therapeutic relationship (Hatcher & Barends, 2006), alliance has come to be seen as an important element of healthcare interventions across a range of disciplines (Doran, 2016), and forms one of the major pillars of this thesis.

1.3.2 Conceptual History of Alliance

An understanding of the history of the provider-patient alliance provides essential context for contemporary research in this area. The conceptual approach to recognising,

assessing, and working with this important variable has evolved significantly over the past century, and modern definitions have diverged substantively from the historical understanding. The key element of a provider-patient alliance which differentiates it from other interpersonal relationships is that it is regarded as an element of the therapeutic process – either in terms of its ability to facilitate treatment, its inevitability and need for management, or indeed as a curative element in and of itself (Lambert & Barley, 2001).

In early psychoanalytic literature, alliance was conceptualised as a positive, rational element of transference (Freud, 1924), the process by which the emotions, desires, and expectations from other relationships are projected into the therapeutic relationship. Freud (2010) characterised this alliance as friendliness and affection, and argued that this positive transference was partly responsible for the client's enduring commitment to treatment. The therapeutic relationship gradually came to be seen as an essential precondition for treatment to be effective (Sterba, 1940), which helped to establish the idea of the therapeutic alliance as a purposeful relationship – i.e. a relationship in which the participants have a shared goal, and which is partly defined by that goal.

The notion of the provider-patient alliance was ultimately formalised by Zetzel (1977) (first published 1956), who created the term 'therapeutic alliance', which she described as a rapport based on a patient's desire to overcome the specific problems which necessitated treatment, as well as their willingness to co-operate and follow directions. She contrasted this with 'transference neurosis', which was related to resistance and disengagement from treatment. This was later expanded upon by Greenson (1965), who used 'working alliance' as an overarching heading. He identified this as the essential, relational rapport between the psychoanalyst and their patient, present in all therapeutic relationships, and without which treatment could not function.

Although the concept of a therapeutic alliance emerged from psychoanalytic literature, its importance has also been recognised across other theoretical orientations. For example, in

client-centred therapy, Rogers (1951) emphasised the importance of the relationship between a clinician and client, which he argued was essential to facilitate successful therapeutic interventions. Similarly, within the cognitive-behavioural therapeutic paradigm, the primacy of rapport is emphasised and the patient is conceptualised as an active, engaged contributor to the process, rather than a passive individual who 'receives' therapy (Wright & Davis, 1994).

1.3.3 Contemporary Model of Working Alliance

Given the broad applicability of the concept of working alliance across psychotherapeutic orientations, Bordin (1979) sought to extend it beyond its psychoanalytic origins by developing a formalised, pan-theoretical conceptualisation. It is this definition which has driven much of the contemporary empirical research in the area of alliance, and which remains the dominant understanding of working alliance today (Doran, 2016; Flückiger, Del Re, Wampold, & Horvath, 2019).

Bordin's (1979) definition of alliance specified that it was a collaborative, goal-driven component of the therapeutic relationship. The model is explicitly designed to be applicable regardless of the clinician's theoretical orientation, and rather than describing a specific therapeutic factor, is intended to summarise the broader "degree to which the therapy dyad is engaged in collaborative, purposive work" (Hatcher & Barends, 2006, p. 293). The model isolates three key components of working alliance (Bordin, 1994), which are considered separate, but interrelated: agreement on *goals*, agreement on *tasks*, and the quality of the relational *bond*.

Agreement on therapeutic goals refers to the extent to which the patient and therapist have reached consensus on the issues to be addressed in treatment, as well as those areas which are not appropriate. For example, a patient may not endorse any desire to change alcohol consumption. Even if the therapist and patient agree that the degree of alcohol consumption is dangerous or problematic, a therapeutic focus on alcohol reduction in this case would represent a low degree of *agreement on goals*.

Agreement on therapeutic tasks summarises the therapy dyad's shared understanding of which interventions, behavioural steps, or lifestyle changes must be undertaken to achieve the mutually agreed-upon goals. Notably, this refers both to actions undertaken by the patient and interventions implemented by the provider. Generally speaking, a high degree of congruence on this factor requires a shared understanding that the identified tasks are both personally valuable and worthwhile (i.e., likely to be effective) (Arnd-Caddigan, 2011; Hatcher & Barends, 2006).

Therapeutic bond is the element which most closely summarises the historical understanding of alliance, referring to the level of trust and mutual positive regard in the therapeutic relationship. Bordin (1992) emphasised that successful collaborative work was difficult or impossible without a bond between the provider and patient. In the pan-theoretical model, the bond is viewed as a necessary but not sufficient condition for healthcare interventions to be effective. Put another way, members of the dyad must like and respect one another *sufficiently to undertake the goal-oriented tasks which form the healthcare intervention* (Hatcher & Barends, 2006).

Bordin's (1979) model has several important strengths. Primarily, it is clear, concise, and well-defined. It also uses a language which can be applied to psychotherapeutic interventions across a range of theoretical orientations, and which has been successfully applied in other areas of healthcare (e.g., primary care, rheumatology) (Fuertes, Anand, Haggerty, Kestenbaum, & Rosenblum, 2015; Fuertes et al., 2007). The model has also been shown to function well outside of healthcare, for example with parole officers and parolees (Walters, 2015), and with alliance between supervisors and counselling trainees (Ladany, Ellis, & Friedlander, 1999).

In short, Bordin's (1979) model appears to have achieved its aim of being truly pan-theoretical and has demonstrated broad applicability in a range of settings. As a result, it has subsequently been subjected to considerable empirical scrutiny, including the development

and validation of numerous scales and measures which take it as their theoretical basis (Doran, 2016; Muran & Barber, 2011).

1.3.4 Empirical Measurement of Working Alliance

The earliest attempt to empirically assess working alliance appears to have been made by Luborsky (1976), who operationalised the purposeful elements of the therapeutic relationship under the name 'helping alliance' and created two measures; The *Helping Alliance Counting Signs (HAcs)* and *Helping Alliance Rating Scale* (HAr). This early research was also among the first studies to find a link between strength of alliance and degree of improvement on outcome measures. Research interest has significantly intensified since that time; meta-analyses (Flückiger et al., 2019; Fluckiger, Del Re, Wampold, Symonds, & Horvath, 2012; Horvath & Symonds, 1991) have identified over 30 empirical measures intended to assess the alliance on some level, with many of these having shortened or abbreviated forms available. The common element which appears to unite the majority of these measures is the "confident collaborative relationship" (Hatcher & Barends, 1996), which aligns with the collaborative theme emphasised in Bordin's (1979) model. In the most recent meta-analysis, Flückiger et al. (2019) noted that the vast majority of studies used some variant of one of four measures: the California Psychotherapy Alliance Scale (CALPAS; Marmar et al., 1986), the Helping Alliance questionnaire (HAq; Alexander & Luborsky, 1986), the Vanderbilt Psychotherapy Process Scale (VPPS; Suh et al., 1986), and the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). The following sections will briefly review each of the major measures, concluding with a discussion of the WAI, which was ultimately chosen to assess working alliance in the studies which comprise this thesis.

1.3.4.1 The California Psychotherapy Alliance Scales (CALPAS) (Gaston & Marmar, 1994; Marmar, Weiss, & Gaston, 1989)

The California Psychotherapy Alliance Scales (CALPAS) was originally adapted from an existing observer-rated instrument called the California Therapeutic Alliance Rating Scales (CALTARS), which itself was later expanded to include patient and therapist variants (Marziali, 1984). The scale went through a number of revisions (Marmar, Weiss, et al., 1989) before arriving at the 24-item version published by Gaston and Marmar (1994). The development of the instrument was partly driven by a perceived need to provide a unified conceptualisation of 'alliance' which considered the various definitions which were available at the time. As such, the 24-item CALPAS is divided into four subscales, intended to assess the following 'alliances'; therapeutic alliance, working alliance, therapist understanding and involvement and, patient-therapist agreement on goals and strategies. Each of the subscale items is rated on a 7-point Likert-type scale, and an overall score as well as subscale scores can be derived.

The CALPAS scales assessing the therapeutic and working alliances both draw from psychoanalytic literature, most particularly the work of Freud (1912) and Zetzel (1977), as well as Sterba (1940). In this model, 'therapeutic' alliance refers to the extent to which the patient is attached to and identifies with the analyst, whereas 'working' alliance broadly reflects Sterba's (1934) 'ego alliance'; an alignment of the patient's ego functioning and the style and orientation of the therapist – arguably more similar to the 'bond' dimension of Bordin's (1979) model. This definition of 'working alliance' is notably distinct from the congruence and process-focussed conceptualisation developed by Bordin (1979), which is better captured by the CALPAS scale of *patient-therapist agreement on goals and strategies* (working strategy consensus, WSC). Finally, the *therapist's understanding and involvement* subscale is related to the behaviours and attitudes of the therapist and the crucial impact these have on the development of alliance in therapy (Gaston & Marmar, 1994).

The CALPAS variants have previously shown good predictive validity when used with patients undergoing various types of therapy for depression (Marmar, Gaston, Gallagher, & Thompson, 1989). It now exists in several forms which allow for triangulation of ratings between therapist, client and observer (Meier, Barrowclough, & Donmall, 2005). It is also one of few scales which has a variant available for group therapy (Delsignore et al., 2014). The breadth and diversity of factors, perspectives and modalities captured in the CALPAS have made it a popular choice for research in which a comprehensive assessment of alliance is needed (Elvins & Green, 2008; Flückiger et al., 2019)

1.3.4.2 The Helping Alliance Questionnaire (HAq-I & HAq-II) (Alexander & Luborsky, 1986; Luborsky, Crits-Christoph, Alexander, Margolis, & Cohen, 1983)

The original Helping Alliance Questionnaire (HAq-I) is part of a larger suite of measures known as the Penn Helping Alliance Scales. The original scale development was heavily influenced by Luborsky's (1984) psychodynamic model of the helping alliance – it is broadly divided into two factors; the patient's perception of the therapist as being able to provide the desired help and; the patient's experience of treatment as collaborative with respect to the goals of treatment. A variety of assessment modalities are available, including therapist, patient, and expert observer variants, however the patient self-report measure (HAq) is the most commonly used by a significant margin (Elvins & Green, 2008; Flückiger et al., 2019).

The HAq subsequently underwent a major revision (HAq-II) (Luborsky et al., 1996), with the removal of six items and the addition of 14 new items, based partly on the criticism that the HAq-I included several confounding items which assessed early symptom improvement, rather than a pure assessment of alliance. The revised version of the scale was heavily informed by Bordin's (1979) pantheoretical model of alliance (Luborsky et al., 1996). As such, the new items added in this revision were intended to emphasise the collaborative elements of the relationship (e.g., "the therapist and I have meaningful exchanges"), as well as the patient's view of the therapist (e.g., their trustworthiness), and their motivation and feeling of mutual

liking. This revision was substantial, with Flückiger et al. (2019) noting that the two versions of the scale had less than 30% of content in common, and choosing to code these as separate measures in their meta-analysis. This revised version demonstrated superior psychometric properties, and a high degree of convergent validity with the CALPAS. As such, it was recommended for use over the HAq-I by its creators (Luborsky et al., 1996).

1.3.4.3 The Vanderbilt Scales (VPPS/VTAS) (Hartley & Strupp, 1983)

The Vanderbilt Psychotherapy Process Scale (VPPS) emerged from the Vanderbilt Psychotherapy Research Project, and represented an attempt to make a comprehensive and broad assessment of the characteristics of the patient, the therapist, and their relationship, including both positive and negative behaviours and attitudes of both parties (O'Malley, Suh, & Strupp, 1983). The instrument was explicitly intended to span a wide range of theoretical orientations on the part of the therapist, and was informed by the dynamic and integrative models of alliance, as well as the pantheoretical model of Bordin (1979), and psychoanalytic conceptualisations of Greenson (1965) and Luborsky (1976). Given the ambitious scope of the instrument, it is understandable that it comprises a total of 80 items, each of which is rated along a 5-point Likert-type scale by an expert clinical observer.

The VPPS was subsequently revised and refined to create the Vanderbilt Therapeutic Alliance Scale (VTAS, Hartley & Strupp, 1983). Like the VPPS, it is an observer-rated measure, intended to be scored by a trained rater. It consists of 44 items, each of which is scored along a 6-point Likert-type scale. The scale is divided into three subscales: Therapist Contribution, Patient Contribution and, Therapist-Patient Interaction. It is notable that the VTAS is one of few observer-only measures, with no patient-rated or therapist-rated variants. Despite this, it compares favourably to other measures of alliance (such as self-report measures) insofar as the items explicitly assess the presence, absence or degree of specific behaviours and speech (e.g., “to what extent did the patient indicate that she experiences the therapist as supporting her?”). This can be contrasted with other measures which necessitate a greater amount of

judgement on the part of the rater (e.g. the WAI-O item "the client feels that the therapist appreciates him") (Shelef, Diamond, Diamond, & Liddle, 2005). The VTAS was subsequently revised (VTAS-R) to omit the items pertaining to the therapist's contribution (Diamond, Liddle, Dakof, & Hogue, 1996), based on the argument that interventions intended to strengthen the alliance should be understood as conceptually distinct from the alliance itself (Frieswyk et al., 1986).

1.3.4.4 The Working Alliance Inventory (Horvath & Greenberg, 1989)

The Working Alliance Inventory (WAI) was developed and validated by Horvath and Greenberg (1989), with two short forms subsequently created by Tracey and Kokotovic (WAI-S; 1989) and Hatcher and Gillaspy (WAI-SR; 2006) respectively. The development of the original instrument was theory-driven, and it was designed to assess the three domains identified by Bordin (1979); *Goals, Tasks* and *Bond*. It contains 36 items, each of which is rated on a 7-point Likert-type scale, with each domain being represented by a 12-item subscale. The scores of these subscales can be examined separately or summed to provide a comprehensive assessment of the alliance.

The WAI is available in three formats; one intended for clients (WAI-C), one for therapists (WAI-T), and one version intended for observers (WAI-O). The multiple forms allow triangulation of perspectives, such that researchers are able to obtain a more complete picture of the alliance, or assess it in cases where one or more perspectives are unavailable (Darchuk et al., 2000). There are minimal changes made between the WAI-C, T and O items, with the principal difference being the transformation of pronouns to suit the appropriate perspective (e.g., *'[Therapist] and I agree on what is important for me to work on.'* to *'We agree on what is important for [Client] to work on.'*). In addition to maintaining the instrument's basis in theory, this also ensures that it is simple to administer, requiring no significant training for raters. This is particularly noteworthy given that the WAI has been shown to achieve comparable results to

several other scales which have much more onerous administration procedures (Tichenor & Hill, 1989).

The 36-item inventory was subsequently revised by Tracey and Kokotovic (1989), who used confirmatory factor analysis to isolate and retain the 12 items which they argued best represented the key domains identified by Bordin (1979), four items for each subscale. Empirical evidence indicated a very high correspondence between the full-scale (WAI) and short (WAI-S) versions, to the point that Busseri & Tyler (2003, p.197) described them as "interchangeable". Given the significant decrease in administration time over the full scale and much greater efficiency of scoring, this represented a meaningful development in the assessment of working alliance.

The WAI-S was then revised a second time by Hatcher and Gillaspy (2006), leading to the development of the working alliance Inventory Short Revised (WAI-SR). This primarily involved discarding negatively worded items (removing the need for reverse scoring, and further simplifying administration), as well as several minor changes to the wording of items. Hatcher and Gillaspy (2006) used a larger sample than Tracey and Kokotovic (1989), and also implemented more sophisticated statistical procedures. They demonstrated that the WAI-SR more closely matched the psychometric properties of the original, 36-item WAI, and achieved greater isolation between the three sub-factors (Tasks, Goals, Bond) which were identified in confirmatory factor analysis and exploratory principal axis factoring. The WAI-SR also retains the advantage of being brief to administer, easily scored, and not requiring significant training or instruction to use. This variant of the WAI is therefore generally recommended for use in contemporary research, due its superior psychometric properties, efficiency of use, and closer relationship to guiding theory (Horvath, 2019).

A broad overview of research conducted since 1980 indicates that the WAI has been employed by the vast majority of researchers interested in the phenomenon of working alliance (Doran, 2016; Martin, Garske, & Davis, 2000). It has also been comprehensively

validated, reliability tested and used with an impressive diversity of languages and ethnic groups. Flückiger et al. (2019) noted in their meta-analysis that 69% of the 105 articles included used some variant of the WAI. This reflects Martin et al.'s (2000, p. 447) argument that the WAI is among the most empirically scrutinised of all alliance measures and is the most likely to be suitable for a range of research projects.

In the research which comprised this thesis, it was important that assessment of working alliance be brief, and it was considered an advantage that it be straightforward and easily scored. It was also considered essential that any instrument used was theory-driven, well-validated and psychometrically sound. In light of its close correspondence with these requirements, the WAI (specifically the WAI-SR) was chosen for this research.

1.3.4.5 Perspective Discrepancies in Working Alliance (Dyadic Convergence)

With the advent of multi-perspective alliance assessment measures, it has become possible to assess the degree to which the patient and provider agree in their evaluation of the therapeutic relationship. The degree of agreement (or disagreement) is generally referred to as 'dyadic convergence', or 'patient-therapist convergence' (Shick Tryon, Collins Blackwell, & Felleman Hammel, 2007). Researchers have invested significant energy in assessing the predictive power of dyadic convergence in therapeutic outcome, with the hypothesis generally being that stronger convergence would be predictive of better outcomes (e.g., greater symptom reduction).

Interestingly, a common finding in alliance research is that client, therapist, and observer ratings can diverge significantly (often rapidly) even when ratings are initially similar, and may never reach significant convergence, even at termination of therapy (Horvath & Symonds, 1991; Shick Tryon et al., 2007). Numerous examples of this are available in the literature; several studies have found low correlations between client and therapist alliance ratings, which sometimes fail to show any meaningful relationship at all (Kivlighan & Shaughnessy, 1995; Mallinckrodt & Nelson, 1991; Meier & Donmall, 2006). Indeed, Meier and

Donmall (2006) found that the level of convergence appeared to *decrease* over time, such that late ratings of the alliance were the most dissimilar, although prior research had suggested that alliance ratings converged over time (Kivlighan & Shaughnessy, 1995). Shick Tryon et al. (2007) offer an explanation for this discrepancy, noting that research using substance-abusing populations (such as those studied by Meier & Donmall, 2006) typically have more discrepant ratings, which they hypothesised may be partly attributable to these clients receiving either free or mandated treatments, with a corresponding impact on their rating of alliance relative to clients who have personally chosen to access (potentially paid) treatment. This discrepancy is likely to have a range of impacts on alliance ratings.

Generally speaking, research has borne out the idea that client ratings of the alliance are typically higher and more consistent over time than those of therapists or observers (Evans-Jones, Peters, & Barker, 2009; Martin et al., 2000; Shick Tryon et al., 2007). Indeed, this finding is so reliable that Shick Tryon et al. (2007) suggested that a client endorsing a lower alliance rating than their therapist "may be an indicator that therapy is not progressing well" (p. 638). The source of this discrepancy has not been empirically established as yet; however, some researchers have argued that it can be understood as a fundamental difference of opinion between clinicians and clients (Horvath, 2000; Meier & Donmall, 2006; Tichenor & Hill, 1989). In particular, it is important to consider that clients may interpret the warm, collaborative therapeutic relationship in the context of other interpersonal relationships, in which case it is likely to be judged as unusually positive and goal-directed (Horvath, 2000; Shick Tryon et al., 2007). By contrast, therapists may be more likely to make theory-based judgements and to compare clients against one another (i.e., one therapist has many clients at any one time, but most clients have only one therapist at a time), whereas clients are unlikely to have access to this perspective (Martin et al., 2000).

In their study – one of few to directly compare client, therapist, and observer perspectives – Tichenor and Hill (1989) summarily observed that "[c]lients, therapists, and

observers clearly did not agree or come to a consensus on what working alliance was, indicating that measures from different perspectives are not interchangeable." (p. 198). By contrast, more recent meta-analytic work (based on a much greater number of studies) found that the therapist-rated and client-rated alliance in psychotherapy "covary in a moderately consistent, positive way, regardless of client disturbance, therapist experience, therapy length, alliance measure, or type of treatment" (Shick Tryon et al., 2007, p. 638). Evidently, there is considerable diversity in findings – however the evidence suggests that correlations between therapist and client views are at best moderately strong.

In general, it seems to be the case that greater dyadic convergence is related to greater treatment gains. Higher convergence has been shown to be related to greater symptom reduction in chronic depression (Laws et al., 2017), greater reductions in worry and distress in severe Generalised Anxiety Disorder (Coyne, Constantino, Laws, Westra, & Antony, 2018), decreased interpersonal problems (Kivlighan & Arthur, 2000), and reduced attrition (Reis & Brown, 1999). Some research has also considered the impact of level of psychiatric disturbance, with the hypothesis that greater symptom intensity would predict lesser dyadic convergence. Interestingly, this hypothesis does not appear to be supported - Shick Tryon et al. (2007) reported that the greatest divergence was found in mildly disturbed clients and moderately disturbed clients with substance abuse, whereas substantially smaller discrepancies were found with severely disturbed and moderately disturbed clients without substance abuse. This also provides context to other research which suggests that dyadic convergence is not predictive of retention in substance abuse populations (Meier et al., 2005; Meier, Donmall, McElduff, Barrowclough, & Heller, 2006). Given the paucity of studies which identify client diagnoses, or fee for service arrangements versus free or mandated treatment, or those which assess the alliance of treatment non-completers, it is difficult to speculate as to why this may be.

1.3.5 Working Alliance Over Time

As with most interpersonal relationships, it is generally understood that working alliance does not remain static over time. Rather, it is subject to change as the provider and patient become accquainted, develop a mutual understanding, and then begin to face challenges as a dyad (Martin et al., 2000; Meier et al., 2006).

Bordin (1979) characterised the alliance over time as a constant pattern of "tear and repair" – strains or ruptures in the alliance develop naturally and predictably and – in successful therapy – are an opportunity for renegotiation and restoration of the relationship. Gelso and Carter (1994) conceptualised this as a "high-low-high" model of alliance development, in which initially high levels of working alliance deteriorate as the dyad moves from the 'getting accquainted' phase of treatment to the confrontation of frustrations and difficulties. As these issues are dealt with collaboratively and (ideally) in parallel with symptom improvement, the alliance would be expected to recover accordingly (Hartley & Strupp, 1983). As such, the greatest symptom reduction would be expected to be related to a "U shaped" pattern of alliance development – a result which has previously been borne out in short psychotherapeutic interventions (Kivlighan & Shaughnessy, 2000). Interestingly, longer-term interventions appear to show multiple rises and falls in alliance level (Stiles et al., 2004), rather than a stable return to a high level of alliance after a rupture. This suggests that long-term psychotherapeutic treatment may be characterised as a long series of rupture-repair sequences, best understood as a series of Gelso and Carter's (1994) high-low-high events, which would also be consistent with Bordin's (1994) model.

Despite these findings, relatively few studies have assessed working alliance at multiple time points. The majority of assessments of alliance take place very early in therapy (Falkenstrom, Granstrom, & Holmqvist, 2014; Safran & Muran, 1996; Tichenor & Hill, 1989). Although these studies have typically indicated that early working alliance is consistently related to outcome, it is questionable whether these provide a complete enough picture of

working alliance. Indeed, Falkenstrom et al. (2014) point out that a single timepoint assessment is at serious risk of being impacted by a range of unrelated factors, such as recent events in patients' lives, mood on the day of measurment or symptom change. Summarily, these models suggest that alliance should – if it is practical – be assessed at multiple timepoints throughout treatment to achieve a comprehensive understanding of the alliance and how it functions.

1.3.6 Clinical Importance and Utility of Working Alliance

1.3.6.1 Working Alliance in Psychotherapy

Theory suggests that working alliance is an essential factor in the success or failure of psychotherapeutic interventions, due to its important role in facilitating engagement, guiding cognitive, metacognitive and behavioural change, and reducing the risk of negative interpersonal experiences within the therapy dyad (Bordin, 1994). Indeed, therapeutic alliance has been argued by some to represent the "main curative component" (Lambert & Barley, 2001, p. 357) in psychotherapy. This view of alliance is broadly in line with the long-held understanding that there are "common factors" in therapeutic settings which are ubiquitous, regardless of the theoretical orientation of the practitioner or the intervention chosen (Rosenzweig, 1936). These common factors are argued to have an impact on therapeutic outcomes irrespective of what the treatment may be (Tracey, Lichtenberg, Goodyear, Claiborn, & Wampold, 2003). Of these, working alliance has emerged as one of the most consistent and agreed-upon by practitioners across a range of orientations and backgrounds (Grencavage & Norcross, 1990). In summary, it is well-established among both researchers and clinicians that working alliance is important in the day-to-day practice of psychotherapy (Arnd-Caddigan, 2011; Martin et al., 2000).

Empirical research has gradually borne out the concept of alliance as a common factor with an important impact on therapeutic outcomes, and it is now appreciated as one of the most reliable predictors of successful therapeutic interventions across a range of approaches. Evidence indicates that therapeutic alliance is related to symptom improvement in mental

illness, client retention and attrition rates, client satisfaction with care, relapse rates, and a range of other variables (Arnd-Caddigan, 2011; Doran, 2016; Fluckiger et al., 2012; Horvath, Del Re, Flückiger, & Symonds, 2011; Martin et al., 2000; Tetzlaff et al., 2005). Meta-analytic studies relating alliance to outcome have generally shown it to be a modest but highly reliable predictor of therapeutic outcomes (Flückiger, Del Re, Wampold, & Horvath, 2018; Fluckiger et al., 2012; Horvath et al., 2011; Horvath & Symonds, 1991; Martin et al., 2000), which generally persists regardless of study design (RCT vs not), researcher interest, disorder-specific manualised treatment approaches, and treatment modality (Fluckiger et al., 2012).

The mechanism by which working alliance relates to therapeutic outcomes has been the subject of considerable interest. The prevailing view is that a functional alliance is a necessary but not sufficient condition for therapeutic change (Raykos et al., 2014), in that some degree of alliance is required for any therapeutic work to take place, and that a stronger alliance permits greater engagement in that work and subsequently greater symptom reduction. Flückiger et al. (2018, p. 330) neatly summarised the difficulty in assessing this hypothesis; “it is ethically and conceptually not possible to randomize patients to treatment conditions where these variables are manipulated (e.g., to a high and low alliance condition).” As such, it is necessary to rely on indirect and contextual evidence, with the key limitation that it is difficult to establish causality.

That said, some research exists which has attempted to clarify mechanisms by which the therapeutic alliance influences outcome. Bordin (1994) originally proposed that one of the primary ways in which alliance was important in therapy was the tendency of a strong alliance to encourage openness in the client, which would then have a corresponding positive impact on the alliance as therapy progressed. Specifically, a strong therapeutic bond and clear agreement on the goals and tasks of therapy are expected to facilitate disclosures, and that openness on the part of the client and clinician are important in order to reach consensus on the goals and tasks of therapy. Indeed, in a guide for clinicians, Newman and Strauss (2003)

specifically identified client untruthfulness as a risk factor for a non-productive therapeutic relationship, arguing that it was likely to generate disagreement about proper interventions and how those should proceed.

Although there have been relatively few empirical studies of disclosure and working alliance, results thus far support this theoretical understanding. For example, in a study of 147 current and former psychotherapy clients, D. Hall and Farber (2001) found that the two best predictors of disclosure to therapists were working alliance and length of time in therapy. They argued that time in therapy naturally increases the number of opportunities to make disclosures, and that a robust therapeutic alliance facilitates these disclosures. Similarly, in a cross-sectional study conducted by Kelly and Yuan (2009), clients who reported keeping a treatment-relevant secret from their therapist also reported substantially weaker working alliances. Interestingly, therapist-rated working alliance was also weaker for these clients, even though therapists were generally unable to accurately determine which clients were keeping secrets. Taken together, these results suggest a reciprocal relationship of disclosure and working alliance.

Ultimately, in therapy dyads with a poor therapeutic alliance, patients are less likely to show symptom improvement, stay in treatment, or report they are fully satisfied with the care they receive, whereas a strong alliance may be facilitative or even necessary for successful therapy. Naturally, such findings have led to the establishment of widespread clinical guidelines which emphasise the importance of focussing on building a strong and collaborative relationship with clients both initially and throughout treatment (Muran & Barber, 2011).

1.3.6.2 Working Alliance in Other Healthcare Settings

It is important to acknowledge that the provision of care for illnesses which are primarily non-psychological in nature is fundamentally different from psychotherapy. Specifically, time spent with medical professionals is typically (though not always) briefer, may

be less recurrent, and aspects of the care provided may occur without the patient's deliberate, autonomous participation (e.g., surgery under general anaesthetic). Nevertheless, there are numerous components of medical care which require patient action or collaboration with healthcare providers, such as adherence to instructions, disclosure of symptoms, continued attendance, lifestyle change, and timely help-seeking.

In recent years, patient-centred care has increasingly become a driver of policy in healthcare (Kitson et al., 2013), likely related in part to an evolving public, academic and clinical view of healthcare relationships, and the centrality of discourse around patient autonomy (Malatesta, 2015). Organisations such as the United Kingdom National Health Service (NHS) specifically identify "patient experience" as one of the key factors of quality healthcare, and emphasise patient satisfaction with care and their autonomy (Department of Health, 2008; Roland et al., 2013), a view which has been echoed in Australia by the Australian Health Practitioner Regulation Agency (AHPRA) (Medical Board of Australia, 2015, 2016) and a range of research and training organisations (Fuertes, Toporovsky, Reyes, & Osborne, 2017).

A significant body of work has been conducted in recent years by Fuertes and colleagues (J. K. Bennett, Fuertes, Keitel, & Phillips, 2011; Fuertes et al., 2015; 2007; Fuertes et al., 2017) to define and study working alliance within the context of patient relationships with their physicians. A review of recent research indicates that their conceptualisation (hereafter referred to as Physician-Patient Working Alliance, PPWA) is the dominant understanding of working alliance in medicine at this time. PPWA as defined by Fuertes et al. (2007) is heavily informed by Bordin's (1979) pan-theoretical model, and maintains its emphasis on goals, tasks and relational bond. It also draws heavily upon the concept of shared decision making (SDM) in healthcare, an approach to making choices about patient care which emphasises negotiation, with a role to be played by both the physician and patient. In SDM, both parties' opinions are considered before a mutually agreed-upon plan is developed and undertaken (Stiggelbout et al., 2012). This model, which is intended to respect and honour patient

autonomy and informed consent, can be contrasted with paternalistic decision making – in which the decision is made entirely by the physician - and autonomous decision making, where the patient alone is responsible for choosing how to proceed. Shared decision making interventions have previously been demonstrated to improve outcomes for disadvantaged patients (e.g. those with lower literacy) (Durand et al., 2014), and improve parent knowledge regarding interventions in paediatric settings (Wyatt et al., 2015).

The primary measure used to assess PPWA is an adapted version of Tracey and Kokotovic's (1989) short form of the Working Alliance Inventory, referred to as the Physician-Patient Working Alliance Inventory (PPWAI). The primary changes made in adapting the scale were to replace references to 'therapist' with 'doctor' and minor alterations to the wording of items to emphasise health improvement, rather than therapeutic change (e.g., "My doctor and I agree about the things I need to do to help improve my health"). The scale has shown good internal consistency reliability, and results from the validation study indicated a strong relationship with perceived utility of care, self-efficacy, adherence, and patient satisfaction (Fuertes et al., 2007). An adapted version of this scale was used in the first study of this thesis (which related to general practitioners, rather than psychologists), with the primary changes being to the wording of items to bring it into line with those in the WAI-SR (Hatcher & Gillaspy, 2006), to ensure consistency with subsequent studies which used this measure.

A recent meta-analysis summarised research in this area, drawing upon studies from a range of illness categories, including HIV/AIDS, Hypertension, Diabetes, Asthma, Cancer, Chronic Disease, Rheumatic Disease, and Renal Disease. Results indicated that patient working alliance ratings were moderately positively related to patient adherence to recommended treatment, patient's self-efficacy regarding adhering to treatment, and to patients' expectations about their health. PPWAI scores were also strongly related to patient satisfaction and perceptions about the utility of treatment (Fuertes et al., 2017). The strength and reliability

of these effects led Fuertes et al. (2017) to conclude that working alliance training for physicians was warranted and worthwhile.

Although research applying working alliance to medical care is evidently in its early stages, these results echo (and in some cases even exceed in effect size) those which have linked working alliance with psychotherapeutic outcomes over the last several decades (Flückiger et al., 2019).

1.3.7 Limitations of the Working Alliance Construct

Although working alliance is evidently one of the most heavily empirically studied and well-evidenced variables in psychotherapeutic outcome studies, it is important to acknowledge that the construct is not without criticism. A common critique of alliance is that although Bordin's (1979) highly influential model distinguishes the major sub-factors of alliance (tasks, goals, bond), past research has often failed to meaningfully isolate them (Hatcher & Barends, 2006; Hatcher & Gillaspy, 2006; Tracey & Kokotovic, 1989), and it has proven to be difficult to identify which components are most important in maximising treatment gains across individuals and time points (Safran & Muran, 2006). As such, many studies examining alliance-outcome relationships use only total alliance ratings (Flückiger et al., 2018), and the usefulness of examining or distinguishing the sub-factors is debated (Doran, 2016).

Furthermore, critics of the alliance construct have argued that the concept of consensus ('agreement') which underlies two out of the three sub-factors in Bordin's model can easily be conflated with conflict-avoidance or compliance. Specifically, critics have argued that a therapeutic relationship in which the participants avoid discussion of difficult topics and defer to one another could ultimately be assessed as a high quality alliance by existing measures, insofar as the parties do not explicitly disagree (Cushman & Gilford, 2000). This is problematic because it fails to capture the important aspects of negotiation and rupture/repair which are typical in the type of meaningful collaboration which is theoretically desirable in therapeutic relationships (Doran, Safran, & Muran, 2017; Gelso & Carter, 1994).

Although a substantive exploration of these critiques is outside the scope of this thesis (see Doran, 2016 for a review), it is noteworthy that new measures have recently become available which purport to better capture the diplomatic aspects of the working alliance, and for which evidence is rapidly building. For example, early research using the Alliance Negotiation Scale (ANS; Doran, Safran, Waizmann, Bolger, & Muran, 2012) suggests that it correlates highly with the WAI, as well as measures of psychiatric distress and interpersonal problems, while also adding additional elements in the form of links between its negotiation subscales and client-rated session impact (Doran, 2016; Doran, Gómez-Penedo, Safran, & Roussos, 2018; Doran et al., 2017). In the future, measures such as these may ultimately be used to supplement or even supplant consensus-focused measures such as the Working Alliance Inventory. Given the emerging nature of the literature in this area, the more established measures of working alliance were chosen for the studies included in this thesis.

1.3.8 Relating Working Alliance to Shame

With the relationship of alliance to outcomes now well-established, the present challenge for researchers is the identification of variables which may affect the development of a robust alliance and, ultimately, which could be subject to targeted interventions. Of these, many are 'dispositional' variables – that is, they are represented by clients' or therapists' tendencies to react or respond in certain ways based on underlying qualities of their personalities. Relatively little research has examined the therapist and patient characteristics which may act as facilitators or inhibitors of building and maintaining a good quality alliance (Doran, 2016). One such characteristic is dispositional shame, which has an intuitive relationship with the formation of interpersonal relationships. The following section will define and discuss dispositional shame in psychological research, and will also clarify its potential links with working alliance.

1.4 Shame

1.4.1 Shame as a Self-Conscious Emotion

The concept of shame as it is generally understood in empirical psychological research is informed by the Western scientific tradition from which it has emerged. Although the present research is based on this definition (as will be explored in this section) it is important to acknowledge that shame is a culture-bound emotional experience, and that the term 'shame' carries different meanings across cultures and philosophical traditions.

An example of culturally distinct conceptualisations of shame is found in Australian Aboriginal culture. Here, shame is often viewed as an emotional experience which is not necessarily negative and which can be found in a variety of situations that non-Aboriginal peoples would not generally recognise as shame-provoking, such as; being praised, being in the presence of close family, learning secret cultural information (e.g. regarding ceremonies) or being near a forbidden place (Harkins, 1990, 1994). Indeed, Harkins (1990) suggested that the Aboriginal conceptualisation of shame may partially overlap with experiences as diverse as the Western definitions of shyness, respect, and embarrassment, while not completely encapsulating any of them. Evidently, there are many unique conceptualisations of shame which could form the basis for extensive anthropological scholarship, however the present thesis is concerned exclusively with the understanding of the term 'shame' as it has been used in the Western empirical tradition.

In psychological research, shame is typically conceptualised as a *self-conscious* emotion, putting it in the same category as guilt, embarrassment and pride (Tracy, Robins, & Tangney, 2007). Theory has distinguished these emotions from the basic emotions (joy, fear, sadness, anger, etc.) by the fact that they necessarily require self-awareness and self-representation (Tracy & Robins, 2004) and as such have clear cognitive antecedents, without which the emotion does not occur. To put this another way, self-conscious emotions are

largely dependent upon the individual's interpretation of events and the accompanying self-evaluative process which takes place, in a way that basic emotions are not.

To aid in understanding how self-conscious emotions differ from basic emotions, Tracy and Robins (2004, p. 105) give the example of winning the lottery versus winning an athletic contest. Although both events are likely to produce the basic emotion of happiness, it is unlikely that a lottery win would result in pride, unless the winner has grossly overestimated their level of control over the outcome. By contrast, the self-evaluative appraisal process which occurs after an athletic win (e.g., "I was successful because of my talent and ability as an athlete") is likely to result in feelings of pride. This also provides an understanding of why two individuals may react with differing self-conscious emotions to the same event – an athlete who interprets their win differently (e.g., "I only won because the other competitors let me win out of pity") is unlikely to feel pride, and may instead feel shame or embarrassment (Lazarus, 1991).

Although basic emotions *can* involve self-evaluative processes, the crucial distinction is therefore that self-conscious emotions are *dependent* upon them to occur. Empirical evidence has generally supported this distinction, with the finding that internal attributions for failures (i.e., "this was my fault") tended to produce self-conscious emotional responses (e.g. shame, guilt), whereas external attributions (i.e., "this was due to circumstance/someone else's fault") typically produced non-self-conscious emotions, including anger and fear (Russell & McAuley, 1986; Tracy & Robins, 2006).

Whereas basic emotions have generally been understood to have an immediate survival function (e.g. fear motivates animals to flee from threats), self-conscious emotions have been theorised to have a socially integrative function, serving to push us towards behaviours which are socially valued and away from behaviours which could lead to social rejection (Tangney & Dearing, 2002). Successfully adhering to the standards and values of our social group (as well as our own internalised values) may lead us to feel pride, whereas a failure

to live up to these standards may cause us to feel guilty or ashamed. Thus, these emotions serve to reinforce prosocial behaviours, and in so doing exercise their own survival function in a potentially longer-term and more complex way than the more immediate function of the basic emotions (Tracy & Robins, 2004).

Shame has long been recognised as the most aversive of the self-conscious emotions (Wicker, Payne, & Morgan, 1983), which is "painful, never pleasant" (Young, 1991, p. 498). It has often been described as a distressing burden (Morrison, 2011) which is incapacitating and overwhelming, accompanied with feelings of physical smallness, sweating, burning, freezing and weakness (Lazare, 1987), a sense of the slowing of time, being exposed and vulnerable (Lindsay-Hartz, 1984), sensations of melting through the floor, having no physical boundaries (Young, 1991), being like a physical blow, and other similarly evocative imagery (Dickerson, Gruenewald, & Kemeny, 2004; Wicker et al., 1983). Evidently, shame has not generally been considered a desirable or even neutral experience.

A common characteristic of these shame descriptions is a feeling of increased bodily awareness and corresponding compulsion to perform certain physical movements (generally hiding or attempting to appear smaller, Young, 1991). Interestingly, specific patterns of nonverbal shame behaviour have been repeatedly observed in empirical research – the most common being downward-directed gaze, postural rigidity, slouching and making oneself appear smaller (Martens, Tracy, & Shariff, 2012). Untrained observers have proven to be adept at identifying these movements as related to shame, rather than embarrassment, guilt or amusement (Keltner, 1995). Furthermore, such behaviours have been reliably observed in many nationalities and ethnic groups, including a sample of congenitally blind athletes who could not have learnt such displays through visual modelling (Tracy & Matsumoto, 2008). The ubiquity of these nonverbal reactions to shame has led researchers to conclude that they may be an innate, evolved response.

Since the beginning of research into self-conscious emotions, two broad schools of thought regarding shame and guilt have emerged – the first, popularised by theorists such as H.B. Lewis and June Tangney, is characterised by the view that guilt is adaptive, whereas shame is maladaptive. The second, more recent perspective is that both guilt and shame can function adaptively or maladaptively, depending on a range of factors. In the following sections, I have referred to these (following the example of Dempsey, 2017) as the 'social-adaptive' and 'functionalist' perspectives, respectively.

1.4.1.1 Social-Adaptive Perspective on Shame

Contemporary psychological research on shame owes much of its conceptual basis to the work of H.B. Lewis, who first proposed a clear distinction between the self-conscious emotions of shame and guilt. She argued:

> The experience of shame is directly about the *self*, which is the focus of evaluation. In guilt, the self is not the central object of negative evaluation, but rather the *thing* done or undone is the focus. In guilt, the self is negatively evaluated in connection with something but is not itself the focus of evaluation (H. B. Lewis, 1971, p. 30, italics original).

Lewis' conceptualisation of shame and guilt emphasises the importance of the nature of the self-evaluation in determining the corresponding emotional response. In this model, guilt is related to a specific behaviour (or lack thereof) which may or may not be typical of an individual. It is recognised as a value transgression, but does not necessarily have implications for the person's identity as a whole (Tangney, 1995). By contrast, shame is produced by an evaluation of the self as fundamentally defective or flawed – an appraisal which is global, stable and pervasive (Tracy & Robins, 2004). These emotions may both be provoked by the same events in different people. For example, after an act of theft, an individual may have the behaviourally-focussed thought "I shouldn't have *done that*. *Stealing* is wrong" and therefore feel guilty, whereas the evaluation "*I'm* a thief. *I'm* a *bad person*" is more likely to arouse

feelings of shame. Naturally, it is admissible (and a common finding) that guilt and shame may co-occur (Leach & Cidam, 2015).

Tangney and colleagues (Tangney, Miller, Flicker, & Barlow, 1996; Tangney, Wagner, & Gramzow, 1992; Tracy et al., 2007) have argued that guilt and shame can also be distinguished by the action tendencies they produce. Specifically, that guilt is defined by remorse and regret over a specific behaviour and therefore often motivates reparative and prosocial behaviours. Indeed, Lindsay-Hartz (1984, p. 693) noted that "[w]hen guilty, many people want to confess and atone". Conversely, proponents of this model argue that the globality and inalterability of shame motivates hiding, withdrawal and other avoidant behaviours, such as externalisation of blame (Gilbert & Andrews, 1998; M. Lewis, 1995). This may itself be related to a protective innate drive to withdraw the self from the social arena as a target for further condemnation – i.e., to reduce opportunities for additional aversive experiences of shame (Scheff, 2000). Summarily, if the entire self is seen as flawed and objectionable, and it cannot be replaced or repaired, the reasonable course of action is to conceal it (H. B. Lewis, 1971).

H. B. Lewis (1971) postulated that the frequency and intensity with which people respond with either shame or guilt when exposed to triggering situations was variable, such that certain individuals were more prone to specific responses (i.e., shame-proneness and guilt-proneness). Shame proneness (also referred to as 'dispositional shame') has received extensive research attention, with most researchers conceptualising it as a tendency to experience shame (or not) in situations which may be regarded as shame-provoking, as well as chronic, generalised feelings of shame (Andrews, 1998; Tangney, Burggraf, & Wagner, 1995). Given the breadth of this definition, it remains the subject of some debate (Leeming & Boyle, 2004); however a number of research instruments have been developed to assess dispositional shame and guilt – the most well-known of which is probably the Test of Self-Conscious Affect (TOSCA) (Giner-Sorolla, Piazza, & Espinosa, 2011; Tangney, 1989).

The social-adaptive perspective on shame generally holds that it is psychologically maladaptive and has a limited usefulness in promoting healthy or productive behaviour, with the best-case scenario being defensiveness and concealment. In addressing the question of why such an unproductive emotion would be preserved as part of our evolutionary heritage, Tangney and colleagues (Tangney et al, 1996, p. 1267) argue that shame may be "a more primitive emotion", which may have been useful in our evolutionary past, or show the most usefulness in childhood for the inhibition of undesirable behaviour prior to the development of the cognitive capacity to experience guilt. Regardless, they argued that "the negative psychological implications of shame are evident across measurement methods, diverse age groups, and populations" (Tangney, Stuewig, & Mashek, 2007, p. 27).

In many ways, this is an intuitive view – the intense negative scrutiny towards oneself, feelings of worthlessness and notions of personal failure which characterise high levels of shame (Tangney et al., 1996) have long been identified in the thinking styles associated with chronic mental illness, particularly in the case of personalisation, catastrophising, and black and white thinking (Beck & Alford, 2009). Consistent with this view of shame as a maladaptive emotion, early empirical research indicated that shame-proneness was related to difficulties in interpersonal relationships, impaired empathy, tendency to externalise blame, and anger and hostility (Tangney et al., 1995; Tangney et al., 1992). More recent meta-analytic work has supported the view that shame-proneness is linked to various psychological problems, including depressive symptoms (Kim, Thibodeau, & Jorgensen, 2011) and a range of anxiety symptoms (Cândea & Szentágotai-Tătar, 2018). It is also noteworthy that high levels of shame appear to promote non-productive behaviour in a psychotherapeutic setting, such as withdrawal, anger, deflection, and externalisation of blame (Black, Curran, & Dyer, 2013; Dearing, Barrick, Dermen, & Walitzer, 2005).

1.4.1.2 *Functionalist Perspective on Shame*

Although the social-adaptive view of shame remains influential in shame research, emotion theorists have increasingly disputed the idea that shame is a necessarily maladaptive or 'ugly' emotion, without a clear function (De Hooge, 2014; Dempsey, 2017). This contrary perspective is based partly in evolutionary psychology, with key proponents arguing the emotions (and the complex behavioural patterns these entail) are adaptive responses which emerged in response to evolutionary pressures faced by our species (Hutcherson & Gross, 2011). In this view, emotions, and the action tendencies they produce, will tend over time to urge individuals towards behaviour which increases their odds of survival.

Perhaps the most well-known model of shame within this framework is the Evolutionary and Biopsychosocial Model of shame (Gilbert, 2002, 2003; Gilbert & McGuire, 1998). In this model, shame is argued to have emerged in our evolutionary history as a mechanism to regulate psychobiological responses to relative social positioning (i.e., social rank). In this sense, the emotional experience of shame is interpreted as a 'warning sign' for potential damages to one's social status and has the function of motivating compliance with social norms, which theoretically increases individual attractiveness to others (both physical and otherwise) and facilitates the formation of sexual and alliance relationships which subsequently increase chances of survival and successful reproduction (Gilbert & McGuire, 1998).

To emphasise this point, the key function of shame in the functionalist perspective is the maintenance of social hierarchies and ranks, and the protection of the social self from threats such as the loss of social bonds (Dickerson et al., 2004). Specifically, shame serves as a reminder to the ashamed person of their relative social position compared to others, and promotes submissive, appeasing, and norm-compliant behaviour when an individual becomes aware that they have violated social norms (Gilbert & McGuire, 1998; Nelissen, Breugelmans, & Zeelenberg, 2013). In this view, shame also functions to alert other group members to the

individual's recognition of the violation of norms, a perspective which is supported by research which suggests that nonverbal shame experiences are highly recognisable to others, and appear to have some universal elements across cultures (Tracy & Matsumoto, 2008).

Thus, contrary to the social-adaptive view, functionalists argue that no emotion is *necessarily* maladaptive. Instead, the extent to which an emotional experience is adaptive is determined by the individual's cognitive and behavioural response to that emotion (Dempsey, 2017). In the case of shame, they argue, several adaptive responses are possible: the individual may attempt to repair damaged interpersonal relationships or reputations, or work to change aspects of their identity that have been identified as objectionable (Cibich, Woodyatt, & Wenzel, 2016; Dempsey, 2017). This view is supported by empirical research which has demonstrated that experiences of shame can sometimes lead to adaptive cognitive and behavioural responses, such as an increased desire for self-improvement and pro-social orientation (De Hooge, Zeelenberg, & Breugelmans, 2010, 2011; Lickel, Kushlev, Savalei, Matta, & Schmader, 2014).

Naturally, maladaptive responses to shame – such as externalisation of blame, defensiveness, rumination, and avoidance – are also possible. Functionalists argue that it is these reactions that are 'toxic', rather than the shame itself (Cibich et al., 2016; Dempsey, 2017). In particular, habitual avoidance responses to shame are unlikely to address the emotion's source, and thus such responses are unlikely to be adaptive in the longer term. This is supported by research which suggests that avoidant coping strategies (rumination, thought suppression, dissociation) mediate the link between traumatic shame memories and depression symptoms (Matos, Pinto-Gouveia, & Costa, 2013), and are related to a process of experiential avoidance which itself has an impact on depression symptoms (Carvalho, Dinis, Pinto-Gouveia, & Estanqueiro, 2015).

Given the multiple possible actions an individual may take in response to shame (approach and repair versus withdraw and avoid, or externalise and avoid), it is important to

understand what may direct the shamed person down each path. De Hooge and colleagues (De Hooge, 2014; De Hooge et al., 2010, 2011) have argued that the degree to which the shamed individual believes the situation is *repairable* is the key determinant of whether they respond with approach or withdrawal behaviours. Specifically, when individuals believe that they have a high degree of influence in restoring their positive self-image, and that such repairs are not prohibitively difficult, they will respond with the types of reparative actions described above. By contrast, the shamed person reverts to avoidant coping strategies (especially withdrawal) if the repair action is perceived as outside their control, too difficult, or impossible.

This model received broad support in a meta-analysis by Leach and Cidam (2015), which indicated that shame was positively related to approach strategies (both behavioural and cognitive) when there was an opportunity to repair the cause of the shame. By contrast, the results suggested that in studies where the source of the shame was less reparable, shame was negatively related to approach strategies, and instead typically resulted in avoidance. Notably, Leach and Cidam (2015) acknowledged that these findings were restricted to studies of *episodic* shame, i.e. shame which is not necessarily chronic, global, or generalised. They argued that chronic, generalised shame is more likely to be perceived as irreparable, owing to its relationship with the person's entire identity, rather than a discrete shaming event. As Cibich et al. (2016), pointed out, this perception of reparability is likely to be influenced by a range of factors: "the reparability of shame may involve the ability to acknowledge one's shame, benevolent responses of others, thinking of self as malleable, and responding to one's failures and shortcomings with self-compassion" (p. 479).

It is important to note that the present thesis is concerned primarily with feelings of shame which are chronic and pervasive (i.e., trait shame, shame-proneness, dispositional shame), and which are consequently unlikely to be perceived as easily repairable in the way that the functionalist perspective suggests would motivate adaptive or prosocial behaviour. As

Dempsey (2017) argued, the functionalist perspective currently lacks a substantive evidence base in the area of chronic, trait shame. In this thesis, this is reflected in the measures which were chosen to represent shame (detailed below), which generally pertain to global rather than event-specific shame appraisals. It also guided the choice to focus primarily on long-standing feelings of shame, rather than asking study participants to reflect on single shaming episodes. Despite this, it is important to acknowledge that contemporary research increasingly disputes the idea that shame is necessarily an 'ugly' emotion (De Hooge, 2014), and it may in fact motivate prosocial or reparative action in cases where this is perceived as useful and not prohibitively costly or difficult.

1.4.1.3 Internal and External Shame

An important conceptual distinction has emerged in shame research which distinguishes two unique sub-types of dispositional shame; *internal shame* and *external shame* (Gilbert, 1998; Goss & Allan, 2009). These are argued to have a fundamentally different character and a correspondingly variable relationship with key outcome measures.

Internal shame can be best understood as a self-evaluative and self-judgemental inner experience. An individual may judge themselves to be deeply personally flawed, powerless, physically and mentally unattractive, and as a failure (Gilbert, 1998), and these evaluations are likely to be experienced as painful and aversive. Statements such as "I'm a waste of space" and "I'm terrible" are characteristic of this emotional experience, which highlights the inward-facing evaluative style for which it is known. By contrast, external shame is characterised by a pervasive belief or fear that negative evaluations are being made by some real or imagined other(s). Notably, these beliefs do not require any actual judgments to have been made explicit by others, but rather are related to the individual's perception that they are being evaluated.

An individual with a high degree of external shame is likely to endorse beliefs that other people view them as inadequate, valueless and inferior, and may endorse intense fears

of social rejection and judgement from others (Goss, Gilbert, & Allan, 1994). Statements such as "everyone thinks I'm ugly" or "people can see my flaws" would be typical of such an emotional experience. High external shame would therefore be expected to be particularly related to concealment and withdrawal from others and a fear of being 'exposed' or 'seen' (M. Lewis, 1995), which in turn may enhance the perceived risk of revealing shame-inducing information. It is also reasonable to suppose that external shame's emphasis on how one is seen in the eyes of others may have greater relevance to the formation of healthcare relationships in which private information or body parts are exposed to potential judgement in a way which could be interpreted as a threat to social rank (Gilbert, 2007).

Although internal and external shame frequently co-occur, and are generally highly correlated (Matos, Pinto-Gouveia, Gilbert, Duarte, & Figueiredo, 2015), Gilbert (1998) argued that the two types are conceptually distinct, giving an example of internal-only shame; "depressed people may feel intense shame even though others assure them that such perceptions are distortions and that they are their own accusers" (p. 22), and external-only shame, such as in cases where an individual fears association with others who have committed an egregious act (as in the example of war criminals) even though in their own minds, they are not associated with that person. Interestingly, the conceptual distinction between internal and external shame appears to be borne out in empirical findings. Recent meta-analyses have demonstrated that compared to measures of internal shame, assessed external shame is a stronger predictor of intensity of depressive symptoms (Kim et al., 2011), as well as symptoms of social anxiety (Cândea & Szentágotai-Tătar, 2018). Such findings suggest that external shame may be related to a more acute experience of mental illness, particularly in cases where social relationships and perceptions of others are highly valued. Indeed, Kim et al. (2011) argued that it was particularly potent as "it reflects evolutionarily primitive anxieties related to the dangerous possibility of abandonment or rejection." (p. 74). This interpretation is generally consistent with the evolutionary and biopsychosocial model of shame and its

conceptualisation of this emotion as a warning sign for social damage, which would be expected to be more acute and painful when externally-focussed (Gilbert & McGuire, 1998).

External shame has also been related to the concept of *stigma consciousness* (Gilbert et al., 2007), a phenomenon in which individuals are fearful of the perception that they are part of a group which – for various reasons – is viewed as deficient or somehow socially unacceptable (Pinel, 1999, 2002). External shame is distinct from stigma consciousness insofar as the former is related to any and all negative judgements made in the mind of others about the self, whereas the latter relates to certain traits which may cause others to group them in a category of 'undesirable' persons (Gilbert et al., 2007). The phenomenon of stigma will be explored in more detail below.

1.4.1.4 Distinguishing Stigma from Shame

In the realm of psychological and emotional experiences, shame and stigma are often viewed as either partially or wholly overlapping constructs. This is perhaps due in part to the range and variety of definitions of shame which have emerged over the past century, leaving researchers and laypeople alike with considerable confusion about what the defining features may be (Link & Phelan, 2001). Nevertheless, there are important theoretical differences between stigma and shame.

Weiss, Ramakrishna and Somma (2006, p. 280) described stigma as "a social process, experienced or anticipated, characterised by exclusion, rejection, blame or devaluation" which was linked to a particular feature of a person's identity (e.g. health problems, mental illness, sexual orientation). Goffman (2009) referred to these identity features as "social abnormalities", which may be innate, cultural, or acquired. For example, health-related stigma is common (Scambler, 2009) and certain medical conditions (e.g. HIV/AIDS) are unfortunately often seen as 'shameful' (Parker & Aggleton, 2003), both socially and by those individuals affected by the disease.

The key conceptual difference between shame and stigma as they are defined here is that shame need not be related to any particular "social abnormality". There is no conceptual or theoretical barrier to individuals experiencing high levels of shame-proneness despite belonging to no stigmatised or marginalised category. Indeed, shame as a dispositional variable presupposes that the individual experiences a susceptibility to shame around most or all aspects of their identity (i.e., the 'entire self', Tangney, Wagner & Gramzow, 1992), rather than a specific area.

In reality, it is likely that many shame experiences will overlap to a certain extent with stigma. In part this is likely due to shame having a relationship with social and cultural understandings of what constitutes an 'acceptable' identity. Goffman (2009) argued persuasively that the experience of stigma is highly probable to result in shame, particularly in the event that stigma is internalised and becomes part of the person's everyday experience. To put this another way, if shame can be understood as an experience of self-devaluation, persistent devaluation and exclusion by others is likely to be facilitative of greater feelings of shame.

1.4.2 Empirical Measurement of Shame

There are a large variety of measures available to researchers wishing to conduct a psychometric assessment of shame and other self-conscious emotions, emerging from a number of different research traditions and theoretical orientations (Dempsey, 2017). Indeed, numerous single-use, idiosyncratic and unvalidated measures have been developed throughout the history of shame research, with the construct sometimes being assessed categorically ("did you feel ashamed?"). Others have made no attempt to differentiate the self-conscious emotions (e.g. shame from guilt) (Tangney, 1996), and still other studies have allowed for 'ashamed' as a write-in response (Kelly, 1998). This section will briefly review some of the major measures, both those which were included in the studies which form the current thesis, as well as several which were not included for various reasons.

1.4.2.1 Test of Self-Conscious Affect (TOSCA) (Tangney, 1989)

Developed by Tangney and colleagues, the TOSCA remains one of the most frequently deployed measures of shame in psychological research (Dempsey, 2017). It is currently in its fourth revision (TOSCA-4); however the third revision (TOSCA-3) remains the most commonly used version. It has been used with a variety of populations, age groups, genders, socio-economic backgrounds, and clinical presentations. It has also been translated into several languages other than English (Nugier, Gil, & Chekroun, 2012; Strömsten, Henningsson, Holm, & Sundbom, 2009; S. Watson, Gomez, & Gullone, 2017; S. D. Watson, Gomez, & Gullone, 2016; Wiklander et al., 2012). The measure was itself based on an earlier instrument; the Self-Conscious Affect and Attribution Inventory (SCAAI), which was intended to assess guilt, shame, pride, externalisation of blame, and detachment (Tangney, 1990). Gramzow and Tangney (1992) noted that the TOSCA was superior to the SCAAI in two important respects; firstly, the items were generated by research participants, rather than researchers, and secondly, that the SCAAI was developed to suit only college-aged students, whereas the TOSCA was theoretically appropriate for all ages.

In the TOSCA-3, participants are presented with 16 brief scenarios (11 negative, 5 positive). After each scenario, participants are asked to rate (on a 5-point, Likert-type scale) the likelihood that they would respond in certain ways which are considered typical of either shame, guilt, pride, externalisation, or detachment. The scenarios generally represent relatively minor moral transgressions which are written to be accessible to a range of people (Gramzow & Tangney, 1992). For example, for the scenario *"You break something at work and then hide it."*, respondents are asked to rate the likelihood of the following statement: *"You would think about quitting."* The complete scale yields indices of shame-proneness, guilt-proneness, externalisation, detachment/unconcern, and alpha pride (pride in oneself) and beta pride (pride in one's behaviour). Of the total 16 items, 11 pertain to shame specifically.

Although the TOSCA is undoubtedly the most common psychometric measure used to assess shame, a number of important criticisms have been made of its method of measurement and researchers have urged caution in its use and interpretation. The major themes of these critiques will be reviewed in the next subsection, however for detailed reviews see Giner-Sorolla et al. (2011) and Dempsey (2017).

1.4.2.1.1 Criticisms of the TOSCA

Several researchers (Cibich et al., 2016; Dempsey, 2017; Giner-Sorolla et al., 2011) have argued that the TOSCA responses are structured in such a way that they presuppose a social-adaptive perspective on self-conscious emotions – that is, that guilt is an adaptive, pro-social response whereas shame is inherently avoidant and maladaptive response. This can be readily observed in the TOSCA items which are coded as either shame- or guilt-typical. Whereas shame responses are typically self-evaluative and involve limited or no reparative possibility (e.g., *"You would think "I'm terrible"*), guilt responses generally include some element of reparation or prosocial action (e.g. *"You'd think you should make it up to him as soon as possible."*). This is particularly noteworthy given the emergent functionalist-oriented research, which suggests that the kind of moral transgressive scenarios included in the TOSCA are precisely the type of events in which shame is likely to be related to a reparative response (Leach & Cidam, 2015). In summary, no option is available in the TOSCA which represents participants who feel shame but choose nevertheless to act in an adaptive way, even though research has demonstrated that this sometimes occurs. With the current item structure, such participants may well select the prototypical guilt response, even when shame is the predominant emotion they would experience.

A related criticism which has been made of the TOSCA is that it does not provide a *global* assessment of shame-proneness, offering instead what Kim et al. (2011) described as an index of *context-dependent shame*. Specifically, the TOSCA generalises responses to a limited subset of situations as representative of a participant's overall shame-proneness. This is

problematic for several reasons, not least of which being that the TOSCA scenarios are explicit moral dilemmas – situations in which guilt, shame and other self-conscious emotions are typical and expected reactions. By contrast, it is unable to offer significant information about individuals who may habitually respond with shame in situations where others would rarely experience this emotion. This is important because truly shame-prone individuals would be expected to experience more shame *in general*. As Dempsey (2017, p.5) emphasised, "because the TOSCA only uses situations in which the majority of people are likely to report feeling ashamed and especially guilty, this measure does little to tell us about people who have particular problems with the emotion." As such, despite purporting to be a global measure of shame-proneness, it may well be the case that the TOSCA's true utility as a shame assessment instrument is limited to context-dependent, moral transgression-related shame.

Despite these criticisms, the TOSCA-3 was included as a measure in the current thesis, in recognition of the frequency and variety of use it has seen in the past. It was also important to establish a baseline using a well-evidenced, well-validated instrument and to determine if this provided any additional information beyond the other measures which were used.

1.4.2.2 State Shame and Guilt Scale (SSGS) (Marschall, Sanftner, & Tangney, 1994)

The State Shame and Guilt Scale (SSGS) is probably best viewed as a companion measure to the TOSCA, intended to assess brief experiences of shame and guilt (i.e. *state* shame and guilt) rather than enduring proneness to experiencing these emotions. Tangney (1996) argued that the SSGS was superior to earlier state measures of shame and guilt (e.g. the State Guilt Scale, Kugler & Jones, 1992) due to its use of phenomenological descriptions of these states (e.g. "I want to sink into the floor and disappear", "I feel humiliated, disgraced"), which do not require participants to distinguish between the terms 'shame' and 'guilt'. The measure is made up of 15 such items, each responded to on a 5-point Likert-type scale.

The SSGS is perhaps most notable for being one of very few assessments of state shame and guilt, and it has therefore unsurprisingly been used in a variety of studies which

required immediate assessments of shame and guilt, such as when conducting a manipulation check or assessing shame or guilt's relationship with a transient experience, such as dissociation (Cavalera, Pepe, Zurloni, Diana, & Realdon, 2017; Platt, Luoma, & Freyd, 2017; Tangney & Dearing, 2002).

It is important to note that the SSGS suffers from some of the same theoretical shortcomings identified in the TOSCA; namely, that it conflates reparation and prosocial action with guilt, and avoidance with shame. For example, two of the key guilt-coded items are "I feel remorse, regret" and "I feel like apologising, confessing", whereas a key shame-coded item is "I want to sink into the floor and disappear". This may limit its usefulness in distinguishing between shame and guilt in situations where reparation is possible, which seems particularly relevant in the case of state emotions, given their supposed transience and reference to recent behaviour.

Interestingly, some novel research has assessed state shame through the coded measurement of nonverbal displays: Randles and Tracy (2013) found that the more shame behaviours (e.g. downward head tilt, slumped shoulders) displayed by recovering alcoholics discussing their past drinking, the more likely they were to experience relapse over the following four months, whereas scores on the SSGS were not significantly associated with relapse risk.

The present research thesis is more concerned with enduring, chronic experiences of shame than their state equivalents, and no meaningful opportunity to assess state shame existed within the studies which make up part of this thesis. Accordingly, the SSGS was not included in any of the studies which comprise this research.

1.4.2.3 Internalised Shame Scale (ISS) (Cook, 1988)

The Internalised Shame Scale (ISS) was developed contemporaneously with the earliest version of the TOSCA, and emerged from the same recognition that - until that time - shame had received limited quantitative empirical scrutiny (Cook, 1988). Cook (1996) developed the

scale based partly on the assumption that shame-proneness would be related to childhood experiences with parents that were shame-inducing, such as abuse or rejection. These emotional experiences would then be internalised and lead to a greater frequency and intensity of shame in later life. Based on this, the original version of the scale included 23 items referring to shame-inducing childhood experiences with parents, as well as 48 items which described the emotional experience of shame. Ultimately, the childhood items were discarded and only the shame experience items were retained, with the final revision having 30 items.

The 30 item Internalised Shame Scale (Cook, 1996) is a self-report measure which assesses two constructs; internalised shame (24 items) and self-esteem (6 reverse-coded items). The shame items typically refer to the generalised, global experience of shame as a self-conscious emotion, and take the form of 'I' statements (e.g., "I feel intensely inadequate"). Each of the items is rated along a 5-point Likert-type scale ranging from *Never* to *Almost Always*. It is common to omit the self-esteem items in studies concerned only with shame (Cunningham et al., 2019; N. D. Ross, Kaminski, & Herrington, 2019). The ISS has been used in dozens of empirical studies, particularly those which have an interest in trait shame (del Rosario & White, 2006; N. D. Ross et al., 2019).

Although the ISS appears to be a valid and reliable measure of trait shame (Cook, 1996; del Rosario & White, 2006), it was not chosen for the current thesis for a number of reasons. Principal among these was a preference for the Experience of Shame Scale's (ESS) greater breadth, covering a larger range of shame domains (e.g. body shame, characterological shame, etc.). An additional concern was that external shame was explicitly considered in the present research, and the ISS has a number of items in common (or partially adapted) with the Other As Shamer Scale (OAS), the only measure currently available to assess external shame. Indeed, in the original validation study for the OAS, the two measures showed a strong correlation (r=.81) (Goss et al., 1994), which is unsurprising given their shared developmental history. It was thus considered that these two scales might not be sufficiently distinct to be

employed within the same study, and as such the decision was made to use an entirely separate measure.

1.4.2.4 Other As Shamer Scale (OAS) (Allan, Gilbert, & Goss, 1994; Goss et al., 1994)

The Other As Shamer Scale (OAS) is the only measure available to assess external shame at the time of writing. As reviewed in previous sections, external shame refers to a shame experience which is predicated on the supposed negative evaluations of the self which are made by real or imagined others. In the original validation paper, Goss et al. (1994) argued that the measures which pre-dated the OAS were concerned primarily internal experiences or responses to shaming events, which ignored an important element of both theoretical and lay descriptions of shame; namely, that self-evaluations are related to, shaped by and informed by the perceived negative evaluations of others (Gilbert, 1998; H. B. Lewis, 1971).

The OAS was developed by adapting items from the Internalised Shame Scale, altering the wording such that internally-focussed items were shifted to an external viewpoint (e.g., "I feel other people see me as not good enough.", "I think others are able to see my defects."). It is intended as a measure of how respondents believe they are perceived by others. It is a self-report measure which contains 18 items, each of which is scored along a 5-point Likert-type scale ranging from 0 (*Never)* to 4 (*Almost* Always). Goss et al. (1994) reported a very high degree of internal consistency for the scale (Cronbach's α = .92). Matos et al. (2015) subsequently revised and shortened the OAS to create the OAS2, which retained 8 of the original 18 items, and which showed comparable internal consistency reliability (Cronbach's α = .82).

The OAS has consistently demonstrated good predictive and convergent validity, showing moderate to high correlations with other measures of shame, depressive symptoms, anger, anxiety, somatic complaints, and social dysfunction (Allan et al., 1994; Matos et al., 2015). Similarly, meta-analyses have demonstrated that OAS scores are associated with larger

effect sizes than internal shame measures in their relationship with depressive symptoms (Kim et al., 2011) and symptoms of social anxiety (Cândea & Szentágotai-Tătar, 2018).

The OAS was an essential component of the present research for several reasons. Chief among these is its clinical applicability insofar as it is related to psychopathology; however, it is also important to note that external shame has an intuitive link to the formation and maintenance of relationships – it stands to reason that an individual with high external shame may have more difficulty with the disclosure and vulnerability inherent in the therapeutic alliance. Given that the OAS was the only measure currently available to assess external shame, it was necessarily selected for the present research.

1.4.2.5 Experience of Shame Scale (ESS) (Andrews, Qian, & Valentine, 2002)

The development of the Experience of Shame Scale (ESS) was informed by two previous assessments: a set of interview prompts ("the shame interview") used by Andrews and colleagues (Andrews, 1995; Andrews & Hunter, 1997) and the TOSCA, detailed above. The instrument is comprised of 25 items which are divided into eight conceptual areas of possible shame, including: personal habits, manner with others, sort of person you are, personal ability, doing something wrong (moral transgressions), saying something stupid, failure in a competitive situation, and bodily shame. The measure is self-report, with each item being rated along a 4-point Likert-type scale, ranging from 1 *(Not at all)* to 4 *(Very much)*. Unlike the TOSCA's scenario-based items, each item on the ESS asks respondents to rate the extent to which they have had (or typically have) certain experiences (e.g., "Have you worried what other people think of the sort of person you are?", "Do you feel ashamed when you do something wrong?"). The ESS has generally shown excellent internal consistency reliability (Cronbach's α = .92 to .94) (Andrews et al., 2002; Matos et al., 2015) and is a frequently used measure of shame.

Although the ESS is a uniquely broad measure of shame, particularly in comparison to the TOSCA's restriction to morally transgressive scenarios, it is important to note that the ESS suffers from a similar conflation of avoidance and shame as seen in the TOSCA. Numerous

items within the measure specifically refer to avoidance behaviours (e.g. "have you avoided contact with anyone who knew you said something stupid?"), with higher responses being interpreted as indicative of greater dispositional shame (Andrews et al., 2002). Similar to the TOSCA, this fails to capture responses from individuals who may have felt an equal amount of shame, but been motivated towards reparative action, rather than avoidance.

Despite these criticisms, the ESS represents a more global, stable, and general evaluation of an individual's dispositional shame than previous measures, with the added advantage of assessing a range of domains which are typically recognised as shame-inducing. It has also been demonstrated to predict depressive symptoms to a greater extent than the TOSCA (Andrews et al., 2002), which the authors argued may have been related to its focus on domains of shame related to a person's identity ('self') rather than scenarios. As such, this measure was employed in all of the empirical studies which form part of this thesis.

1.4.2.6 Guilt and Shame Proneness Scale (GASP) (Cohen, Wolf, Panter, & Insko, 2011)

The Guilt and Shame Proneness Scale (GASP) represents a concerted effort by the researchers to disentangle the appraisal and motivational components of the two self-conscious emotions. This is intended to take into account the functionalist critique of earlier measures that they conflate shame with avoidance and guilt with reparation (approach), often within the same items. As such, it contains four subscales – two guilt subscales which assess negative behaviour evaluations (NBEs) and repair action tendencies respectively, and two shame subscales which assess negative self-evaluations (NSEs) and withdrawal action tendencies. The authors argued that this was necessary because "shame can and often does lead to avoidance behaviors, but shame can also lead to more positive approach-oriented actions as well." (Cohen et al., 2011, p. 948).

The GASP is a 16-item self-report trait measure of guilt and shame which, like the TOSCA, presents participants with a variety of scenarios in which they are asked to rate the likelihood they would respond in particular ways along a 7-point Likert-type scale from 1 (*Very*

unlikely) to 7 (*Very likely*). The negative self-evaluation (NSE) subscale comprises four items which are self-referential (e.g., "… this would make you feel like a bad person"), whereas the negative behaviour evaluations (NBE) subscale includes four items which are behaviour-referential (e.g., "… you would feel the way you acted was pathetic."). The remaining eight items are divided evenly between the withdrawal subscale (a tendency to avoid, e.g., "… you would avoid the guests until they leave") and the repair subscale (a tendency to try and make amends, e.g., "this would lead you to become more responsible about attending school").

Interestingly, in the original validation study, Cohen et al. (2011) found that while higher scores on the shame-withdraw scale were predictive of greater delinquent behaviours and lower scores on honesty, agreeableness, conscientiousness, and altruism, higher shame-NSE scores were related to *fewer* unethical decisions and *less* delinquent behaviour. This, among other similar results, led them to conclude that "[s]hame–withdraw measures the darker, maladaptive aspect of shame proneness, while shame–NSE measures the more moral, prosocial aspect of shame proneness." (p. 962). Despite this, they acknowledged that shame-NSE was not universally positive, as it was also correlated with greater neuroticism, personal distress, low self-esteem, low self-compassion, and rumination, whereas guilt-proneness (NBE) did not have these links.

Although the GASP provides novel information in the form of distinguishing action orientation from emotional response, it is arguably less relevant in cases where the source of shame is likely to be characterological, rather than moral (i.e., based on one's identity, rather than one's actions). Given that the focus of the current thesis was primarily within a clinical environment, where the expectation was that shame would be related to stable evaluations which are difficult to repair, this measure was not considered appropriate for this research.

1.4.3 Relating Shame to Working Alliance

Shame, with its conceptual links to interpersonal relationships, differential avoidance and reparative tendencies, concealment, and vulnerability, is an intuitively relevant

dispositional variable to examine in greater detail for its relationship with alliance. When encountered in a psychotherapeutic setting, shame is likely to be intense, longstanding, and aversive. This is related primarily to the fact that therapy is frequently a venue in which individuals are made vulnerable, and core aspects of identity and socially unsanctioned behaviour (e.g. drug use, self-harm) are key topics of conversation. Longhofer (2013) argued persuasively that shame-provoking experiences in therapy may present a significant risk of rupturing a nascent working alliance, owing to the tendency of shamed persons to withdraw, disengage or become defensive. Indeed, shame does appear to pose a barrier to disclosure and engagement in therapy: In studies which asked open-ended questions about reasons for non-disclosure, 18% (Kelly, 1998) and 53% (Hill, Thompson, Cogar, & Denman, 1993) of participants respectively referred to shame or embarrassment as a reason. Hook and Andrews (2005) reported that when "too ashamed" was available as a specific prompt, up to 76% of self-reported non-disclosers selected this option. Safran and Muran (1996) observed that therapists may unknowingly take part in interactions with clients which expose these shameful feelings. If these feelings are not anticipated and well-managed, they may then lead to the client perceiving the therapist as unempathetic, which itself presents a threat to the working alliance.

The role of the therapist in anticipating and managing shame has received some empirical scrutiny. For example, observer-ratings of recorded therapy sessions suggested that therapeutic encounters in which clients felt less well-liked featured fewer shame-inducing disclosures (J. C. Watson, Goldman, & Greenberg, 2007). As such, the "Bond" element of working alliance would be expected to be the most closely related to shame expressed in session, and the therapist's style of addressing this – accepting and empathetic versus confrontational or non-reactive – to be ultimately related to outcomes (J. C. Watson & Kalogerakos, 2010). This is compounded by findings that individuals with the highest levels of

expressed shame typically anticipate less support from counsellors, and may have more difficulty forming a bond in the first instance (DeLong & Kahn, 2014).

Within non-psychotherapeutic healthcare relationships, shame has received limited empirical attention, despite the call to action sounded by Lazare's (1987) article *Shame and Humiliation in the Medical Encounter* (Dolezal, 2015). This is surprising, given that the experience of medical interventions can – at times – be a venue for a variety of shame-inducing experiences which doctors must manage (Dolezal, 2015; Dolezal & Lyons, 2017; Stevens, 1996). These interactions frequently involve the revealing of normally private parts of the body, as well as the acknowledgement of illness, frailty, or vulnerability, which can be powerful triggers for shame (M. Lewis, 1995; Lindsay-Hartz, 1984). Medical encounters may also necessitate the shameful uncovering of perceived moral transgressions, insofar as patients may be fearful that their ailments will be judged as self-inflicted or brought about by their own failure to care for themselves (Gilbert & Miles, 2014; Harris & Darby, 2009).

With regards to patient factors, limited evidence has indicated that withdrawal-based shame coping styles – in which individuals deliberately avoid confronting and processing shameful feelings – are associated with lower-rated working alliance (Black et al., 2013), whereas other coping styles do not appear to have a similar relationship. Such findings support Longhofer's (2013) argument that the successful confrontation of shame in the therapeutic encounter helps to foster an alliance, whereas withdrawal and concealment are likely to pose a threat to a good working relationship. Confrontation of difficult emotions also presents opportunities for the 'tear and repair' events identified as being crucial for alliance development and successful therapy (Bordin, 1994; Gelso & Carter, 1994).

When assessing shame using psychometric scales, evidence suggests that the approach to measurement is important in detecting the anticipated relationship with disclosure. For example, with the Test of Self-Conscious Affect-3 (TOSCA-3) (Tangney et al., 1996), D. Hall and Farber (2001) did not find any link between shame-proneness and degree of

disclosure to therapists. By contrast, Hook and Andrews (2005) assessed shame-proneness using the Experience of Shame Scale (ESS) (Andrews et al., 2002) and were able to demonstrate that shame was related to both non-disclosure in a therapeutic setting and to current depressive symptoms, and that non-disclosure partially mediated the shame/symptoms relationship. A similar result was found by Swan and Andrews (2003), who reported that higher shame as assessed by the ESS was related to non-disclosure in a sample of women diagnosed with eating disorders. The reasons for these discrepancies may be partly related to the context-dependent, scenario-based measurement method employed by the TOSCA (as explored in the previous section), whereas the ESS is a specific measure of shame-proneness. Hook and Andrews (2005) argued that the TOSCA items may not be sufficiently focussed on shame to detect effects which could be discerned using a more direct measure, such as the ESS.

The mechanism by which dispositional shame may influence a therapy participant's decision to disclose or conceal treatment-relevant material is not yet fully understood, however DeLong and Kahn (2014) proposed that greater dispositional shame may lead to exaggerated perceived risks of making disclosures. In a study of 312 college students, they were able to demonstrate that higher shame-proneness predicted higher anticipated risk of disclosure as expected, and that outcome expectations substantially mediated the shame-disclosure relationship. As such, they argued that shame-prone individuals might reserve information for fear of negative or judgemental reactions from their therapist. This model has also emerged in qualitative work, which suggested that the main motivation for non-disclosure was the fear of being judged, misunderstood or thought of as "crazy" (Satterwhite, Lauer, Bakaeva, & Hill, 2017).

Interestingly, DeLong and Kahn (2014) also suggested that efficient and frequent addressing of outcome expectations may be a key point of intervention to reduce the impact of shame-proneness on disclosure via the mechanism of perceived risk. In a series of semi-

structured interviews with 85 women who were primary care patients, Sankar and Jones (2005) had a similar finding; in addition to emphasising non-judgement and sensitivity, participants highly valued clear and frequent explanations of why healthcare providers might ask particular questions, and what purpose the information would serve. These recommendations echo working alliance theory's focus on agreement on goals and tasks, as well as the underlying bond.

Ultimately, the research evidence which is currently available points strongly in the direction of a complex and multi-directional relationship between shame, working alliance, and patient engagement with healthcare. Further research is needed to determine the nature of this relationship and how it may function, the results of which may facilitate clearer guidelines for clinicians on how to detect and respond to dispositional shame. It is hoped that such recommendations may assist in the development of robust working alliances, and the range of benefits which such alliances confer.

1.5 Aims of Thesis

The aim of this research was to determine whether there was any meaningful relationship between a patient's dispositional shame and the working alliance which develops between that person and their healthcare provider. It is well-evidenced that working alliance is an important 'common factor' in the successful treatment of mental disorders and it is also increasingly recognised as essential in the treatment of physiological illness. As such, ongoing research is needed to determine which characteristics may threaten the development of a robust alliance, allowing clinicians the possibility of addressing these directly in the early stages of treatment.

Based on this, the first objective was to explore past research examining shame and working alliance, both directly and peripherally, to obtain a better understanding of the state of the evidence up to the present day. The results of this review would inform a pilot study, which would seek to clarify whether patients' retrospective evaluations of their alliance with

primary healthcare providers was related to their assessed level of dispositional shame. If the pilot study were successful, it would be followed by a second retrospective study which examined the same variables in the context of a psychotherapy relationship, as well as expanding the variables assessed to include hypothesised mechanisms linking shame and alliance (e.g., willingness to disclose distressing information, both specific and general). Finally, the combined results of this research would inform an ongoing study in a clinical setting. This study would include real-time (session-to-session) evaluations of alliance from both a client and clinician perspective, as well as a range of shame and disclosure measures, with the intent of conducting an *in vivo* assessment of the hypothesised relationship between shame and alliance.

The results of the thesis were intended to assist in the development of competency-based training programs for a variety of healthcare professionals, but particularly those working in psychological therapies. A better understanding of how therapeutic alliance relates to dispositional characteristics would assist clinicians to identify and target these characteristics for treatment, as well as respond in a more thoughtful and considered way during the therapeutic encounter.

CHAPTER 2. STUDY ONE: WORKING ALLIANCE AND SHAME: A SCOPING REVIEW

2.1 Preamble

The aim of Study 1 was to undertake a thorough review of all past literature which quantitatively examined the hypothesised relationship between dispositional shame and working alliance. As such, the search terms were kept deliberately broad and research from a variety of disciplines and databases was ultimately included. The methodology of a scoping review was chosen in recognition of identified lack of past research which synthesised knowledge or commented authoritatively on shame's relationship with the working alliance. This review was conducted partially concurrent with study 2 (pilot study) and due to the long search period, was able to include results from study 2 when it was published in 2019. It was anticipated that this scoping review would identify key measures used in the area, as well as establishing a baseline of what was known about the relationship between shame and alliance which would then be built upon by subsequent studies.

2.2 Statement of Authorship

Title of Paper	Working Alliance & Shame: A Scoping Review
Publication Status	Submitted for Publication
Publication Details	Health Psychology Review

Principal Author

Principal Author (PhD Candidate)	Daniel Carabellese
Contribution to the Paper	Reviewed literature and prepared aims and hypotheses. Planned and executed major elements of the research, including designing initial search strategies, conducting searches, and reviewing titles, abstracts and full-text papers. Writing and editing of the manuscript in collaboration with supervisors. Submission of the manuscript to journal and implementation of subsequent revisions. Corresponding author for the paper.
Overall percentage	90%
Certification	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is

	not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.
Signature	
Date	2021-02-15

Co-Author Contributions

By signing the Statement of Authorship, each author certifies that: i. the candidate's stated contribution to the publication is accurate (as detailed above); ii. permission is granted for the candidate in include the publication in the thesis; and iii. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.	
Co-Authors	Dr Michael Proeve Associate Professor Rachel Roberts
Contribution to the Paper	Supervisors of the PhD research program. Oversaw research conceptualisation and planning, including revision of search strategies. Provided regular supervision and discussion of research process. Collaborated in developing the content and structure of the published manuscript, and reviewed drafts. Provided supervision and guidance around adapting and responding to reviewer comments.

Signatures

Date 1 March 2021	Michael Proeve
Date	Rachel Roberts Rachel Roberts Digitally signed by Associate Professor Rachel Roberts Date: 2021.03.01 16:18:25 +10'30'

2.3 Submitted Manuscript

2.3.1 Title Page

Title: Working Alliance and Shame: A scoping review

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Keywords:

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Data availability statement:

Data sharing is not applicable to this article as no new data were created or analysed in this study. Materials are provided in Table 1 and Appendix B which allow the total reproduction of the searches which comprise the data for this scoping review. Database listings and inclusion criteria are included in the Abstract and Methods sections of the paper.

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2.3.2 Abstract

Shame is frequently evoked in healthcare contexts and has attracted an increasing amount of research interest over the last decade. Concurrently, researchers have sought to understand which variables influence healthcare consumers' working relationship with care providers – the working alliance. The potential impacts of shame on the formation of a robust alliance are unknown. Accordingly, this scoping review investigated empirical evidence assessing the hypothesised relationship between these variables.

A scoping review methodology was used. This included a systematic search of published literature in the databases PubMed, PsycInfo, Embase and CINAHL. A grey literature search was also completed. Studies were included if they were quantitative in nature, in English, assessed healthcare relationships, assessed shame, and described or assessed the relationship between shame and healthcare relationships. The observed findings were then combined to form a synthesis.

Thirteen studies were identified which met criteria. All had been conducted in the last two decades. The most used measure of healthcare relationships was the Working Alliance Inventory (WAI), whereas shame was assessed with a variety of measures. The majority of studies showed small, negative correlations between shame and healthcare relationships, or their proxies.

Greater shame appeared to be modestly negatively related to perceived quality of healthcare relationships; however, the data were preliminary in nature. Substantial further research is required. Recommendations were offered for optimising future research, such as using validated measures, assessing multiple perspectives, and taking measurements over time.

2.3.3 Introduction

Working alliance as a predictor of positive outcomes in psychotherapeutic interventions is one of the best-evidenced and most reliable findings in psychological research (Doran, 2016; Flückiger et al., 2019; Fluckiger et al., 2012). Similar results have been found in medical research, where stronger alliance has been demonstrated to predict treatment adherence and satisfaction with treatment (J. K. Bennett et al., 2011; Fuertes et al., 2015; Fuertes et al., 2007). With the relationship of alliance to health outcomes now well-established, the present challenge is the identification of variables which may affect the development of a robust alliance and which could ultimately be subject to targeted interventions. Of these, many are 'dispositional' variables – that is, they are represented by healthcare consumers' tendencies to react or respond in certain ways based on underlying qualities of their personalities. Some examples of this may include generalised anticipated support from others, traits consistent with personality disorders, agreeableness, openness, extraversion, and conscientiousness (Coleman, 2006; DeLong & Kahn, 2014; Taft, Murphy, Musser, & Remington, 2004). One of the most impactful dispositional characteristics in terms of interpersonal relationships is shame (DeLong & Kahn, 2014; Dempsey, 2017; Dolezal, 2015; Tangney, 1995), and it is the theorised relationship between shame and working alliance in healthcare relationships that is the focus of this scoping review.

In psychological research, shame is typically conceptualised as a self-conscious emotional experience. It is seen as a social emotion (i.e., felt in reference to social norms) which is related to the whole identity of a person (Gilbert, 2003). It is also said to be experienced in response to failure to meet ideals, which can be contrasted with guilt, which is generally viewed as being related to specific behaviours rather than identity, and arguably relates more to prohibited behaviours than personal or social standards (H. B. Lewis, 1971; Teroni & Deonna, 2008).

Shame has also been recognised as the most aversive of the self-conscious emotions (Wicker et al., 1983), which is "painful, never pleasant" (Young, 1991, p. 498), and a distressing burden (Morrison, 2011). Shame is incapacitating and overwhelming, accompanied by feelings of physical smallness, sweating, burning, freezing and weakness (Lazare, 1987), a sense of the slowing of time, being exposed and vulnerable (Lindsay-Hartz, 1984), sensations of melting through the floor, having no physical boundaries (Young, 1991), being like a physical blow, and other similarly evocative imagery (Dickerson et al., 2004; Wicker et al., 1983).

It is important to acknowledge that the precise nature of shame as a dispositional variable is still subject to debate (Leeming & Boyle, 2004); however, theorists typically agree that it refers to the general tendency to experience the emotion of shame (or not) in situations which are commonly thought of as "shame-provoking". It can also refer to generalised or enduring feelings of shame which persist without specific provocation (Andrews, 1998). The presence of a generalised tendency to experience shame (i.e., dispositional shame) has also historically been associated with difficulties in interpersonal relationships, impaired empathy, tendency to externalise blame, and anger and hostility (Tangney et al., 1995; Tangney et al., 1992). Given the relevance of shame in relationships, it is intuitively appealing to hypothesise that it would have some bearing on the relationship between healthcare providers and those accessing care, and thus the working alliance which forms part of this relationship.

Arguably the most influential model of working alliance was devised by Bordin (1979), who identified three factors: client-practitioner agreement on the specific goals of treatment; client-practitioner agreement on which tasks are best suited to accomplish those goals; and the relational bond between the client and practitioner, which is generally characterised by feelings of liking, trust and empathy. Hatcher and Barends (2006, p. 293) defined this model of working alliance as "the degree to which the therapy dyad is engaged in collaborative, purposive work". This definition of alliance was used to inform the search strategy and inclusion criteria of the present research.

It is important to acknowledge that alliance research is drawn from a broad range of literature, from aged care research (Boggatz, Farid, Mohammedin, & Dassen, 2009) to medical treatment (Fuertes et al., 2007) and of course to psychotherapy, where it first emerged (Flückiger et al., 2019). As much as possible, the original terminology of the research has been preserved in this paper. As such, terms such as 'patient', 'client', 'healthcare consumer' and others are used. Similarly, the original roles of clinicians are respected, and terms such as 'doctor', 'therapist', 'clinician' and 'counsellor' appear in the text.

Psychotherapy research has borne out the importance of working alliance as one of the most reliable predictors of successful therapeutic interventions, and a factor which facilitates the success of almost all treatment approaches in reducing symptoms of mental illness, retaining clients for the duration of treatment, and ensuring clients are satisfied with their care (Arnd-Caddigan, 2011; Doran, 2016; Fluckiger et al., 2012; Horvath et al., 2011; Martin et al., 2000; Tetzlaff et al., 2005). Although the majority of working alliance research has been in psychotherapy settings, these findings appear to be consistent with those in medical studies, with increasingly robust evidence supporting the predictive power of working alliance in a range of areas (J. K. Bennett et al., 2011; Fuertes et al., 2015; Fuertes et al., 2007). Specifically, medical patients with stronger alliances appear to have a more favourable perception of the utility of treatment, greater adherence to treatment plans, and greater satisfaction with treatment (Fuertes et al., 2007; Fuertes et al., 2017).

Ultimately, healthcare consumers of many kinds reporting a poor working alliance are less likely to show symptom improvement, stay in treatment for the appropriate time period, or report that they are fully satisfied with the care they receive. Therefore, healthcare professionals have a responsibility to identify any threats to the alliance to allow these to be mitigated, to ensure that treatment is as successful as possible.

With specific regard to working alliance (as an element of healthcare relationships) and shame, Longhofer (2013) argued that therapeutic encounters with shame-prone clients might

present a greater risk of rupturing a nascent alliance. In a review focusing on lesbian, gay, bisexual, transgender and queer clients, he argued that identity-related shame was a crucial factor for the clinician to monitor for the development and maintenance of a robust working alliance. Safran and Muran (1996) similarly observed that therapists who unknowingly expose shameful feelings might cause clients to view the therapist as unempathetic, and therefore lead to ruptures in the alliance. This risk appears to be particularly acute in populations who may already face stigma or have suffered public denouncements, such as LGBTI persons (as highlighted by Longhofer, 2013) and individuals accused of sex offences (Serran, Fernandez, Marshall, & Mann, 2003). Indeed, such populations are known to face community condemnation, which has previously been demonstrated to foster greater feelings of shame (Serran et al., 2003) and to lead to disengagement from treatment in a broader healthcare context (Harris & Darby, 2009).

There is some evidence to suggest that the approach of the therapist may also be relevant in shame/alliance relationships. For example, a study in which observers reviewed and rated six recorded case studies suggested that therapeutic encounters in which clients felt less well-liked featured fewer potentially shame-inducing disclosures, which seems to suggest that feelings of liking may be related to willingness to disclose (J. C. Watson et al., 2007). As such, the "Bond" element of working alliance would be expected to be the most closely related to shame expressed in session, and the therapist's style of addressing this – accepting and empathetic versus confrontational or non-reactive – to be ultimately related to outcomes (J. C. Watson & Kalogerakos, 2010). This is compounded by findings that individuals with the highest levels of expressed shame typically anticipate less support from counsellors, and may have more difficulty forming a bond in the first instance (DeLong & Kahn, 2014).

Although it has long been recognised that shame is relevant in the development and maintenance of mental illness (H. B. Lewis, 1971), shame research has become more prominent in the last 20 years and has contributed significantly to the development of a number of

therapeutic approaches which focus on the concept of self-compassion (Kirby, 2017). Therapeutic approaches such as Compassion-Focused Therapy (Gilbert, 2009) and Mindful Self-Compassion (Neff & Germer, 2013), as well as the self-compassion components of Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 2009) explicitly identify high levels of shame and self-criticism as treatment targets. The existence of such targeted interventions for shame as a pathological process provided significant motivation for the present scoping review. If it is indeed the case that high levels of dispositional shame may result in treatment avoidance or threaten the development of a nascent therapeutic alliance, this information may provide a valuable incentive to prioritise addressing shame therapeutically in the pursuit of a strong alliance. The main aim of the present scoping review was therefore to identify and summarise what is known regarding the relationship of shame with working alliance in healthcare relationships.

2.3.4 Methods

The format of a scoping review was chosen based on the results of initial searches, which failed to locate any narrative reviews, systematic reviews or meta-analyses which assessed relationships between shame and working alliance. In such situations, a scoping review is the preferred research design (Arksey & O'Malley, 2005; Peters et al., 2015). The purpose of a scoping review is to rapidly but systematically survey and summarise the available research in emergent areas. Generally speaking, the methodology involves iterative searches in which the search criteria are modified according to what is found in the early phases of review, followed by close review, and summarising of the available data. The present study's research design was guided by literature addressing rigor in scoping reviews (Levac, Colquhoun, & O'Brien, 2010; Pham et al., 2014) with particular reference to Tricco and colleagues' (2018) PRISMA extension for scoping reviews (PRISMA-ScR). A PRISMA-ScR checklist is available at Appendix A.

2.3.4.1 Research Question

The research question, “What is known about the relationship between shame and working alliance?” was chosen to maintain a broad scope and maximise the range of literature available for review. Working alliance was defined broadly, with the intent of including any collaborative, purposive relationship between a healthcare provider (of any kind) and a person accessing healthcare, rather than solely between mental health clinicians and their clients, despite this being the population most commonly associated with working alliance (Flückiger et al., 2019).

2.3.4.2 Search Strategy

The search strategy was developed by and implemented by the first author in consultation with a senior research librarian, with supervision and review by the second and third authors. There was no fixed date restriction on the search, and as such the screening date range was 1831 to April 2020. The search terms were developed based on key references in the areas of shame and working alliance respectively (Flückiger et al., 2019; Gilbert, 1998, 2003; Horvath et al., 2011; H. B. Lewis, 1971; Tangney, 1995; Tangney et al., 1995). Major healthcare-related databases PubMed, PsycInfo, Embase, and CINAHL were searched. The original search was conducted in January 2019; however, an ongoing alert was monitored for all databases with relevant citations added to the data until the final search on the tenth of May 2020.

It was decided that the search terms should be kept sufficiently broad to capture any literature which might make oblique references to ‘shame’ or ‘working alliance’, as it was noted that the term ‘working alliance’ was less commonly used in medical literature as compared to psychological literature. As such, terms such as “interpersonal relat*”, “doctor patient relat*” and “physician attitude” were included. Where possible, Boolean strings with truncated search terms were used to ensure that the search captured terms with the same root words (e.g., “relat*” for “relations”, “relationships” etc.). No fixed theoretical perspective or conceptualisation of shame was imposed, with the intent of surveying the literature as

completely as possible. Database-specific search terms (including exploded terms) and specified subject fields were included or substituted for generic terms when these were available. Database-agnostic final search terms are presented alongside an example logic grid (PubMed) in Appendix B.

Grey literature searching included two databases of past research theses (*ProQuest Dissertations & Theses Global* and *Dissertation Abstracts International*) and the grey literature-specific database OpenGrey, but excluded conference papers, government reports, magazines, newspapers, and commercial websites due to the low likelihood of these sources meeting inclusion criteria.

After removal of duplicates, search results were assessed for eligibility through an initial title/abstract screen. Articles identified as potentially meeting the inclusion criteria were subsequently subjected to full text review. To ensure the comprehensiveness of this search, reference lists of any eligible articles were then reviewed for studies not identified in the original search. Corresponding authors from each of the included full text screened papers were then e-mailed with requests to identify any unincluded papers they were aware of which would meet the inclusion criteria, which identified no additional papers. Figure 1 shows a PRISMA (Moher, Liberati, Tetzlaff, Altman, & Group, 2009) flowchart summarising this process.

2.3.4.3 Study Selection

To be included, articles were required to meet the following criteria**:** a) original quantitative research either published in a peer-reviewed journal or identifiable in grey literature searches; b) written in English; c) include an empirical measure of shame, either a validated or unvalidated quantitative measure; d) include an assessment of working alliance (i.e. the collaborative, purposive relationship between a healthcare provider and person accessing healthcare), or an appropriate proxy such as engagement with treatment; e) be specifically concerned with healthcare or the provision of health services; f) examine, assess or comment on, in some way, the relationship between shame and working alliance.

When assessing grey literature, conference proceedings, books/book sections and reviews were examined for links to peer-reviewed journal articles but were not themselves included.

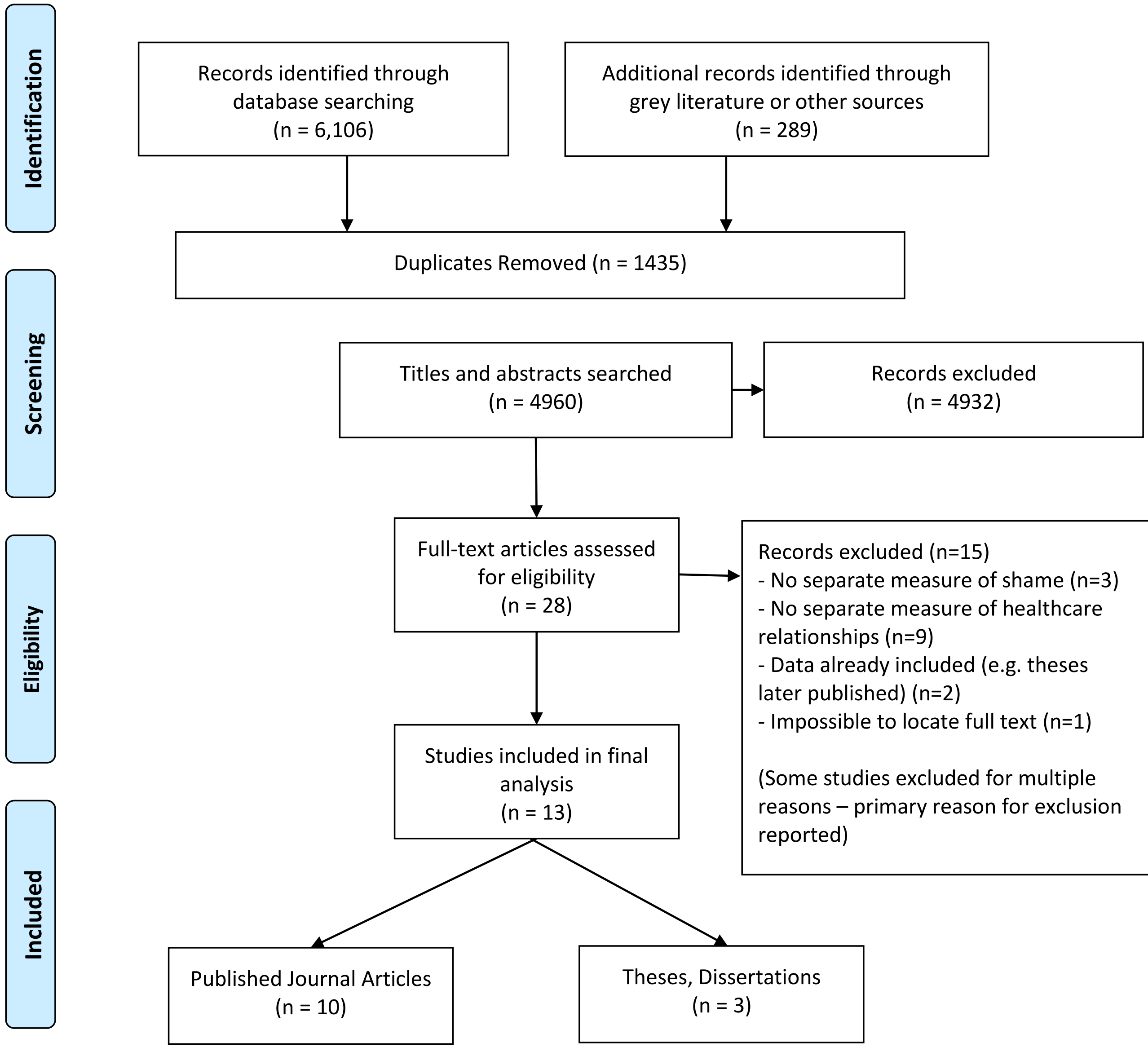

Figure 1.
PRISMA-ScR (Moher et al., 2009 & Tricco et al., 2018) flow chart of study screening and selection.

It was decided that the inclusions would be limited to quantitative studies in recognition of the fact that 'shame' and 'relationships' are sufficiently broad topics as to be included peripherally in such a volume of studies that the time required for full-text review would be prohibitive. Furthermore, the intent of this research was to review the state of

empirical assessment of these variables. Nevertheless, a variety of qualitative papers were reviewed by the authors to assist in the development of search terms and inform the final inclusion criteria.

Ultimately, 4960 papers were reviewed at the title and abstract level, 28 at the full-text level, and 13 were found to meet final inclusion criteria, of which three were unpublished dissertations (see Fig 1).

2.3.4.4 Charting the Data

Following the PRISMA-ScR recommendations (Tricco et al., 2018), a data chart was developed to summarise key information about each study included in the review. Each study was summarised according to Study, Country, Participant Group/Clinical Population, Focus/Aim of Study, Design/Methods, Measurement of Healthcare Relationships and Measurement of Shame. Additional information was added iteratively as findings were synthesised. Finally, a second section was added which summarised the significant findings regarding the relationship between healthcare relationships and shame. Any commentary on the shame-alliance association was included in this section upon review by the first author, and the level of detail subsequently revised in consultation with the second and third authors. Table 1 shows the final version of this chart.

2.3.5 Results

2.3.5.1 Nature & Distribution of the Studies

Ten published papers and three unpublished doctoral theses were included in this review, for a total of 13 included studies. Twelve of the included studies were cross-sectional designs, whereas one was a time-series design. The data were drawn from a relatively broad range of geographical and cultural settings; although the USA had the strongest representation with five (39%) studies, including the three doctoral theses. Two of the included studies were published in the United Kingdom and one each from Egypt, Sweden, Finland,

Germany, Italy, and Australia. The earliest paper included dated from 2002, whereas 12 (92%) had been published since 2009.

2.3.5.2 Sample Characteristics and Power

The majority of studies (seven, 54%) included participants who were engaged in psychological treatment, although the presenting problem varied (general mental health, substance abuse, sexual trauma, alcohol use) as did the method of recruitment (community advertising, recruited from treatment programs, Amazon Mechanical Turk). The remaining study populations were highly varied, with one each of older persons, medical patients, adolescents, patients of general practitioners, and college students and community members.

Given that the relationship between shame and alliance is not presently well understood, it would arguably be of benefit to seek sufficient power to detect even modest effect sizes. Where relationships between working alliance and shame were assessed, the majority of studies did so with correlational analyses. A conservative power analysis suggests that a sample of approximately 120 participants would be required to detect a small correlation (r =.20) with power (1 - β) set at .80 and α = .05 (Hulley, Cummings, Browner, Grady, & Newman, 2013). All included studies were appropriately powered to detect an effect of this size, with the exception of Nelson (2012, N=24), Black et al. (2013, N=50) and Gooch (2018, N=27).

2.3.5.3 Measurement of Working Alliance and Shame

Eight measures of working alliance were identified in the 13 studies shown in Table 1. The most utilised measure was the Working Alliance Inventory, with eight of the studies employing some variant. One study employed the full, 36-item WAI, with five using the WAI-S (Tracey & Kokotovic, 1989), one using the WAI-S Bond subscale, and one using the WAI-SR (Hatcher & Gillaspy, 2006). Three studies used subscales of other questionnaires, which variously measured communication competence, staff interactions, feelings of autonomy, and healthcare stress. Two studies used unvalidated, study-specific measures; one a 3-point Likert-

type scale asking participants to rate care acceptability (i.e., perceived appropriateness of the type of care provided), and one a checklist of negative experiences with doctors.

It is important to acknowledge that several of these scales represent imperfect or incomplete proxies for true assessments of working alliance. In each of these cases, the assorted measures were considered by the authors of this review to map adequately onto one or more of the three domains of working alliance defined by Bordin (1979). For example, Hamann et al. (2017) employed the Autonomy Preference Index (API, Ende, Kazis, Ash, & Moskowitz, 1989), a measure which assesses healthcare consumers' preference to follow the guidance of their doctor versus make their own decisions, as well as their desire to be well-informed regarding their treatment. Hamann et al. (2017) also employed the validated German Communication Competence Questionnaire (CoCo) (Farin, Schmidt, & Gramm, 2014) which assesses (among other things) a patient's perception of their ability to pose questions about treatment and communicate actively in the healthcare relationship. Combined, these two measures were considered sufficiently similar to Bordin's (1979) agreement on tasks and agreement on goals of treatment to be included, although it is important to acknowledge that neither measure pertains to a specific healthcare practitioner or encounter: the API assesses preference rather than rating, and the CoCo is a general assessment of a patient's self-perception. As such, these results should be interpreted with caution.

Similarly, the 'Healthcare Stress' Questionnaire created by Mensinger et al. (2018) was developed to assess the level of stress experienced by a healthcare consumer when contemplating interacting with a healthcare provider. As with the CoCo, this measure is general in nature and does not pertain to a specific healthcare encounter or provider. The authors of this review considered this an adequate assessment of a generalised level of liking and trust towards healthcare providers (i.e., Bordin's 'Bond' dimension), however it must be noted that consumers might experience stress about healthcare interactions for a variety of

reasons independent of their relationship with their provider. Once again, these results must then be interpreted with caution in the context of this review.

Shame was assessed with a range of both empirically validated and unvalidated measures. The most commonly used measures were the Test of Self-Conscious Affect 3 (TOSCA-3, Tangney, 1989) shame subscale, the Experience of Shame Scale (ESS, Andrews, Qian, & Valentine, 2002), Compass of Shame Scale (CoSS, Elison, Lennon, & Pulos, 2006), and Other As Shamer Scale (OAS, Goss, Gilbert, & Allan, 1994), each of which was used in two studies in the sample. The Internalised Shame Scale (ISS, Cook, 1988) and Weight, Eating, and Body-Related Shame and Guilt Scale (WEB-SG, Conradt et al., 2007) each appeared in one study, as did the Shame and Guilt subscale of the Patient Dental Staff Interaction Questionnaire (PDSIQ, Jaakkola et al., 2014) . Three studies employed single-item, unvalidated shame measures, typically consisting of a Likert-type scale or categorical response item which asked participants to rate how ashamed/shamed they felt under a specific circumstance.

The Self-Hate dimension of the Interpersonal Guilt Rating Scale-15 Self Report (IGRS-15s, Gazzillo et al., 2018) was also considered a shame measure for the purposes of this review and was included in one paper. It was treated as a measure of shame despite the fact that the authors described it as a measure of guilt. This was related to the provided definition of 'Self-hate'; "based on the pathogenic beliefs of being bad, rotten, inadequate, and worthless… this is a self-accusation about what one is, rather than what one has done or might potentially do" (Faccini et al., p. 81). This description has a great deal in common with well-established theoretical descriptions of shame – specifically, that shame refers to a global, characterological experience which is concerned directly with the self (H. B. Lewis, 1971; Tangney & Dearing, 2002). This can be contrasted with guilt, which is generally theorised to be concerned with a person's behaviour, a distinction which is sometimes summarised as "I am bad" (shame) versus "I did a bad thing" (guilt). The resemblance of the 'Self-hate' dimension to other included shame measures warranted its inclusion in the review.

Table 1.

Data collection table of descriptive information, including key outcomes regarding healthcare relationships and shame.

Year	1st Author, Location, Type	Participant Group or Clinical Population	Focus & Aims	Design & Methods	Measurement of: Working Alliance	Measurement of: Shame	Key Outcomes (RE: Shame & Working Alliance)
2002	Farber, USA, Journal Article	Current psychotherapy patients (*N*=147), recruited from a pool of graduate students, interns, psychiatric residents, and their acquaintances, as well as recruitment by questionnaires displayed in several psychotherapist waiting rooms.	Investigate the extent to which clients disclose various topics to their therapists, and to examine the effects of gender, shame-proneness, and therapeutic alliance on disclosure.	Cross-sectional study; survey; single sample; recruited over unspecified time period. Current self-report (patients currently receiving therapy). Correlation analyses.	WAI-S (Client) (Tracey & Kokotovic)	TOSCA-3 Shame Subscale	No correlations reported for shame and therapeutic alliance, however strength of alliance was associated with overall disclosure (*r*=.28) as well as tendency to discuss various themes regarded as shame-provoking, such as negative affect and intimacy (*r*s ranging from .28 to .35). No significant correlations were found between shame and total disclosure (*r*=-.03, non-significant).
2009	Boggatz, Egypt, Journal Article	Older persons receiving home care or staying in a nursing home (N=344) and non-care recipients (N=267).	Determine which factors were related to the acceptance of home care and nursing homes among older Egyptians.	Cross-sectional study; survey; two group comparative design; single time point; self-report. Binary logistic regression analyses.	Unique 3-point Likert-type scales assessing acceptance of receiving home care and acceptance of staying in a nursing home.	Single item, 3-point Likert-type scale with a question about the feeling of shame while receiving care from non-family members.	Decreased feelings of shame were related to increased acceptance of home care for both non-care recipients (adjusted Odds Ratio: 2.95) and care recipients (adjusted Odds Ratio: 1.43). The same result was found for acceptability of nursing home care for non-care recipients (adjusted Odds Ratio: 1.73) and care recipients (adjusted Odds Ratio: 1.76).

2012	Nelson, USA, PhD Dissertation	European Americans, aged 21-60 (*N*=24), with a primary diagnosis of substance abuse or dependency.	Investigate whether client shame, working alliance, and aftercare support interact to impact substance abuse treatment outcomes.	Time-series design (measures taken at admission, end of treatment, and 6 months post-treatment; working alliance assessed only at end of treatment); pen-and-paper questionnaire; correlation analyses, multiple regression analyses.	WAI(C) - original 36-item inventory (Horvath & Greenberg)	Internalised Shame Scale (ISS), Shame subscale (24 items)	No statistically significant correlations were found between ISS scores and WAI scores (*r*=-.01, non-sig), suggesting no relationship between these variables in this sample.
2013	Black, UK, Journal Article	Adults receiving treatment for common mental health difficulties (*n*=50) in a clinical psychology service.	Examine the role of shame coping styles and state shame in predicting therapeutic alliance and intimate relationship functioning.	Cross-sectional study; in-person questionnaire/interview; single sample; single time point. No fixed number of therapy sessions required (between 3 and 30 attended, M=9, SD = 5). Hierarchical multiple regression analyses and correlation analyses.	WAI-S (Client) (Tracey & Kokotovic)	Compass of Shame Scale, one time point.	Shame coping style of withdrawal was negatively correlated with therapeutic alliance (*r*=-.32). No significant relationships were found between therapeutic alliance and state shame, or other shame coping styles. Withdrawal shame coping style accounted for 11% of the variance in therapeutic alliance in a hierarchical regression model.
2013	Lynoe, Sweden, Journal Article (Brief report)	Long-term sick-listed patients in Sweden (N=5802) of whom 1628 had experienced negative encounters with doctors.	Examine if the appearance of shame in a healthcare setting could be interpreted as a reaction to having one's honour wronged.	Cross-sectional study; survey; single sample; single time point. Retrospective self-report. Relative and attributable risk analysis with a 95% CI using a modified Poisson model.	Self-report of "feeling wronged" (categorical yes/no measure) in relationships with doctors, plus a 23-item checklist of negative experiences, such as "not believing in me, doubting my condition, treating me as stupid, questioning my motivation to work".	Self-report of "feeling shamed" (categorical yes/no measure).	Of those who reported feeling shamed, 93% also felt wronged. The relative risk for shame (4.5) was greater than for other emotional reactions. Almost all who felt ashamed had also been wronged.

2014	Jaakkola, Finland, Journal Article	A population-based sample of 18-yr-old adolescents (N = 773) as part of the Finnish Family Competence Study (FFCS)	Explore whether subjective perception of interaction with dental staff is associated with dental fear in the target population.	Cross-sectional study; questionnaire; single sample; single time point; self-report. Exploratory Factor Analysis, Confirmatory Factor Analysis, Univariate and Bivariate Logistic Regression analyses.	Modified Dental Anxiety Scale (MDAS), which includes items such as; "If you went to your dentist for treatment tomorrow, how would you feel?" and "If you were sitting in the waiting room (waiting for treatment), yow would you feel?", which are rated along a 5-point Likert-type scale from 0 (Not anxious) to 5 (Extremely anxious). Sub-factor of the Patient Dental Staff Interaction Questionnaire named by the authors as "kind atmosphere and mutual communication".	Sub-factors of the Patient Dental Staff Interaction Questionnaire, named by the authors as "Shame and Guilt".	Those in the High Dental Fear group also experienced greater shame and guilt, among a range of other factors, compared to those in the Low Dental Fear group (Univariate OR [95% CI]: 2.1 [1.1–4.1], Multivariate OR [95% CI]: 1.9 [1.0–3.7]). Correlations between factors "shame and guilt" and "kind atmosphere and mutual communication" were small and negative (-.22), suggesting that positive perceptions of atmosphere and communication were negatively related to shame and guilt.
2017	Simonds, UK, Journal Article	Members of a UK eating disorder charity database who were aged 16+ (*N*=120) and had received psychotherapy for eating problems (current or past).	Assess perceived helpfulness of therapist self-disclosures with current eating disorder symptoms severity through therapeutic alliance, patient self-disclosure, and shame.	Cross-sectional study; online questionnaire; single sample; single time point. Retrospective self-report. Correlation analyses and serial multiple mediation analyses.	WAI-S (Client) (Tracey & Kokotovic)	Experience of Shame Scale	Total shame was negatively correlated with working alliance (r=-.20), as was the 'eating shame' subscale (r=-.22). Mediation suggested therapist disclosure affected eating problems through therapeutic alliance, patient self-disclosure, and shame.

2017	Hamann, Germany, Journal Article	Participants with either a schizophrenia spectrum disorder (N=126) or an affective disorder (N=203) diagnosis, from inpatient and outpatient departments of psychiatric hospitals and practitioners in Germany.	To assess whether self-stigma and shame were associated with patients' participation preferences and behaviour in consultations, with particular reference to Shared Decision Making.	Cross-sectional study; questionnaire; two samples; single time-point; self-report plus ratings provided by treating physicians. Correlation analyses, Linear Regression Analyses, Structural Equation Modelling.	Autonomy Preference Index (Desire to Participate in Decision Making), plus Communication Competence Questionnaire (adherence in communication, critical and participative communication, and disease related communication), representing an assessment of willingness to participate in clinical decision making, express opinions in treatment, and overall communicative relationship with the doctor.	One self-report item; "I am ashamed to have a mental illness", rated from 1 (not at all) to 9 (very much).	Shame was negatively correlated with Critical and Participative communication (r=-.28) and Active Disease-related communication (r=-.18), but no significant correlation was found with Adherence in Communication (r=-.08, not significant). Self-stigma and shame were associated with reduced critical and participative communication.
2018	Mensinger, USA, Journal Article	Females aged 25-85 years (*N*=313) recruited from a US-based healthcare research panel co-ordinated by a Qualtrics Project Manager.	To develop and test a model of variables linking body mass index (BMI) and healthcare avoidance, based on Stereotype Threat Theory and Social Identity Threat.	Cross-sectional study; online survey; single sample; single time-point (responses gathered over two weeks); self-report. Correlation analyses and path analyses.	Healthcare Stress Questionnaire (developed by the authors), which asks respondents to rate their level of stress from 0 (No stress) to 10 (Very stressed), with statements such as "When you think about going to see your healthcare provider for a wellness visit." Also, Healthcare Avoidance Questionnaire (developed by the authors) rated along a scale from 1 (Always) to 5 (Never), with statements such as "Do you receive annual wellness visits with your primary care provider?"	The 12-item Weight, Eating, and Body-Related Shame and Guilt Scale (WEB-SG; Conradt et al., 2007)	Body-related shame was positively correlated with Healthcare Stress (r=.30), but not directly with Healthcare Avoidance (r=−.07, not significant), suggesting that medical visits are experienced as more stressful for participants with greater body-related shame. Indirect association between body related shame and healthcare avoidance through healthcare-related stress.

2018	Gooch, USA, PhD Dissertation	Female survivors of sexual trauma aged 18 and older (*N*=27) recruited from a Group Treatment programs at a Rape Crisis Centre.	Examine relational group psychotherapy processes as crucial components of the treatment of sexual trauma survivors.	Cross-sectional study; questionnaire-based; five groups combined into single sample; multiple time points during treatment (5, 10, 15, 23 weeks). Growth curve modelling in HLM.	WAI-S (Client) (Tracey & Kokotovic) Bond subscale (4 items) - modified to replace "therapist" with "group leaders", plus Group Cohesion Questionnaire (GCQ).	Compass of Shame Scale (CoSS)	No statistically significant decreases in group members perceptions of shame reactions over time were evident in the data. The hypothesised relationship between group cohesion and shame reactions was also not supported, with no statistically significant relationships. The text did not include any data on correlations been WAI-Bond and CoSS-Shame.
2018	Kraus, USA, PhD Dissertation	Community members aged over 18 who had previously been in individual outpatient counselling to address alcohol use, treated in and residing in the USA (*N*=289) recruited via Amazon Mechanical Turk.	Learn more about individuals' experience in treatment for problematic alcohol use with specific reference to the effects of both dispositional and situational shame.	Cross-sectional study; online questionnaire; single sample; single time-point; ANOVA, ANCOVA, regression analyses.	WAI-S (Client) (Tracey & Kokotovic)	Internalised Shame Scale (ISS), plus a 1-item question about shame frequency; "How frequently did you experience shame in session with your therapist/counselor?"	Higher dispositional shame predicted participants' ratings on the alliance measure (*Rsquared* = .14), indicating that the higher the dispositional shame, the lower the level of alliance. No statistically significant relationship between shame experience frequency in treatment and working alliance.
2019	Carabellese, Australia, Journal Article	Community members (*n*=127) who had regularly accessed the care of a GP over the past year.	Explore the relationship of internal and external shame with working alliance and patient satisfaction.	Cross-sectional study; online questionnaire; single sample; single time point. Retrospective self-report. Correlation analyses and mediation analyses.	WAI-SR (Client) (Hatcher & Gillaspy), adapted by the researchers to refer to GPs rather than therapists.	TOSCA-3 Shame Subscale, Other As Shamer Scale (OAS), Experience Of Shame Scale (ESS).	External shame (OAS score) was negatively correlated with overall working alliance score (ρ=-.24), whereas other shame measures showed no relationship. Mediation analysis showed a small, statistically significant indirect effect of external shame on patient satisfaction via working alliance.

2020	Faccini, Italy, Journal Article	Italian college students and their friends and relatives, as well as patients of the clinicians in the Control-Mastery Theory Italian Group (CMT-IG) (total *N*=448).	To present data contributing to the validation of the Interpersonal Guilt Rating Scale-15 Self Report (IGRS-15s)	Cross-sectional study; pencil-and-paper survey; single sample; single time-point (Oct 2018 to Jan 2019); self-report. Confirmatory factor analysis, correlation analyses.	WAI-S (Client) (Tracey & Kokotovic)	Other As Shamer Scale (OAS), plus arguably the "Self-hate" dimension on the IGRS-15s (see discussion). "Self-hate, which is based on the pathogenic beliefs of being bad, rotten, inadequate, and worthless."	Negative correlation between self-hate factor of IGRS-15s and working alliance (*r*=-.21) including sub-factors Task (*r*=-.22) and Bond (*R*=-.26) but not Goal (-.13, non-significant). OAS scores (external shame) showed moderate, positive correlations with self-hate factor (*r*=.57). No results were published for correlations between OAS scores and working alliance or its subfactors.

2.3.5.4 Statistical Relationships Between Working Alliance and Shame

A detailed summary of the statistical results of each included paper or dissertation is available in Table 1. Five studies published correlations between shame measures and measures of alliance, with reliably small (between -.20 and -.30), negative correlations being found in these cases. One study found that withdrawal (i.e., avoidant) shame coping styles showed a similarly small negative correlation with working alliance. One study included odds ratio scores (see Table 1) which suggested that lower shame was related to greater acceptance of home care for older participants, and another reported that 93% of patients who felt shamed also felt that they had been wronged in their relationship with their doctors. Due to shame and working alliance not being a primary focus in the majority of included studies, the range of statistical information was sometimes limited, with one study included in the review not publishing statistical significance data regarding correlations, and two studies not publishing correlation data between measures of shame and working alliance. The authors of these studies were contacted to attempt to obtain these data, but no response was received prior to submission.

In the included doctoral dissertations, no correlation between shame and working alliance scores was reported in one case, another made no direct comparison of working alliance and shame measures, and the final dissertation reported that higher dispositional shame was related to a lower level of working alliance, with a small effect size.

2.3.6 Discussion

With regards to the research question; "What is known about the relationship between shame and working alliance?", it is difficult to make generalisations from the small pool of data currently available. The results of this review suggest that dispositional shame, assessed in a variety of ways, shows reliable, small, negative correlations with working alliance and similar

constructs, such as perceptions of atmosphere and mutual communication, and participative communication. From this, it can be inferred that those healthcare consumers with greater degrees of dispositional shame may experience and evaluate working alliance more negatively, which may potentially lead to lower engagement with treatment and ultimately worse treatment outcomes. Similarly, the results of the included studies suggest that fear and avoidance are associated with greater experienced shame, as are practitioner actions which negatively affect the healthcare relationship (e.g., 'doubting my condition').

Although these results are indicative of a relationship in which higher dispositional shame is related to lower reported working alliance, it is important to acknowledge the preliminary nature of the findings – few of the included studies set out to make explicit comparison of shame and working alliance and none measured working alliance at more than one time point, which might have allowed for an assessment of whether degree of dispositional shame has any impact on the development and maintenance of alliance over time. An additional point to consider is that two of the included studies (Nelson, 2012 & Black et al. 2013) were not sufficiently powered to detect small or very small correlations. That said, it should be noted that Black et al. (2013) nevertheless reported statistically significant correlations with a comparable and the predicted direction. By contrast, Nelson (2012) reported a shame-alliance correlation of only r=-.01, with results which suggested no linear relationship whatsoever, statistically significant or otherwise. Gooch (2018) did not report any data on correlations, and as such it is impossible to comment on this.

Similarly, it is unfortunate that no studies included measures of working alliance from the perspective of practitioners, despite these being available. This is a common shortcoming of working alliance research (Shick Tryon et al., 2007) and represents a valuable source of information which is routinely unavailable. The outcome of this omission is that we cannot be at all confident that the relationships between shame and alliance detected when assessing client perspectives would be similar in strength or direction with clinician perspectives, nor are

we able to comment on whether shame has any impact on convergence-divergence (client-clinician similarity in alliance ratings). It will be crucial for future research to approach this area in a more systematic way before definitive answers can be found. To put this another way – research investigating possible links between shame and working alliance is clearly in its most preliminary stages.

This scoping review represents an effort to map what is known about the relationship between dispositional shame and relationships between healthcare consumers and providers. Thirteen studies were identified which had attempted to make a direct assessment of this relationship, including three unpublished doctoral dissertations. It is also noteworthy that the earliest study which was located by the research team was published in 2002 (Farber & Hall, 2002) despite the fact that the importance of understanding shame's impact on healthcare relationships was explicitly identified as early as 1987 (Lazare, 1987). This synthesis will hopefully provide a foundation for ongoing research in this area by collecting and summarising the key empirical findings.

One of the most noteworthy findings which emerged from this review was the number of studies which employed unvalidated measures of both working alliance and dispositional shame. Although many of the studies employed well-known and validated measures, a comparable number used single-item assessments of shame such as "how ashamed did you feel?" or "did you feel ashamed?" with an attached rating scale. It is important to note that the use of ultra-brief measures is not inherently problematic; some data exist which suggest that single-item assessments of psychiatric symptom severity, self-esteem, and other important domains are highly valid and reliable when compared to full-length questionnaires (Robins, Hendin, & Trzesniewski, 2001; Zimmerman et al., 2006). Indeed, single items such as "do you think you suffer from depression?" have sometimes been shown to be as good or better at screening for depressive disorders than full-length screening questionnaires (Ayalon, Goldfracht, & Bech, 2010). That said, the existence of such research demonstrates that single-

item measures can be empirically validated against established inventories, and it is not clear that any of the shame items were subjected to this level of scrutiny, nor were the authors of this review able to locate any empirically validated single-item shame measures available at the time of writing. As Tangney (1996) argued in an early review of measurement of shame and guilt, the assessment of shame is complex, partly due to its tendency to be conflated with guilt and self-esteem. Until validated single-item measures of shame are available, it is recommended that a validated shame inventory be used.

It is beyond the scope of this review to provide an in-depth examination of all available validated measures of shame; however, it is also important to acknowledge that the majority of studies assessing shame employ the TOSCA-3 shame subscales, including two studies included in this review. The TOSCA has been recently criticised as being unable to provide a global assessment of shame-proneness due to its focus on moral transgressions and specific scenarios, rather than enduring aspects of a person's character, appearance or other common elements of identity that may be related to shame. As Dempsey (2017, p.5) emphasised, "because the TOSCA only uses situations in which the majority of people are likely to report feeling ashamed and especially guilty, this measure does little to tell us about people who have particular problems with the emotion." Critical reviews of the TOSCA and other shame measures are provided by Cibich et al. (2016), Dempsey (2017), and Giner-Sorolla et al. (2011).

Regrettably, few studies included multiple measures of shame which limits our ability to make inferences about the varied domains of shame (e.g., body shame, internal shame, external shame, etc.). Only two studies (Carabellese et al., 2019; Faccini et al., 2020) included multiple shame dimensions, with explicit acknowledgement of internal and external shame. Internal shame can be best understood as a self-evaluative and self-judgemental inner experience (Gilbert, 1998). By contrast, external shame is characterised by a pervasive belief or fear that negative evaluations are being made by some real or imagined other(s). Recent meta-analyses have demonstrated that compared to measures of internal shame, external

shame is a stronger predictor of intensity of depressive symptoms (Kim et al., 2011), as well as symptoms of social anxiety (Cândea & Szentágotai-Tătar, 2018). It is logical to suppose that a disposition towards experiencing external shame would then be more strongly negatively related to working alliance, which was supported by the single included study which examined this directly (Carabellese et al., 2019).

Given its prominence, it is unsurprising to note that the majority of included studies used some variant of the working alliance inventory (WAI). A broad overview of research conducted since 1980 indicates that the WAI has been employed by the vast majority of researchers interested in the phenomenon of working alliance (Doran, 2016; Flückiger et al., 2019; Martin et al., 2000). It has also been comprehensively validated, found to be reliable, and has been used with a diverse range of languages and ethnic groups. Flückiger et al. (2019) noted in their meta-analysis that 69% of the 105 articles included used some variant of the WAI. Interestingly, the majority of studies in this review used the older Tracey and Kokotovic (1989) short-form WAI (WAI-S), despite the fact that the more recent Hatcher and Gillaspy (2006) revision (WAI-SR) is generally recommended for use in contemporary research, due its superior psychometric properties, efficiency of use, and closer relationship to guiding theory (Hatcher & Gillaspy, 2006; Horvath, 2019). It is difficult to speculate as to why this may be, as both measures are accessible online (Horvath, 2019) and are of comparable length, and the WAI-SR is simpler to administer, requiring no reverse scoring. A reasonable hypothesis may be that the WAI-S is preferred by some researchers as it has been employed in a greater range of populations and settings, due to its age and widespread uptake. Nevertheless, for those wishing to use a brief assessment of working alliance, it is recommended to use the newer Hatcher and Gillaspy (2006) variant unless a specific comparison with other work using different versions is required.

Despite this, it is interesting to note that those studies which used non-WAI instruments to assess working alliance-like constructs (Hamann et al., 2017; Jaakkola et al.,

2014; Mensinger et al., 2018) showed correlations with shame of a similar strength and direction with shame measures where these were reported (excepting Mensinger et al., 2018, where the negatively-worded measure of "Healthcare Stress" was *positively* correlated with shame to a similar extent, as would be expected from the other findings). As such, it would appear that working alliance and its proxies maintain this small, negative relationship with shame regardless of the measure used.

Until recently, relatively few validated measures existed to assess working alliance in a non-psychotherapeutic context; however, a significant body of work has been conducted by Fuertes and colleagues (J. K. Bennett et al., 2011; Fuertes et al., 2015; 2007; Fuertes et al., 2017) to define and study working alliance within the context of patient relationships with physicians. A review of recent research indicates that their conceptualisation (hereafter referred to as Physician-Patient Working Alliance, PPWA) appears to be an increasingly influential understanding of working alliance in medicine. PPWA as defined by Fuertes et al. (2007) is heavily informed by Bordin's (1979) pantheoretical model, and maintains its emphasis on goals, tasks and relational bond. The primary measure used to assess PPWA is an adapted version of Tracey and Kokotovic's (1989) short form WAI, referred to as the Physician-Patient Working Alliance Inventory (PPWAI). This measure was not used in any of the included studies, but would be recommended for future research of physician-patient relationships to ensure consistency and maximise the ability to compare results with psychological research, where the WAI and its variants are the dominant measures (Flückiger et al., 2019).

From the perspective of clinical practice, the primary implication is that a greater tendency to experience shame is likely to be related to lower ratings of working alliance by healthcare consumers, which suggests they may have a less positive experience of the relationship and thus greater care, warmth and empathy may be required on the part of the practitioner (Safran & Muran, 1996). It is important to interpret this implication in the context

of the mixed evidence and small effect sizes, and it should be regarded as provisional pending the emergence of stronger evidence.

2.3.7 Strengths and Limitations

A strength of the present study was the examination and inclusion of grey literature, particularly unpublished doctoral theses, which provided greater access to detailed data than their published counterparts, which sometimes omitted key analyses. Similarly, the examination of a broad range of journals (e.g., psychology, nursing, medicine, etc.) may increase the applicability of findings beyond psychotherapy and into medical disciplines, which are a growing area for alliance research. It is strongly recommended that future research in this area take a similarly broad view where possible, to increase the likelihood of capturing research from a variety of healthcare areas where working alliance may be important.

A notable limitation of the present scoping review was the absence of qualitative or mixed-methods literature. Although the decision to exclude this literature was made on a practical basis, (i.e., narrowing the focus to a manageable number of results) it is nevertheless unfortunate that the important perspectives of researchers using these modalities were not included. Similarly, material not in English was excluded, which may have omitted key findings not published in this language.

2.3.8 Conclusion

The data presented in this scoping review suggested that higher dispositional shame (and its proxies) is reliably related to lower working alliance (and its proxies) in healthcare settings, albeit a small relationship. The review identified methodological shortcomings of existing research, such as inconsistent use of best-practice measures of shame and alliance, lack of longitudinal data, and lack of uniformity in assessment of these variables. Cultural diversity in the included studies was also relatively low, with a significant majority of studies conducted in predominantly white, English-speaking areas. These represent gaps to be addressed in future research. Overall, the reviewed studies paint a picture of an emergent area

of research in which there is not currently sufficient data to make an authoritative statement about how shame may relate to working alliance, and thus they illuminate the need for further investigation.

2.3.9 Appendix A PRISMA-ScR Checklist

Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist, reporting for the paper: "Working Alliance and Shame: A Scoping Review".

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED IN SECTION
TITLE			
Title	1	Identify the report as a scoping review.	Title, abstract
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	Abstract
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	Methods
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.	Research Question
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.	N/A: No specific protocol published.
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale.	Study Selection
Information sources*	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.	Search Strategy
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.	Appendix B

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED IN SECTION
Selection of sources of evidence†	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	Study Selection
Data charting process‡	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	Charting the Data
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	Study Selection
Critical appraisal of individual sources of evidence§	12	If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).	N/A: Not performed for this review.
Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	Charting the Data
RESULTS			
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.	Figure 1: PRISMA-ScR diagram
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations.	Results & Table 1, Data Chart
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	N/A: See item 12.
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	Results
Synthesis of results	18	Summarize and/or present the charting results as they relate to the review questions and objectives.	Results, Statistical relationships between working alliance and shame
DISCUSSION			
Summary of evidence	19	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	Discussion
Limitations	20	Discuss the limitations of the scoping review process.	Strengths & Limitations

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED IN SECTION
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	Conclusion
FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	N/A, nil external funding.

JBI = Joanna Briggs Institute; PRISMA-ScR = Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews.
* Where *sources of evidence* (see second footnote) are compiled from, such as bibliographic databases, social media platforms, and Web sites.
† A more inclusive/heterogeneous term used to account for the different types of evidence or data sources (e.g., quantitative and/or qualitative research, expert opinion, and policy documents) that may be eligible in a scoping review as opposed to only studies. This is not to be confused with *information sources* (see first footnote).
‡ The frameworks by Arksey and O'Malley (6) and Levac and colleagues (7) and the JBI guidance (4, 5) refer to the process of data extraction in a scoping review as data charting.
§ The process of systematically examining research evidence to assess its validity, results, and relevance before using it to inform a decision. This term is used for items 12 and 19 instead of "risk of bias" (which is more applicable to systematic reviews of interventions) to include and acknowledge the various sources of evidence that may be used in a scoping review (e.g., quantitative and/or qualitative research, expert opinion, and policy document).

From: Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA Extension for Scoping Reviews (PRISMAScR): Checklist and Explanation. Ann Intern Med. 2018;169:467–473. doi: 10.7326/M18-0850.

2.3.10 Appendix B Search Terms and Logic Grid

Database-agnostic search terms and example logic grid (PubMed).

Database Agnostic Search Terms
Shame Shame, ashamed, shaming, body shame, humiliation, shameful, self-conscious emotion ***Interpersonal Relations*** Interpersonal relations, doctor patient relations, health care personnel, health personnel attitude, interpersonal communication, mental health care, physician attitude, professional patient relations, interprofessional relations, physician-patient relations, physician-patient alliance, working alliance, therapeutic alliance, alliance, therapeutic relationship, clinical relationship, psychological relationship

PubMed Logic Grid, including MESH terms, combined with 'AND'	
Shame	***Interpersonal relations***
"Shame"[mh] OR shame[tiab] OR ashamed[tiab] OR shaming[tiab] OR body shame[tiab] OR humiliation[tiab] OR shameful[tiab] OR self-conscious emotion*[tiab]	"Interpersonal Relations"[mh] OR Interpersonal relat*[tiab] OR doctor patient relat*[tiab] OR health care personnel[tiab] OR health personnel attitude[tiab] OR interpersonal communication[tiab] OR mental health care[tiab] OR physician attitude[tiab] OR professional-patient relat*[tiab] OR interprofessional relat*[tiab] OR physician-patient relat*[tiab] OR working alliance[tiab] OR [tiab] OR therapeutic alliance[tiab] OR physician-patient alliance[tiab] OR alliance[tiab] OR therapeutic relat*[tiab] OR clinical relat*[tiab] OR psychological relat*[tiab]

CHAPTER 3. STUDY TWO: RELATIONSHIP OF PATIENT SHAME TO WORKING ALLIANCE AND SATISFACTION: A PRELIMINARY INVESTIGATION

3.1 Preamble

The aim of the first empirical study was to conduct an initial investigation of the hypothesised relationship between shame and working alliance. As demonstrated in prior literature reviews, limited quantitative research had yet been conducted and the strength, direction and nature of this relationship was not well understood. A variety of shame measures were included, and it was anticipated that different subtypes of shame (internal, external, context-dependent) might show differing relationships with working alliance. It was intended that this preliminary study would then be followed by further community research, as well as a clinical study, which would use a similar selection of major measures.

3.2 Statement of Authorship

Title of Paper	Relationship of patient shame to working alliance and satisfaction: a preliminary investigation
Publication Status	Published
Publication Details	Journal of Mental Health Training, Education and Practice

Principal Author

Principal Author (PhD Candidate)	Daniel Carabellese
Contribution to the Paper	Reviewed literature and prepared aims and hypotheses. Planned and executed major elements of the research, including ethics submissions, programming online platforms, and the majority of analyses. Writing and editing of the manuscript in collaboration with supervisors. Submission of the manuscript to journal and implementation of subsequent revisions. Corresponding author for the paper.
Overall percentage	85%
Certification	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its

	inclusion in this thesis. I am the primary author of this paper.
Signature	
Date	2021-02-15

Co-Author Contributions

By signing the Statement of Authorship, each author certifies that: i. the candidate's stated contribution to the publication is accurate (as detailed above); ii. permission is granted for the candidate in include the publication in the thesis; and iii. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.	
Co-Authors	Dr Michael Proeve Associate Professor Rachel Roberts
Contribution to the Paper	Supervisors of the PhD research program. Oversaw research conceptualisation and planning. Provided regular supervision and discussion of research process. Collaborated in developing the content and structure of the published manuscript, and reviewed drafts. Provided supervision and guidance around adapting and responding to reviewer comments.

Signatures

Date 1 March 2021	Michael Proeve Michael Proeve
Date	Rachel Roberts Digitally signed by Associate Professor Rachel Roberts Date: 2021.03.01 16:19:17 +10'30'

3.3 Submitted Manuscript

3.3.1 Title Page

Title: The Impact of Patient Shame on Working Alliance and Satisfaction: A Preliminary Investigation

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Acknowledgments (if applicable): N/A

Keywords: working alliance; patient satisfaction; internal shame; external shame; mediation; shame

Article Classification: Research Paper

Ethical Approval: This study was approved by the University of Adelaide Human Research Ethics Psychology Sub-Committee, approval #1681.

Conflicts of interest: The authors declare that there are no conflicts of interest.

Competing interests: The authors declare that there are no competing interests.

3.3.2 Abstract

Purpose

The purpose of this paper is to explore the relationship of two distinct variants of dispositional shame (internal and external shame) with collaborative, purpose-driven aspects of the patient-provider relationship (working alliance) and patient satisfaction. The aim of this research was to conduct a preliminary investigation into the relevance of dispositional shame in a general healthcare population.

Design/Methodology/Approach

127 community members (mean age 25.9 years) who reported that they had regularly seen a GP over the past year were recruited at an Australian university. Participants were asked to reflect on their relationship with their GP, and completed instruments assessing various domains of shame, as well as working alliance and patient satisfaction.

Findings

Nonparametric correlations were examined to determine the direction and strength of relationships, as well as conducting mediation analyses where applicable. Small, negative correlations were evident between external shame and working alliance. Both external and internal shame measures were also negatively correlated with patient satisfaction. Finally, the relationship of external shame to patient satisfaction was partially mediated by working alliance.

Practical Implications

Both the reported quality of patient-provider working alliance, and level of patient satisfaction are related to levels of dispositional shame in patients, and working alliance may act as a mediator for this relationship.

Originality/Value

The findings from this preliminary study suggest that internal and external shame are important factors to consider in the provision of medical care to maximise the quality of patient experience and working alliance.

Keywords: working alliance; patient satisfaction; internal shame; external shame; mediation analysis

3.3.3 Submitted Manuscript

3.3.3.1 Introduction

Medicine in the 21st century is increasingly viewed not as a discipline in which physicians practise *on* patients, but rather one in which physicians, patients and healthcare professionals form a multi-disciplinary team arrayed in opposition against illness and health concerns (Kitson et al., 2013). One of the consequences of this shift in perspective is that medical professionals generally now recognise and have practice requirements (Caesar, 2016) regarding the importance of *patient participation* in healthcare and the value of the physician-patient relationship. This is arguably a pillar of effective healthcare, in terms of its ability to influence adherence to healthcare instructions and medication regimens (Fuertes et al., 2007), as well as patient willingness to disclose vital health information, seek help and remain in treatment (Fuertes et al., 2015; Harris & Darby, 2009).

As patient-centred care increasingly becomes a driver of policy in various healthcare disciplines (Kitson et al., 2013), research attention has turned to the physician-patient relationship. Although the therapeutic relationship has been recognised throughout history (Bordin, 1979), it is only more recently that this relationship has been measured empirically using various research instruments, some of which are used for official purposes in the recertification of medical credentials. For example, in the United Kingdom doctors undergoing periodic revalidation are required to obtain patient evaluations of the concrete aspects of practising medicine as well as their ability to "put [the patient] at ease" and to "involv[e] [the

patient] in medical care" (Roland et al., 2013). The United Kingdom National Health Service (NHS) Outcomes Framework specifically names "patient experience" as one of the key factors of quality in healthcare (Department of Health, 2008). This includes metrics such as patient satisfaction with care provided, as well as satisfaction with logistical factors affecting access to care (e.g. access to parking and administrative matters) (Roland et al., 2013) Similar initiatives are currently under review by the Australian Health Practitioner Regulation Agency (AHPRA) and are likely to be adopted in future (Medical Board of Australia, 2015, 2016)[1]. In the present study, the physician-patient relationship was operationalised in terms of "working alliance", a construct which has attracted increased research interest in medicine over the last ten years (Doyle, Lennox, & Bell, 2013; Fuertes et al., 2015; Fuertes et al., 2007; Sturgiss, Sargent, Haesler, Rieger, & Douglas, 2016).

The concept of a practitioner-patient alliance has been central to psychotherapy since its inception, beginning with Freud (1924) and later Greenson (1965), who first used the term "working alliance". Although these researchers were undoubtedly influential, the modern understanding of working alliance owes much of its conceptual basis to Bordin (1979), who developed a new definition of working alliance that was broadly applicable in healthcare settings.

Bordin's definition of working alliance comprises three factors: patient-provider agreement on the specific goals of treatment; patient-provider agreement regarding which tasks are best suited to achieve these goals; and the relational bond between the patient and provider, including feelings of liking, trust and empathy present in the relationship. Specifically,

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[1] The Expert Advisory Group convened by AHPRA to consider the question of medical revalidation ultimately recommended against using the term 'revalidation' as it was decided that this "did not accurately describe the [Medical] Board's approach" (Medical Board of Australia, 2018). The Board instead proposed developing a Professional Performance Framework intended to assist medical practitioners to collectively raise professional standards, with an emphasis on continuing professional development requirements and identifying risk factors for poor performance in medical practitioners to allow for proactive remediation.

“[a]lliance describes the degree to which the therapy dyad is engaged in collaborative, purposive work.” (Hatcher and Barends, 2006, p. 293). In psychological research, working alliance has gradually come to be understood as one of the most reliable predictors of successful therapeutic interventions (Arnd-Caddigan, 2011; Martin et al., 2000), without which effective therapy may be impossible.

Providing care for primarily physiological illnesses has a fundamentally different character to the treatment of psychological problems, such that interventions may be undertaken without the patient being awake, aware or (technically, in cases of clinical death; Safar, 1988) even alive. However, there are several crucial components of medical care that require patient action, such as adherence to medication regimens, disclosure of symptoms, continued attendance, and making lifestyle changes. Each of these factors respectively has been demonstrated to be influenced by working alliance in past research across a range of illness categories (Bar-Sela et al., 2016; Fuertes et al., 2015; Fuertes et al., 2007). Significant empirical research has also emphasised that working alliance is strongly related to patient-rated satisfaction with treatment, in the provision of both psychological and medical care (J. K. Bennett et al., 2011; Fuertes et al., 2015; Horvath & Greenberg, 1989; Martin et al., 2000; Tetzlaff et al., 2005). In general, patients who rate their alliance with their provider poorly are correspondingly unlikely to be satisfied with the treatment they receive, irrespective of the type or efficacy of that treatment.

Based on this understanding of the importance of working alliance in healthcare and its relationship with a range of outcomes, the present study investigated a variable that is not yet well understood in the context of working alliance. Specifically, this research targeted potential relationships of patient-rated alliance with patient shame, which may have an impact on the formation and maintenance of a functional, high quality alliance.

Although the character of the physician-patient relationship is demonstrably influenced by the actions of the healthcare professional (Dolezal, 2015), certain patient

characteristics, such as dispositional shame, arguably have a part to play in the development of a good working relationship (Tangney, 1995). There is some debate about the precise nature of dispositional shame (Leeming & Boyle, 2004), but most theorists conceptualise it as the tendency to experience shame (or not) in situations which are recognised as shame-provoking (i.e. "shame proneness"), as well as longstanding or frequent generalised feelings of shame (Andrews, 1998).

When discussing shame in a healthcare context, it is important to consider the related concept of 'stigma'. Although the two are often conflated, and substantial variation in definitions exists (Link & Phelan, 2001), there are important theoretical differences. Weiss, Ramakrishna, and Somma (2006) described stigma as "a social process, experienced or anticipated, characterised by exclusion, rejection, blame or devaluation" (p. 280), which they linked to a feature of an individual's identity (e.g. a health problem), sometimes described as a "social abnormality" (Goffman, 2009). For example, Health-related stigma is commonplace (Scambler, 2009) and medical conditions (e.g. HIV/AIDS) are unfortunately routinely regarded as 'shameful' (Parker & Aggleton, 2003), both by society and by individuals affected by the disease. By contrast, dispositional shame need not be related to any 'social abnormality' - it is conceptually admissible that persons belonging to no stigmatised category can nevertheless experience high levels of shame-proneness, and vice-versa. Having said this, Goffman (2009) also made the important point that the experience of stigma is highly probable to result in shame, and as such the two experiences are likely to co-occur in a variety of situations.

Shame is best regarded as a self-conscious emotion with a strong interpersonal dimension – that is, it is most likely to arise in relation to or through comparison to other people. In shame, the entire self is subjected to intense negative evaluation - by oneself or by the presumed mind of others. Feelings of worthlessness and negative self-appraisals result in actions such as withdrawing from others, or self-isolation (Tangney et al., 1996). Shame is

almost universally recognised as an emotion which can be destructive and painful, and is often described as being overpowering and incapacitating (Wicker et al., 1983).

Shame in doctor-patient consultations has received little scientific scrutiny since the publication of Lazare's (1987) article *Shame and Humiliation in the Medical Encounter* (Dolezal, 2015). This is surprising, given that the experience of attending a doctor's surgery has been recognised as a particularly intense venue for shame-inducing experiences (Dolezal, 2015; Stevens, 1996). These occasions often involve the revealing of normally private parts of the body, as well as the acknowledgement of illness, which can sometimes be interpreted as a personal deficiency or failure (Harris & Darby, 2009; Lazare, 1987). This is especially true in cases in which patients are fearful the ailment may be viewed as self-inflicted, such as smoking-related illnesses (Gilbert & Miles, 2014; Harris & Darby, 2009).

It is useful to make a theoretical distinction between two different subtypes of shame – *internal* and *external* shame (Goss & Allan, 2009). The former refers to self-evaluative experiences, where an individual may judge *themselves* to be deeply personally flawed, powerless, physically and mentally unattractive, and as a failure (Gilbert, 1998). By contrast, those experiencing external shame are likely to be fearful of negative evaluations and beliefs on the part of some real or theoretical "other(s)" but may not necessarily evaluate themselves negatively. In this way, the shamed person believes that other people view them as being inadequate, valueless and inferior, and may be fearful of social rejection, which may in turn be related to concealing certain sources of bodily or emotional shame from others (M. Lewis, 1995). Meta-analyses (Cândea & Szentágotai-Tătar, 2018; Kim et al., 2011) have demonstrated that external shame is a stronger predictor of depressive symptoms and social anxiety symptoms than internal shame.

External shame, although not always explicitly acknowledged, is frequently identified as a barrier to effective treatment in medicine (Stevens, 1996; Zinn, 1993). In these cases, patients may demonstrate behaviours congruent with responses to external shame, such as concealing

(partially or wholly) the true nature of their illness from physicians, refusal to expose parts of the body of which they may fear judgement, or misleading healthcare professionals regarding behaviours for which they risk condemnation (e.g. smoking or unsafe sex practices) (Dolezal, 2015; Gilbert & Miles, 2014; Zinn, 1993). Harris and Darby (2009) found that one in five participants reported that they had stopped seeing a physician as a direct result of a shaming event. High levels of shame may also be related to non-productive behaviour in a healthcare setting, such as withdrawal, anger, deflection, and externalisation of blame (Black et al., 2013; Tangney et al., 1996), although this has yet to be demonstrated explicitly.

Fortunately, there are measures to assess internal and external shame. The Other as Shamer Scale (Allan et al., 1994; Goss et al., 1994) is a measure of external shame which prompts participant ratings based on statements about others' perceptions of them. This can be contrasted with the TOSCA-III (Tangney & Dearing, 2002), which measures a propensity to experience shame in common situations and is concerned with shame-related behaviours and negative self-evaluations by oneself (Kim et al., 2011). Given the presumed value of identifying different subtypes of shame, both of these measures were included in the present investigation, as well as the Experience of Shame Scale (Andrews et al., 2002), which assesses a broad variety of shame-provoking areas.

It is not difficult to imagine that a high degree of shame – especially external shame – may be related to the formation of a less effective working alliance. Furthermore, by restricting the development of the alliance, shame might then have the indirect effect of reducing patient satisfaction with treatment. Despite the intuitive appeal of this proposition, few studies have linked shame, working alliance, and satisfaction, and those studies are marked by methodological shortcomings, such as small sample sizes and overreliance on post-hoc reviews of data not initially intended to assess this relationship (Black et al., 2013).

Although it has long been recognised that empathy on the part of physicians is valuable in patient consultations (Zinn, 1993), it may well be that patients may require a

different interpersonal approach according to their level of dispositional shame. This is not simply a matter of compassion on the part of healthcare providers; tailored approaches may be essential for the treatment to be effective, delivered in a timely manner, and for instructions to be followed correctly (Harris & Darby, 2009).

In the current study, it was hypothesised that *there would be at least small, negative correlations between measures of dispositional shame and patient-evaluated working alliance*. Furthermore, that *external shame would prove a greater barrier to building an effective alliance with a physician, and therefore would show stronger negative correlations with measures of both alliance and patient satisfaction than measures of internal shame.* Finally, it was hypothesised that shame *would be negatively related to patient satisfaction indirectly through working alliance.*

3.3.3.2 Methods

Power analysis indicated that a total sample of 123 participants would be required to detect a small correlation (r =.20) with power (1 - β) set at .80 and α = .05 (Hulley et al., 2013). The source of participants was the University of Adelaide community, ranging from ages 18 to 76. Table 1 presents demographic information for these participants. Participants were recruited via the Learning Management System to which all students and staff have access, and the entirety of the questionnaire was completed anonymously online. Participants were eligible to participate if they were over the age of 18, fluent speakers of English and had visited a GP at least bimonthly throughout the past year, with the most recent visit being within the previous three months. No monetary incentive was offered for participation; however, certain undergraduate students were eligible to receive course credit for introductory Psychology courses.

Table 1

Participants' demographic information and reports regarding GP visits, (*N*=127).

Sex (%)	
Male	28 (22%)
Female	99 (78%)
Mean Age (SD)	25.9 (11.38)
Most recent visit to a GP (%)	
<1 month ago	86 (67.7%)
1-3 months ago	41 (32.3%)
Frequency of GP visits (%)	
Very regularly (>1 visit per month)	14 (11.02%)
Regularly (~1 visit per month)	27 (21.26%)
Somewhat regularly (e.g. bimonthly)	86 (67.72%)
Recruitment status (%)	
Credited Participant*	52 (40.94%)
Uncredited Community Member	75 (59.06%)
Confidence in GP Honesty & Trustworthiness (%)	
Yes, definitely	96 (75.60%)
Yes, to some extent	30 (23.60%)
No, not at all	1 (0.80%)
Confidence in GP Confidentiality (%)	
Yes, definitely	110 (86.60%)
Yes, to some extent	15 (11.80%)
No, not at all	2 (1.60%)
Happy to see this GP again (%)	
Yes	117 (92.10%)
No	10 (7.90%)

**** Participants enrolling in the study from Undergraduate Psychology courses were eligible for course credit for participation.***

The University population was chosen in recognition of the fact that the University campuses contain no fewer than three GP clinics (in which care is available for free for staff and students) and that high levels of educational attainment have previously been associated with higher health literacy, which in turn increases the likelihood of regular GP visits (Von Wagner, Knight, Steptoe, & Wardle, 2007). Regular visits were considered essential for participants in the present study, given that psychotherapy research has demonstrated that working alliance

develops over time (Kivlighan & Shaughnessy, 2000). Accordingly, inclusion criteria included the stipulation that participants had "regularly seen the same GP for the past year", with the minimum acceptable regularity being bimonthly.

Measures

General Practice Assessment Questionnaire (GPAQ-R)

The GPAQ-R is an instrument developed by Roland, Roberts, Rhenius and Campbell (2013) for the purpose of revalidation of General Practitioner practice skills. This is a requirement in the United Kingdom, as doctors must periodically demonstrate that they remain fit to practise medicine (Caesar, 2016). The questions in this instrument were developed based on systematic reviews of aspects of care which were judged to be important by patients (Cheraghi-Sohi et al., 2006). It contains 11 core items. These include questions such as; *"How good was the GP at: Providing or arranging treatment for you?",* which are rated on a 5-point Likert-type scale, as well as categorical response questions, such as *"Would you be completely happy to see this GP again?"*. Each question also has "does not apply" as an optional response. This instrument has previously been shown to be reliable and valid (Roland et al., 2013), and was included as a source of valuable patient satisfaction data.

Following the procedure outlined by the instrument's developers (Roland et al., 2013), valid responses on GPAQ-R items 1-8 were averaged to create an overall statistic, which they refer to as "Communication". Because only this averaged score was used in analyses, cases in which participants returned one or more answers of "does not apply" (5 participants) were considered invalid and excluded from all relevant analyses. Internal consistency reliability for the Communication scale was high (N=122, Cronbach's α = .93). Items 9-11 were not relevant to the research questions, however as seen in Table 1, responses to these items indicated a high degree of Patient Confidence (Roland et al., 2013) overall.

The Working Alliance Inventory Short Revised Version Client Form (WAI-SR-C)

The WAI is a measure of working alliance as defined by Bordin (1979), divided into the three key areas of agreement on tasks, agreement on goals and the therapeutic bond. It has been exhaustively validated, reliability tested and used with a huge variety of populations, including dozens of languages and ethnic groups. The Hatcher and Gillaspy variant of the WAI (Hatcher & Gillaspy, 2006) demonstrates excellent internal consistency reliability (subscale alphas ranging from .85 to .90, total score alphas from .91 to .92), as well as very strong correlations (.94 to .95) with the original Working Alliance Inventory developed by Horvath (Hatcher & Gillaspy, 2006; Tracey & Kokotovic, 1989).

Following the example set by Fuertes et al. (2007), the present study employed a modified WAI-SR-C to refer to working alliance with general practitioners, rather than to psychotherapists. Participants were asked to rate their answers on a 5-point Likert-type scale ranging from 1 *(Seldom)* to 5 *(Always)*. Items included; *"I feel that the things I do as a result of consultations with my doctor will help me to improve my health." (Tasks); "My doctor and I collaborate on setting goals for my health care." (Goals)* and*; "My doctor and I respect each other." (Bond).* Internal consistency reliability for our modified instrument was high both for full-scale (Cronbach's $\alpha = .95$) and subscale scores ($\alpha = .87$ to .90).

Test of Self-Conscious Affect, Shame Subscale (TOSCA-3-Shame).

The Test of Self-Conscious Affect-3 (Tangney & Dearing, 2002) is designed to assess dispositional emotions. Participants are prompted with 16 scenarios, each of which is followed by four descriptions of thoughts or behaviours to which participants must then respond on a scale ranging from 1 *(Not likely)* to 5 *(Very likely)*. For example, for the scenario *"You break something at work and then hide it."*, respondents are asked to rate the likelihood of the following statement: *"You would think about quitting."* The TOSCA is considered an industry standard and is used very frequently in studies concerned with shame and guilt (Andrews et al.,

2002). In the present study, only the 11 items pertaining to shame were included. The TOSCA-3-Shame subscale showed an internal consistency reliability of .80. This measure was used to assess internal shame; specifically, context-dependent dispositional shame.

Other As Shamer Scale (OAS).

Allan et al. (1994) and Goss et al. (1994) developed the Other as Shamer scale in order to assess global judgements of how participants think others view them. It contains 18 items which are scored by participants on a 5-point scale ranging from 0 *(Never)* to 4 *(Almost Always)*. These items are worded in the first person, and invite participants to rate their thoughts and feelings, e.g. "I feel other people see me as not good enough." or "I think others are able to see my defects." Goss et al. (1994) reported a very high degree of internal consistency for this scale (Cronbach's α = .92). This scale was used to assess individual levels of external shame.

Experience of Shame Scale (ESS).

The Experience of Shame Scale (Andrews et al., 2002) is comprised of 25 items which are divided into eight conceptual areas of shame, including shame related to; personal habits; manner with others; sort of person you are; personal ability; doing something wrong; saying something stupid; failure in competitive situations; and bodily shame. Each item is rated by participants on a 4-point Likert-type scale, ranging from 1 *(Not at all)* to 4 *(Very much)*. Items ask respondents to rate the extent to which they have had certain experiences, e.g. "Have you worried what other people think of the sort of person you are?", "Do you feel ashamed when you do something wrong?". Andrews et al. (2002) report that this scale has a high level of test-retest reliability over a time of approximately 11 weeks (r=.83) and strong internal consistency (Cronbach's α=.92). This scale has a primarily internal focus, and has previously been classified as a measure of contextual shame (Kim et al., 2011), however it does include some items

relating to others' perceptions. For the purposes of this study, it was treated as a measure of internal shame.

Planned Analyses

In order to examine hypotheses 1 and 2, concerning the relationship of various shame measures to patient-rated working alliance and satisfaction with treatment, examination of correlations was planned. Variables to be included in these analyses included WAI total scores, WAI subscale scores, OAS, ESS, and TOSCA-3 scores, and Communication (Satisfaction) scores. Given that both WAI and Communication subscale ratings were positively skewed, non-parametric Spearman's Rank-Order Correlation was selected as the appropriate methodology.

Similarly, non-parametric bootstrapping analyses were chosen to test the hypothesised indirect relationship between external shame and patient satisfaction through working alliance. This type of analysis is recommended in cases in which the sample size is small or there is non-normality in the data (Preacher & Hayes, 2004).

3.3.3.3 Results

Table 2 presents the means, standard deviations, and inter-correlations for all primary measures. There were several statistically significant differences between participants who identified as male or female on three variables. Independent samples *t*-tests revealed that there was a significant difference in TOSCA-Shame between female (M=36.19, SD=8.59) and male (M=32.39, SD=7.54) participants, $t(125)=-2.12$, $p=.036$, with female participants scoring higher. Similarly, examination of overall WAI scores suggested that female (M=45.19, SD=10.06) participants rated the alliance higher on average than their male counterparts (M=40.71, SD=11.31), $t(125)=-2.02$, $p=.045$. A similar result was evident in the Bond subscale of the WAI, with females (M=15.74, SD=3.38) giving higher ratings than males (M=13.86, SD=4.27), $t(125)=2.45$, $p=.016$. There were no other differences on any of the variables of interest based on sex, age, recruitment status or regularity and recency of GP visits.

Table 2

Means, standard deviations and correlations (Spearman's rho) among study variables. (*N*=127, except Communication, where *N*=122).

Variable	M	SD	WAI	OAS Shame	TOSCA Shame	ESS Shame	Communication
WAI	44.20	10.47	-	-	-	-	-
OAS Shame	31.24	15.52	-.24**	-	-	-	-
TOSCA Shame	35.35	8.49	-.01	.56**	-	-	-
ESS Shame	64.02	18.19	-.11	.74**	.64**	-	-
Communication	4.30	.77	.69**	-.35**	-.15	-.22*	-

**p<0.05*

***p<0.01*

Because WAI and Communication ratings were positively skewed, non-parametric Spearman's rho values are reported in Table 2. No significant correlations were evident between overall working alliance ratings and shame as assessed by the TOSCA-3 or the ESS. In contrast, there was a small, negative correlation between scores on the OAS and overall WAI scores. As such, the hypothesis that external shame would be more related to working alliance than other assessed forms of shame was supported. Similarly, OAS and ESS scores were modestly negatively correlated with Communication, but TOSCA-Shame scores showed no significant correlation. This suggests that context-dependent shame (as assessed by the TOSCA (Kim et al., 2011) is not as relevant to patient satisfaction as other types of shame.

As anticipated, the averaged Communication rating showed a moderate, positive correlation with overall WAI score, suggesting that participants who rated their satisfaction with their GP's performance highly were correspondingly more likely to report a greater working alliance. Similarly, all three measures of shame showed moderate-to-strong positive intercorrelations, lending convergent validity to these as measures suitable for assessing shame.

All WAI subscale ratings failed to show any significant correlations with TOSCA-Shame or ESS scores. By contrast, OAS scores evinced small, negative correlations with both the Bond (r_s = -.23, p<.001) and Task (r_s = -.28, p<.001) subscale scores, while correlations with the Goal subscale were not significant (r_s = -.17, p>.05). Communication was also positively correlated with all dimensions of working alliance (r_s = .61 to .70, p<.001).

Non-parametric bootstrapping analyses were employed to test the hypothesised indirect relationship between external shame and patient satisfaction through working alliance (Fig. 1). As shown in Figure 1, there was a statistically significant total effect of external shame on patient satisfaction, b = -.015, [-.024, -.006].

In partial support of the hypotheses, analyses revealed a small, statistically significant indirect effect of external shame on patient satisfaction via working alliance, b = -.009, BCa CI [-.015, -.002], r^2 = .08, 95% BCa CI [.012, .181]. Figure 1 shows that there was also a direct effect, suggesting that part, but not all, of the effect of external shame on patient satisfaction was accounted for by its effect on working alliance.

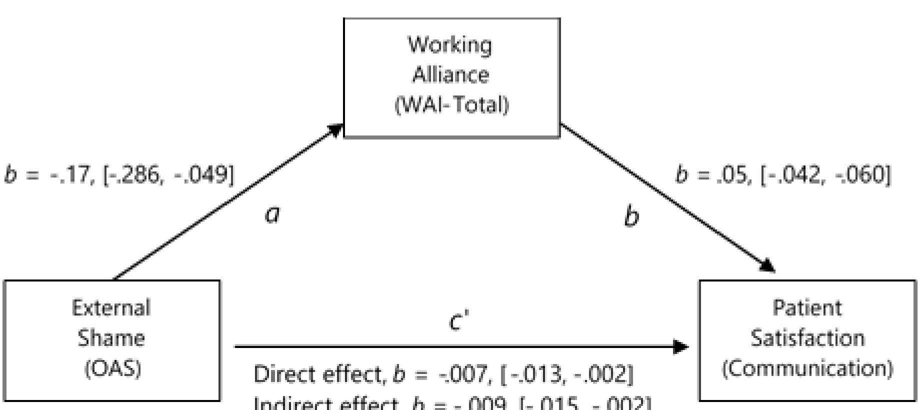

Figure 1. Model of external shame as a predictor of patient satisfaction, mediated by working alliance. The confidence interval for the indirect effect is a BCa bootstrapped CI based on 1000 samples.

3.3.3.4 Discussion

The hypotheses that shame would be negatively related to measures of patient satisfaction and working alliance were partially supported. It is noteworthy that the only measure of shame to evince *any* correlation with both working alliance *and* patient satisfaction was the OAS, which assesses external shame. Thus, these results provide evidence of a modest relationship between levels of external shame and retrospective evaluations of working alliance. They also reinforce decades of research which suggest that patient satisfaction – although empirically distinct from working alliance - is strongly related to it, such that a patient reporting a poor alliance is highly unlikely to be satisfied with treatment (Fuertes et al., 2015; Martin et al., 2000; Tetzlaff et al., 2005). Indeed, these findings demonstrated that part of the relationship between external shame and satisfaction was accounted for *by* alliance, which further underscores the importance of attending to working alliance in provider-patient consultations.

The results of this study suggest that those patients who enter a consultation with feelings of fearfulness regarding the judgement of others may be less likely to develop a good relationship with their doctor, and more likely to be unsatisfied with treatment. This relationship may hold – to a lesser extent – with feelings of shame in general. This corresponds well with existing research evidence, which indicates that patients may exhibit withdrawal and avoidant behaviours when dealing with high levels of shame, and that fear of condemnation is a powerful motivator to remain silent, not disclose, and not engage well with treatment (Black et al., 2013; Dolezal, 2015; Lazare, 1987; Stevens, 1996). Such findings should be of particular interest to general practitioners, especially those who see the same patients on a regular, ongoing basis (e.g. the "family doctor"). Such professionals have the scope to develop meaningful, long-term alliances with their patients, and a failure to do so effectively may have flow-on effects that are not yet fully understood.

It is important to be aware of the limitations imposed by the preliminary state of these findings. Most notably, the retrospective nature of the study and its correlational design limit the possibility of inferences regarding causal relationships. Although it is reasonable to suppose that propensity towards shame temporally precedes consultations with doctors, it cannot be assured that its effects on patient-rated satisfaction and alliance are unidirectional. Future research should address this issue by ensuring that the variables under consideration are assessed in a temporally logical way, with dispositional measures being administered either preceding consultations with physicians, or before and after. Satisfaction and working alliance measures would also ideally be obtained after each session, rather than a single, global alliance rating. This is particularly important given that past research suggests that alliance levels fluctuate throughout treatment (Kivlighan & Shaughnessy, 2000). Similarly, it was not possible to collect assessments of physician-rated working alliance. Although it is common in alliance research to obtain a unilateral assessment of alliance (generally from the client perspective) (Doran, 2016; Fuertes et al., 2015; Fuertes et al., 2007), research suggests that provider-patient disparity in alliance rating often occurs (Meier & Donmall, 2006), and this information would be desirable to provide a more complete picture of the treatment landscape.

The present sample was a convenience sample, recruited through the university, which limits the generalisability of our findings to a young, relatively well-educated, and affluent population. Information regarding participants' illness category, duration of illness or ethnic background was not collected, each of which may influence levels of shame (Tang, Wang, Qian, Gao, & Zhang, 2008), working alliance reports (Doran, 2016; Walling, Suvak, Howard, Taft, & Murphy, 2012) and patient satisfaction (Chung, Palaniappan, Gamboa, & Luft, 2014; J. A. Hall & Dornan, 1990). It would be important to assess ethnic and socioeconomic status and to expand the diversity of participant samples in future research in order to broaden the generalisability of findings.

3.3.3.5 Conclusions

These preliminary results indicate that the reported quality of patient-provider working alliance is related to levels of dispositional shame in patients, such that greater levels of external shame are related to weaker reported alliance. The evidence also suggests that external and internal shame may be related to patient satisfaction with treatment provided by general practitioners. The relationship between external shame and satisfaction is partially accounted for by working alliance, but it is also directly related to patient satisfaction. In the context of this exploratory study, it has been demonstrated that external shame is a particularly relevant form of dispositional shame.

It is important to recognise the potential impact of external shame on working alliance and ultimately on patient satisfaction. Attending carefully to shame in clinical consultations may allow doctors to predict and pre-empt negative self-related evaluations, poor alliance and the low adherence and limited disclosure which evidence suggests go along with these (Bar-Sela et al., 2016; DeLong & Kahn, 2014; Fuertes et al., 2015; Fuertes et al., 2007; Harris & Darby, 2009; Macdonald & Morley, 2001).

There are several empirically-supported nonverbal indicators of patient shame which may act as signs for doctors in patient consultations, such as slumped posture and downward head tilt (Martens et al., 2012; Randles & Tracy, 2013; Tracy & Matsumoto, 2008). These have been observed across a range of cultural and ethnic groups in response to shaming stimuli (Tracy & Matsumoto, 2008). Evidently, there are also several empirically-validated scales which can assess levels of dispositional shame if time allows (Andrews et al., 2002; Goss et al., 1994), although these have not yet been trialled for use in medical practice.

Regardless of the means of identification, when high levels of shame *are* identified, it is generally recommended that practitioners provide patients with opportunities to express feelings of dissatisfaction or discomfort (Gilbert, 1999). Receiving statements about shame and humiliation with empathy may also be helpful in reducing the impact of shame-inducing

experiences, and it is noteworthy that empathy, acceptance and validation are also recommended for repairing ruptures in working alliance (Safran & Muran, 1996).

Finally, these results once again underscore the importance of developing and maintaining a good working alliance in healthcare (Bar-Sela et al., 2016; Doran, 2016; Fuertes et al., 2015; Horvath & Symonds, 1991), given its important relationship with patient satisfaction. They also suggest that it may be useful to administer the WAI routinely in practice. This simple, 12-item measure may provide doctors with important insights regarding patients' perception of the healthcare relationship, and help them address patient concerns in a way that reaches a satisfying resolution for all parties.

CHAPTER 4. STUDIES THREE AND FOUR: PILOT FOLLOW-UP AND CLINICAL STUDY: CLIENT SHAME, WORKING ALLIANCE, AND DISTRESS DISCLOSURE

4.1 Preamble

The aim of the first study in this combined paper was to replicate and expand upon the results from the pilot study, as well as including some additional measures to begin exploring potential mechanisms by which dispositional shame may exert influence over working alliance, such as tendency to disclose distressing information. Concurrent with this follow-up study, data collection had also begun for the second study summarised here, which aimed to assess the relationship between shame and working alliance in a clinical psychology sample. It was anticipated that these parallel studies would provide further information regarding the scope and nature of this relationship and allow for greater speculation on the potential mechanisms which may help to explain it.

4.2 Statement of Authorship

Title of Paper	Client Shame, Working Alliance and Distress Disclosure: Examining the Impacts of Shame-Proneness
Publication Status	Unpublished and Unsubmitted work written in manuscript style.
Publication Details	N/A

Principal Author

Principal Author (PhD Candidate)	Daniel Carabellese
Contribution to the Paper	Reviewed literature and prepared aims and hypotheses. Planned and executed major elements of the research, including ethics submissions, programming online platforms, developing pencil-and-paper questionnaires, and liaising with statistical services regarding analyses. Writing and editing of the manuscript in collaboration with supervisors. Preparation of the manuscript for submission to journal.
Overall percentage	85%

Certification	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.
Signature	
Date	2021-02-15

Co-Author Contributions

By signing the Statement of Authorship, each author certifies that: i. the candidate's stated contribution to the publication is accurate (as detailed above); ii. permission is granted for the candidate in include the publication in the thesis; and iii. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.	
Co-Authors	Dr Michael Proeve Associate Professor Rachel Roberts
Contribution to the Paper	Supervisors of the PhD research program. Oversaw research conceptualisation and planning. Provided regular supervision and discussion of research process. Collaborated in developing the content and structure of the manuscript, and reviewed drafts. Provided supervision and guidance around formatting the final results to form part of this thesis.

Signatures

Date 1 March 2021	Michael Proeve Michael Proeve
Date	Rachel Roberts Digitally signed by Associate Professor Rachel Roberts Date: 2021.03.01 16:19:58 +10'30'

4.3 Combined Manuscript

4.3.1 Introduction

Working alliance refers to the collaborative and goal-directed elements of the therapeutic relationship which forms between a healthcare provider and an individual accessing healthcare (Hatcher & Barends, 2006). In the context of psychotherapy, it is typically understood as one of the major drivers of therapeutic change and an extremely important element of therapy which reliably predicts client outcomes (Doran, 2016; Flückiger et al., 2018). It is of increasing interest to researchers to determine which characteristics of individuals entering the therapy relationship (i.e., 'dispositional' or personality variables) are predictive of a strong alliance versus those which threaten its development. A recent variable of interest which has emerged in this area is dispositional shame, and thus dispositional shame formed the focus of the two studies presented below.

The most common model of working alliance in psychological research is the tripartite model proposed by Bordin (1979), who divided the construct into three theoretical factors: client-practitioner agreement on the specific goals of treatment; client-practitioner agreement on which tasks are best suited to accomplish those goals; and the relational bond between the client and practitioner. Bordin (1994) and others have subsequently emphasised the importance of collaboration and purpose in this relationship, qualities which help to distinguish working alliance from other relationships which are less explicitly goal-directed (Hatcher & Barends, 2006).

Interestingly, there is some debate about the extent to which clients' and clinicians' ratings of alliance converge or diverge, and indeed about how meaningful such convergence or divergence may be (Kivlighan & Shaughnessy, 1995; Mallinckrodt & Nelson, 1991; Meier & Donmall, 2006). Recent meta-analytic work (Shick Tryon et al., 2007) broadly indicated that the ratings between clients and clinicians tended to be moderately positively correlated regardless of treatment setting or measurement modality; however, some past research has shown

significant divergence or indeed no relationship whatsoever (Kivlighan & Shaughnessy, 1995; Mallinckrodt & Nelson, 1991; Meier & Donmall, 2006).

Research suggests that a strong alliance is a reliable predictor of reduced symptoms of mental illness, reduced attrition in therapy, and increased client satisfaction with treatment, along with a range of other outcomes (Arnd-Caddigan, 2011; Doran, 2016; Fluckiger et al., 2012; Horvath et al., 2011; Martin et al., 2000; Tetzlaff et al., 2005). It is clear from this body of research that a strong alliance is highly desirable and must be attended to carefully to maximise the efficacy of treatment. One way in which clinicians may do this is to screen incoming clients for dispositional traits which are known to predict poor alliance, so that these can be addressed and managed early in treatment.

There is preliminary evidence to suggest that high dispositional shame may be related to weaker working alliance, and therefore indirectly related to worse therapeutic outcomes. For example, small negative correlations between working alliance ratings (of various forms) and scales assessing participant shame have previously been found in a range of studies across a variety of healthcare disciplines, including psychology, general practice, aged care, and others (Black et al., 2013; Carabellese et al., 2019; Faccini et al., 2020; Hamann et al., 2017; Lynoe et al., 2013; Mensinger et al., 2018). These studies are the subject of the review in Chapter 2. It is therefore of interest to examine shame in therapeutic relationships more closely in order to better understand what impact it may have, and how this can be mitigated if necessary.

Dispositional shame can generally be understood to mean a generalised tendency to experience shame in situations that would typically be regarded as shame-provoking. For example, a person with high dispositional shame is more likely to feel ashamed when making a social error (and thus experience this as more painful) than a person with lower shame proneness (Tangney et al., 1995). Notably, the term “dispositional shame” has also been used to refer to generalised or chronic feelings of shame which are present even when not specifically triggered by shaming events (Andrews, 1998; Leeming & Boyle, 2004). These

definitions, while not incompatible, reveal an ongoing debate in this area regarding the precise nature of this variable, however it is notable that both chronic shame and tendency to experience shame could be of relevance in healthcare relationships.

Shame as an experience is typically seen as self-referential – it is an emotion which relates to the undermining or negative evaluation of a person's identity (H. B. Lewis, 1971). Common sentiments emblematic of shame include "I am a bad person" and "I'm terrible", and the emotion is understandably described by most individuals as highly aversive, painful and often overpowering (Lindsay-Hartz, 1984; Wicker et al., 1983). It should also be noted that greater shame has been shown to be related to higher levels of psychopathology, including higher scores on measures of symptom severity in depression and anxiety (Cândea & Szentágotai-Tătar, 2013, 2018; Castilho, Pinto-Gouveia, & Duarte, 2017; Kim et al., 2011). High levels of shame may also be related to unhelpful behaviour in a therapy setting, including withdrawal, anger, deflection, and externalisation of blame (Black et al., 2013; Dearing, Stuewig, & Tangney, 2005).

Research on the relationship between shame and psychopathology increasingly makes the distinction between two sub-types of shame: internal and external shame (Cândea & Szentágotai-Tătar, 2018; Goss et al., 1994). In brief, internal shame refers to a judgement which a person makes about themselves (e.g., "I am a failure"), whereas external shame represents a fear or belief that others are making a negative evaluation (e.g., "everyone thinks I'm a failure"). External shame appears to have greater emphasis on the risk of exposure and social rejection (Gilbert, McEwan, Bellew, Mills, & Gale, 2009; M. Lewis, 1995). Some research has suggested that external shame may be the more impactful of the two types, in terms of severity of psychopathology (Cândea & Szentágotai-Tătar, 2018; Kim et al., 2011). This is perhaps reflective of the inherently high survival value of social relationships for humans. Indeed, the evolutionary and biopsychosocial model of shame suggests that a primary function of this

emotion is as a warning system for threats to social rank, to which humans have evolved to be extremely sensitive (Gilbert, 2003; Gilbert & McGuire, 1998).

Few studies have examined the impact of client shame on the development of a robust and functional working alliance (see Chapter 2) however theory regarding shame suggests that it is frequently related to avoidance and withdrawal (Tangney et al., 1992), particularly when the shame experienced is intense and the object of shame is difficult to repair. Given that psychotherapy is a setting in which exposure of highly personal and shame-inducing material is commonplace, it is reasonable to suppose that those people more likely to experience frequent, intense and highly aversive shame may have a correspondingly difficult time forming a strong and purposeful relationship with their therapist, and may be more prone to experiencing ruptures in the alliance (Safran & Muran, 1996).

The exact mechanism by which dispositional shame may threaten the alliance is unclear; however DeLong and Kahn (2014) illuminated a potential avenue of interest in their study of secret-specific disclosures. They observed that individuals with higher levels of expressed shame typically anticipated less support from counsellors, which had the flow-on effect of predicting lower willingness to disclose specific secrets. Past research assessing reasons for non-disclosure in therapy has typically shown similar results, with shame and embarrassment being explicitly identified by participants (Hill et al., 1993; Hook & Andrews, 2005; Kelly, 1998). Highly shame-prone individuals may be less likely to share their true thoughts and feelings in therapy and may be correspondingly less likely to benefit from therapeutic interventions. This may then have the flow-on effect of generating disagreement about the goals of therapy and the proper steps to address these goals (Newman & Strauss, 2003), which naturally has implications for the alliance.

Similarly, Kelly and Yuan (2009) found that clients who reported keeping treatment-relevant secrets from their therapist also returned lower ratings of working alliance. Interestingly, they observed that therapists also rated these alliances as weaker, despite the

fact that they were typically unable to discern which clients had been less forthcoming. D. Hall and Farber (2001) argued that the relationship between working alliance and disclosure was likely reciprocal, with their results suggesting that working alliance and time in therapy were both predictive of increased disclosures. The limited empirical work available in this area thus far is therefore supportive of the hypothesis that shame-prone individuals may disclose less in treatment, which raises the possibility that the alliance may be threatened by unvoiced disagreements about the objectives and appropriate treatment options for the undisclosed issues.

Although these results do suggest a reciprocal relationship of disclosure and working alliance, it is noteworthy that past research has generally failed to find much evidence for non-disclosure having an immediate negative effect on the severity of mental illness (Kelly, 1998; Kelly & Yuan, 2009). It may then be the case that disclosure's immediate effect is restricted to working alliance, and that its impact on outcomes is only relevant insofar as working alliance is related to outcomes (Doran, 2016; Martin et al., 2000).

Although the literature reviewed thus far illuminates the possibility of a shame-alliance relationship, there has been limited work thus far which has directly investigated this issue. Furthermore, few studies exist which attempt to examine dispositional variables' relationships with alliance over time, despite the prediction that alliance will grow and change over the course of treatment (Gelso & Carter, 1994). The aim of the two studies summarised in this paper was therefore to investigate the hypothesised relationship between dispositional shame (of various forms) and willingness to disclose distressing or secret information, with an emphasis on the potential flow-on impacts on working alliance. This was pursued first in a larger, non-clinical sample as a proof-of-concept (study 3, 'Community Sample'), with a second study run partially in parallel (study 4, 'Clinical Sample') which extended this framework into a sample of participants currently receiving treatment for various forms of mental illness. It was hypothesised that relationships would be detected between dispositional shame levels and

willingness to disclose distressing information in both cases, with a corresponding effect on working alliance both at a single time point when recalled retrospectively (study 3) and over time when measured contemporaneously (study 4).

4.3.2 Study 3 – Community Sample

4.3.2.1 Aims & Hypotheses

The primary aim of study 3 was to investigate hypothesised relationships between various forms of dispositional shame and individuals' willingness to disclose distressing or secret material, both in a general sense as well as regarding specific secrets. A secondary aim was a partial replication and extension of DeLong and Kahn's (2014) finding that shame was related to secret-specific disclosures, with the important addition of measures concerning past experiences of psychotherapy (including working alliance). Finally, study 3 aimed to build upon findings by Carabellese et al. (2019) with a partial replication of the methodology used in this study, with the key difference being that the retrospective evaluation of working alliance pertained to mental health clinicians, rather than to primary care physicians. The intent was thus to establish whether the relationship between shame and alliance detected in Carabellese et al. (2019) was also present in a mental health sample.

Accordingly, it was hypothesised that:

1. Dispositional shame (both internal and external) would be negatively related to retrospective ratings of working alliance, with external shame predicted to have the strongest relationship.
2. Generalised tendency to disclose distressing information would be positively related to retrospective evaluation of working alliance.
3. Both dispositional shame and secret-specific shame would be negatively related to generalised tendency to disclose distressing information, as well as willingness to disclose specific secrets.

The following supplementary hypotheses were also proposed:

4. Greater levels of shame (of all kinds) would be associated with more severe pathology (i.e., higher scores on mental illness symptom inventories).
5. Positive past experiences of therapy (i.e., higher working alliance ratings) would be associated with greater secret-specific willingness to disclose to an imagined therapist.
6. Dispositional shame (of all kinds) would be positively associated with shame regarding a specific secret (i.e., generalised tendency to experience shame predicts experiencing shame on a specific topic).

4.3.2.2 Method

Power analysis indicated that a total sample of approximately 120 participants would be required to detect the anticipated small correlations between shame and alliance measures (~.25) with power (1 - β) set at .80 and α = .05 (Hulley et al., 2013). Participants were 177 members of the University of Adelaide community (primarily staff and students), ranging from ages 18 to 71. The sample was predominantly female, with a notably smaller percentage of male or non-binary participants. The majority had attained at least a High School education, and nearly 60% of the sample reported previous experience with psychotherapy. Although participants were asked about their ethnic or cultural background, the data collected by the write-in box provided was unfortunately uninterpretable, and therefore was not included. Table 1 presents demographic information for these participants.

Recruitment was managed through the university's online learning platform to which all students and staff have access, and the entirety of the questionnaire was completed anonymously online. As such, all participants in the study were affiliated with the university in some way, either staff, students, or visitors with access to the university intranet. In order to capture a sample large enough to satisfy the requirements, the study was made accessible for the entirety of an academic year (approximately 10 months) and was open to any member of the university community.

Although one of the major areas of interest in the study was working alliance and thus participants with past therapy experience were preferred, the study was also opened to prospective participants without therapy experience. This was done to increase the likelihood of obtaining a sufficient sample (and thus statistical power) for the imaginal secret-specific disclosure section of the study which was intended to facilitate analysis of the relationship between shame and secret-specific disclosure. This section was completed by all participants and did not require past therapy experience.

Table 1[2]
Descriptive statistics for study 3 participants (*N*=177)

Gender (%)	
Female	120 (68%)
Male	54 (31%)
Nonbinary	2 (1%)
No response	1 (<1%)
Mean Age (SD)	25.7 (10.24)
Level of Education (%)	
Primary School	1 (<1%)
High School	94 (53%)
Bachelor's Degree	46 (26%)
Trade/Technical/Vocational Certification	20 (11%)
Graduate Diploma	5 (3%)
Postgraduate Degree	11 (6%)
Previous psychotherapy experience (%)	
Yes	104 (59%)
No	68 (38%)
Prefer not to say	5 (3%)

Eligibility criteria were deliberately broad, with the intent of capturing a range of experiences and points of view; any person aged over 18 who was a fluent speaker of English and willing and able to give informed consent was invited to participate. Participants entering the study were eligible to enter a draw to with one of two $50 (AUD) gift cards to a local

[2] Tables numbered individually by study (study 3, study 4) in order of appearance.

electronics retailer, and 29 undergraduate psychology students (16% of total sample) were awarded course credit for introductory Psychology courses. No other incentive for participation was provided.

Ethical approval for the study protocol was granted by the University of Adelaide School of Psychology Human Research Ethics Subcommittee (approval number 1950).

4.3.2.2.1 Measures

In addition to the instruments described below, participants were asked to provide a range of demographic information including age, level of education, and ethnic or cultural background.

Dispositional Measures

Depression Anxiety & Stress Scale 21 (DASS-21)

The DASS-21 is a shortened version of the original, 42-item P. F. Lovibond and S. H. Lovibond (1995) self-report questionnaire designed to assess core symptoms of depression, anxiety and stress. Each of the 21 items is scored on a 4-point scale which asks participants to rate the extent to which each emotional state has been experienced over the past week. It has generally been shown to have good construct validity, with each subscale being distinct, while also serving as a reliable measure of general psychological distress (Henry & Crawford, 2005). The DASS-21 is extensively used as a screening tool by healthcare professionals in Australia and has previously shown acceptable internal consistency reliability in both clinical and non-clinical samples (Antony, Bieling, Cox, Enns, & Swinson, 1998; Crawford & Henry, 2003; P. F. Lovibond & S. H. Lovibond, 1995). In this study, it was included to provide a measure of psychological distress. In this sample, the coefficient alphas for the depressive, anxiety and stress subscales were .83, .87 and .72, respectively.

Other As Shamer Scale (OAS).

Allan et al. (1994) and Goss et al. (1994) developed the Other as Shamer scale in order to assess global judgements of how participants think others view them. It contains 18 items which are scored by participants on a 5-point scale ranging from 0 (*Never*) to 4 (*Almost Always*). These items are worded in the first person, and invite participants to rate their thoughts and feelings, e.g., "I feel other people see me as not good enough." or "I think others are able to see my defects." Goss et al. reported a very high degree of internal consistency for this scale (Cronbach's α = .92) (Goss et al., 1994). This scale was used to assess individual levels of external shame. The coefficient alpha in this sample was .89.

Experience of Shame Scale (ESS).

The Experience of Shame Scale (Andrews et al., 2002) is comprised of 25 items which are divided into eight conceptual areas of shame, including shame related to; personal habits; manner with others; sort of person you are; personal ability; doing something wrong; saying something stupid; failure in competitive situations; and bodily shame. Each item is rated by participants on a 4-point Likert-type scale, ranging from 1 (Not at all) to 4 (Very much). Items ask respondents to rate the extent to which they have had certain experiences, e.g. "Have you worried what other people think of the sort of person you are?", "Do you feel ashamed when you do something wrong?". Andrews et al. (2002) reported that this scale has a high level of test-retest reliability over a time of approximately 11 weeks (r=.83) and strong internal consistency (Cronbach's α=.92). The ESS was used as a global assessment of dispositional shame. The coefficient alpha in this sample was .93.

Test of Self-Conscious Affect, Shame Subscale (TOSCA-3-Shame).

The Test of Self-Conscious Affect-3 (Tangney & Dearing, 2002) is a test of dispositional emotions experienced in specific contexts. Respondents are presented with 16 scenarios, each

of which is followed by a block of four potential responses which are rated in terms of likelihood for that person from 1 (*Not Likely*) to 5 (*Very Likely*). For example, for the scenario "You break something at work and then hide it.", respondents are asked to rate the likelihood of the following statement: "You would think about quitting." The TOSCA is commonly used in studies of shame and guilt (Andrews et al., 2002). In the present study, only the 11 items pertaining to shame were included, and the TOSCA was treated as a measure of context-dependent internal shame (Kim et al., 2011). The coefficient alpha for the included items was .76.

Distress Disclosure Index (DDI)

The DDI (Kahn & Hessling, 2001) is a brief, 12-item questionnaire intended to assess a person's general tendency to disclose (rather than conceal) information which they find distressing or upsetting (Kahn & Hessling, 2001). Items are scored by participants on a 5-point Likert-type scale ranging from 1 (*Strongly Disagree*) to 5 (*Strongly Agree*). Total scores can range from 12 to 60, with higher scores reflecting a greater tendency towards disclosing distress. It includes items such as "I prefer not to talk about my problems" and "I am willing to tell others my distressing thoughts." Kahn, Hucke, Bradley, Glinski, and Malak (2012) reported that the scale shows strong internal consistency (Cronbach's α=.93), and that DDI scores were strongly associated with self-reported disclosing behaviour. The coefficient alpha in this sample was .91.

Secret-Specific Measures

In order to assess the impact of dispositional shame on willingness to disclose a specific secret, the procedure described by DeLong and Kahn (2014) was adopted for this study. Specifically, participants were asked to imagine a specific secret and rate the intensity of shameful feelings associated with this, as well as their predicted willingness to disclose this

secret to an imagined counsellor. The specific prompt was reproduced verbatim from DeLong and Kahn (2014, p. 295).

Participants were not asked to describe their secret in detail, but instead were able to nominate one of ten categories adapted from Kelly and Yip (2006) and DeLong and Kahn (2014). Specifically, these categories were: (1) sex, (2) desiring or having a romantic relationship with a particular person, (3) a family secret, (4) a health problem, (5) death, (6) socially unacceptable behaviour (like cheating on a test or taking drugs), (7) an eating disorder, (8) abortion or pregnancy, (9) feeling alienated from others or, (10) other (please specify). Notably, it was decided to change the original category of item 6 ("delinquency") to "socially unacceptable behaviour" and provide an example after several pilot participants expressed confusion over the meaning of the word "delinquency" and were unable to think of examples of what this might mean. The categories were presented in a randomised order to each participant, to avoid influencing responses.

As in DeLong and Kahn (2014, p. 295), secret-specific shame was assessed using the following method:

> Participants were first instructed, "How strongly does your secret make you feel …," followed by three theoretically derived shame-specific emotions or experiences, namely "shame," "like hiding or disappearing," and "exposed."

The shame-specific emotion prompts formed part of a 13-item list with other emotion-related prompts, such as "cheerful", "like breaking something" and "satisfied". These prompts were also presented in a randomised order, with the logic of the survey designed such that the three shame-specific prompts would never occur in sequence. Participants rated their agreement with each emotion prompt on a 5-point Likert-type scale from 1 (*Very Slightly or Not at all*) to 5 (*Extremely*). Their scores on the three shame-specific items were then averaged

to create a composite score, the coefficient alpha for which was .75, indicating good internal consistency reliability.

Finally, participants were asked to imagine that they had sought counselling related to their secret. They then rated their willingness to disclose the specific secret with responses to three specific items, adapted from Garrison, Kahn, Sauer, and Florczak (2012) and DeLong and Kahn (2014): "To what degree would you share information about this secret with your counsellor?", "How much would you want to keep your thoughts about this secret to yourself?" (reverse scored) and "How much would you share your feelings about this secret?" The same 5-point Likert-type scale was used for these responses. Again, responses were averaged to derive a composite score, for which the coefficient alpha was .82, indicating a high level of internal consistency reliability.

Past Experience of Therapy Measures

On the final page of the questionnaire, participants were asked if they had previously seen a psychologist, counsellor, or other mental health professional at any time in their lives. Those who answered affirmatively (N=104, 59% of the sample) were asked to provide additional information about this experience. This included the length of time since their last appointment, how many sessions they had attended, the regularity of sessions, and a general comment on the presenting issue for which they sought treatment. In order to maximise the number of responses, no restrictions were placed on recency or frequency of past treatment attendance. Although this ensured a larger sample, it also introduced a considerable degree of variability in the number of therapy sessions and time elapsed since sessions. Participant responses to the relevant items are summarised in Table 2.

These participants were also asked to make a retrospective evaluation of their working alliance with this professional, by completing the Working Alliance Inventory (see below), with the added prompt:

We understand that your last experience of therapy may have been some time ago - please try and answer as accurately as possible based on your memory of your past experience.

Table 2
Details of past therapy attendance for subsample with past therapy experience (n=104)

Time since last appointment (% of sample)	
Days	14 (13%)
Weeks	8 (8%)
1-2 months	16 (15%)
3-6 months	12 (12%)
7-11 months	10 (10%)
1-5 years	35 (34%)
6-10 years	4 (4%)
Over 10 years	5 (5%)
Regularity of Appointments (% of sample)	
One-off	16 (15%)
Rarely	7 (7%)
Not at all regularly	8 (8%)
Somewhat regularly (e.g. bi-monthly)	20 (19%)
Regularly (e.g. monthly)	30 (29%)
Very regularly (e.g. fortnightly)	23 (22%)
Number of sessions attended* **	
Range	1 - 200
Mean (SD)	11.97 (22.63)
Median	5
Lower Quartile | Upper Quartile	2 | 12

*** Median and lower and upper quartile reported as extreme outliers were present.**
**** *N*=103, as one response was uninterpretable.**

The Working Alliance Inventory Short Revised Version: Client Variant (WAI-SR-C)

The WAI is a measure of working alliance as defined by Bordin (1979), divided into the three key areas of agreement on tasks, agreement on goals and the therapeutic bond. It has been exhaustively validated, reliability tested and used with a huge variety of populations, including dozens of languages and ethnic groups. The Hatcher and Gillaspy variant of the WAI (Hatcher & Gillaspy, 2006) demonstrates excellent internal consistency reliability (subscale alphas ranging from .85 to .90, total score alphas from .91 to .92), as well as very strong

correlations (.94 to .95) with the original Working Alliance Inventory developed by Horvath and colleagues (Hatcher & Gillaspy, 2006; Tracey & Kokotovic, 1989).

Procedure

Participants were recruited via traditional advertising (e.g., posters around the university campus) as well as digital advertising displayed on the university's intranet which provided them with a direct URL to access the anonymous online study platform and complete the survey. Alternatively, first-year psychology students who completed the study for course credit were able to view a short introduction and access the study directly through the School of Psychology's online research management system. They were then presented with an information page regarding the study and asked to give their informed consent by clicking "next". The study was advertised as being related to shame and secret keeping, with an emphasis on the anonymity of responses. Participants were advised that they could withdraw at any time, and data were stored only for those that completed the entire questionnaire (i.e., no partial records were kept).

Participants were then directed to complete a short demographic questionnaire, followed by the measures described above in the order: (a) dispositional measures, (b) secret-specific measures and (c) past experience of therapy measures. Only those participants who indicated they had previously attended therapy (n=104, 59%) completed phase (c), with the remaining participants (n=73) being directed to the debriefing page which briefly summarised the aims of the study and provided contact information for the researchers. Those participants who completed phase (c) were also subsequently directed to this page. On the debriefing page, participants were also able to anonymously provide feedback or comments.

Data Analysis

In order to assess hypothesised relationships between dispositional and secret-specific shame measures (ESS, TOSCA-3, OAS, shame composite score) and overall and subscale retrospective working alliance ratings (WAI, and B, T, G subscales), Pearson's correlational analyses were planned. Such analyses were also planned to assess relationships between these measures and indices of disclosure (DDI, secret-specific disclosure) and severity of symptoms of depression, anxiety and stress as assessed by the DASS-21.

To examine the relative contribution of different subtypes of dispositional shame in predicting working alliance, disclosure tendency, secret-specific shame, and secret-specific willingness to disclose, multiple linear regression analyses were also planned, with an additional linear regression model planned to assess the predictive power of generalised tendency to disclose (DDI scores) on likelihood of making specific disclosure.

Examination of histograms and scatter plots indicated that all study variables were normally distributed and satisfied the assumptions of both Pearson's correlational analyses and multiple linear regression analyses.

All analyses were conducted using statistical software SAS 9.4 (SAS Institute Inc., Cary, NC, USA) and Stata Statistical Software: Release 15.1 College Station, TX: StataCorp LP.

4.3.2.3 Results

Table 3 presents the means, standard deviations, and correlations among all study variables. Although the sample in study 3 was a non-clinical group, mean DASS-21 depression (M=15.34) and anxiety (M=13.02) scores fell in the 'extremely severe' range, and the mean stress score (M=15.82) in the 'severe' range according to recommended cut-offs (S. H. Lovibond & P. F. Lovibond, 1995), suggestive of a relatively high level of psychological distress across these categories.

With regards to the specific secrets described by participants during the imaginal phase of the study, 20% (*n*=36) of participants indicated their secret was about sex, 23% (*n*=41) desiring or having a romantic relationship with a particular person, 16% (*n*=28) family secrets, 18% (*n*=32) health problems, 11% (*n*=19) death, 28% (*n*=49) socially unacceptable behaviour, 6% (*n*=10) eating disorders, 5% (*n*=9) abortion or pregnancy, and 18% (*n*=32) feeling alienated from others. Sixteen percent (*n*=28) of participants responded "other", with example secrets including gender identity, mental illness and self-harm, sexual assault/rape, and unusual sexual or romantic interests. Participants were able to select multiple categories to describe their secret and as such the sum of percentages is greater than 100%.

No statistically significant correlations were evident between any of the dispositional shame scores (ESS, TOSCA-3, OAS) and overall or subscale retrospective working alliance ratings (WAI, and B, T, G subscales) although there were several non-significant correlations in the predicted direction (small and negative) (*rs*=-.1 to -.3). As such, H1 that dispositional shame would be negatively related to working alliance had limited evidence to support it.

The majority of correlations between DDI scores and WAI scores were non-significant; however, a small, positive correlation was detected between DDI and WAI-T, suggesting that generalised tendency to disclose distressing information was positively related to retrospectively rated agreement on tasks of therapy. As such, H2 that tendency to disclose distressing information would be positively related to retrospectively rated working alliance had limited support.

As anticipated, dispositional shame scores on all three shame measures (ESS, OAS, TOSCA-3) showed small, negative correlations with DDI scores; however, only the correlation with the TOSCA-3 was statistically significant. Similarly, the relationship between secret-specific shame composite scores and DDI scores was in the expected negative direction but non-significant. Secret-specific disclosure composite scores showed no statistically significant relationship with any shame measures, including secret-specific shame composite scores.

Taken together, these results suggest that H3 was generally unsupported, with little evidence of a relationship, albeit with one statistically significant correlation of the expected size and direction.

With regards to the supplementary hypotheses, dispositional shame scores of all kinds, as well as shame composite scores, showed small to moderate positive correlations (*rs*= .34 to .65) with severity of symptoms of depression, anxiety and stress as assessed by the DASS-21. The OAS and ESS showed larger correlations with DASS-21 subscales than did the TOSCA-3. As such, H4 that greater shame would be associated with more severe psychopathology in this sample was supported.

Working alliance (total and subscale) ratings showed small to moderate positive correlations (*rs*=.27 to .42) with secret-specific willingness to disclose composite scores. This provided support for H5: that more positively rated retrospective working alliance would be associated with a greater willingness to disclose a secret to an imagined future therapist.

Finally, secret-specific shame composite scores showed moderate, positive correlations with all dispositional shame measures (ESS, OAS, TOSCA-3), which provided support for the supplementary hypothesis H6 that dispositional shame scores would be related to secret-specific shame scores.

Table 3

Means, standard deviations and correlations (Pearson's *r*) among major study variables, including Experience of Shame Scale scores (ESS Shame), Test of Self-Conscious Affect shame scores (TOSCA Shame), Other as Shamer Scale scores (OAS Shame), Distress Disclosure Index scores (DDI), and Depression, Anxiety, Stress scale and subscale scores (DASS) (*N*=177), as well as retrospectively rated Working Alliance Inventory scores and subscale scores (WAI) (*n*=104).

Variable	M	SD	ESS Shame	TOSCA Shame	OAS Shame	Distress Disclosure (DDI)	Shame Composite Score	Disclosure Composite Score	DASS-Depression	DASS-Anxiety	DASS-Stress
ESS Shame	63.62	16.85	-								
TOSCA Shame	35.04	8.65	.60**	-							
OAS Shame	29.08	15.70	.70**	.50**	-						
DDI	35.86	11.19	-.10	-.18*	-.15	-					
Shame Comp.	2.81	1.16	.61**	.47**	.53**	-.10	-				
Disclosure Comp.	3.16	1.10	-.04	-.06	-.14	.43**	.01	-			
DASS-Depression	15.34	6.18	.55**	.34**	.62**	-.17*	.45**	-.12	-		
DASS-Anxiety	13.02	4.98	.56**	.36**	.55**	-.09	.39**	-.02	.66**	-	
DASS-Stress	15.82	5.43	.64**	.41**	.65**	-.06	.44*	-.07	.73**	.78*	-

Previous Therapy (*n*=104)	M	SD	ESS Shame	TOSCA Shame	OAS Shame	Distress Disclosure (DDI)	Shame Composite Score	Disclosure Composite Score	DASS-Depression	DASS-Anxiety	DASS-Stress	WAI-Bond (*N*=104)	WAI-Tasks (*N*=104)	WAI-Goals (*N*=104)	WAI-Total (*N*=104)
WAI-Bond	12.87	4.78	-.08	-.01	-.03	.15	.12	.29*	-.19	-.13	-.12	-			
WAI-Tasks	11.73	4.70	-.12	-.05	-.16	.20*	-.05	.42*	-.32*	-.28*	-.30*	.78**	-		
WAI-Goals	12.55	4.81	-.22	-.08	-.24	.14	-.03	.27*	-.32*	-.25*	-.25*	.82**	.83**	-	
WAI-Total	37.14	13.35	-.15	-.16	-.11	.18	.01	.35*	-.29*	-.23*	-.24*	.93**	.93**	.95**	-

**p<.05*
***p<.0001*

It was also of interest to examine the relative contribution of different subtypes of dispositional shame in predicting working alliance, disclosure tendency, secret-specific shame, and secret-specific willingness to disclose. As such, four separate multiple linear regression models were conducted, with variables entered simultaneously. Assumptions of a linear model were found to be upheld throughout by inspection of scatter plots and histograms of residuals and predicted values. Results of these analyses are presented in Table 4.

No significant associations emerged in regression analyses of dispositional shame variables versus working alliance, nor those of dispositional shame versus DDI scores. Similarly, secret-specific disclosure did not appear to show any significant associations with dispositional shame scores. As such, none of the hypothesised relationships between these variables were detected in these data.

In contrast, there were significant associations between OAS scores and secret-specific shame scores, as well as between ESS scores and secret-specific shame scores. These results indicated that each one-point increase in OAS score was predictive of a .01-point increase in secret-specific shame score, whereas each one-point increase in ESS score was predictive of a .03-point increase in secret-specific shame score, adjusting for all covariates in that model. This was supportive of the supplementary hypothesis H7 that higher dispositional shame would be predictive of greater shame regarding a specific secret, albeit with a small effect.

In addition to the regression models displayed in Table 4, a final linear regression model was conducted to assess the predictive power of generalised tendency to disclose (DDI scores) on likelihood of making specific disclosure. Results of the linear regression indicated that there was a significant association between DDI and secret-specific disclosure composite score (Estimated mean difference=.04, [95% CI=0.03, 0.06], $\chi 2(1)=40.54$, $p<.0001$), such that for every one-unit increase in DDI, the mean secret-specific willingness to disclose composite score increased by approximately .04 units.

Table 4

Multivariable linear regression models, including separate models for Working Alliance Inventory (WAI) score, Distress Disclosure Index (DDI) score, secret-specific shame composite score and secret-specific willingness to disclose composite scores versus dispositional shame (Other As Shamer Scale, Experience of Shame Scale and Test of Self-Conscious Affect scale scores). The scale parameter was estimated by maximum likelihood.

Outcome	Predictors	Mean Difference (Estimated)	95% CI	$\chi2$ (df)	Global *p* value
WAI-Total[a]	OAS-Shame	-0.02	(-0.24, 0.20)	0.02 (1)	0.881
	ESS-Shame	-0.15	(-0.38, 0.08)	1.59 (1)	0.208
	TOSCA-Shame	0.13	(-0.26, 0.52)	0.41 (1)	0.524
DDI-Total[b]	OAS total	-0.09	(-0.23, 0.06)	1.38 (1)	0.241
	ESS total	0.06	(-0.08, 0.21)	0.71 (1)	0.399
	TOSCA total	-0.23	(-0.47, 0.00)	3.70 (1)	0.054
Secret-specific Shame[b]	OAS total	0.01*	(0.00, 0.03)	4.95 (1)	0.026
	ESS total	0.03*	(0.01, 0.04)	19.28 (1)	<0.0001
	TOSCA total	0.02	(0.00, 0.04)	3.73 (1)	0.053
Secret-specific Disclosure[b]	OAS total	-0.02*	(-0.03, -0.001)	4.29 (1)	0.038
	ESS total	0.01	(-0.01, 0.02)	1.53 (1)	0.217
	TOSCA total	-0.005	(-0.03, 0.02)	0.16 (1)	0.686

*$p<.05$

[a] $n=104$ participants with past experiences of therapy.

[b] $N=177$ for total sample.

Given the discrepancy between these results and those of the pilot study (Carabellese et al., 2019), particularly with regards to correlations between shame and working alliance, supplementary analyses were conducted. It was hypothesised that the discrepancy may be accounted for by the fact that participants in the pilot study were required to have regularly seen the same GP over the past year, whereas participants in this study were able to report on therapy experience from any time in the past. As such, the supplementary analyses involved separating out the subset of participants who had experienced therapy within the past year ($n=60$) and running correlational analyses only for this group. Evidently, this further reduced the statistical power to detect small effects, however this was considered acceptable for

exploratory purposes. No meaningful differences between the initial correlations and those of this subgroup were detected in these analyses, and no correlations not previously significant reached statistical significance.

4.3.3 Study 4 – Clinical Sample

Concurrent with Study 3, data collection had also been initiated for Study 4, the design of which is summarised below. This clinically-focussed and longitudinal study was intended to address several key shortcomings of Study 3. Most notably, Study 3's retrospective design did not allow for longitudinal commentary on the development of working alliance, nor did it capture clinician perspectives. It was also desirable to take baseline assessments of dispositional variables (e.g., shame-proneness, disclosure tendency) prior to ratings of alliance, which would allow for greater ability to comment on temporal sequence and causality.

Furthermore, although the community sample in Study 3 reported a relatively high level of psychological distress on the DASS-21, it was considered important to capture data from participants currently receiving treatment for psychological disorders This was particularly pertinent given the emphasis on working alliance.

4.3.3.1 Aims & Hypotheses

The primary aim of study 4 was to translate the methodology of Carabellese et al. (2019) and study 3 into a clinical sample, with the intent of assessing the extent to which the relationships detected were present in this population. Specifically, this study aimed to investigate the hypothesised relationship between shame (internal and external) and working alliance. Similar to study 3, a secondary aim was to ascertain whether the hypothesised relationship between shame and working alliance was mediated to any extent by a generalised tendency to disclose distressing information. It was also planned that working alliance ratings would be gathered over time and contemporaneously, rather than single time point retrospective ratings as in previous studies. This was intended to allow for examination of alliance scores across the duration of treatment, as well as improving the fidelity of ratings by

ensuring they were taken immediately following the experience of therapy, rather than recollected later. This was also in recognition of a tertiary aim of establishing whether the shame-alliance relationship remained constant throughout treatment, or changed in strength over time.

Accordingly, it was hypothesised that:

1. Baseline dispositional shame would be negatively related to both client- and clinician-rated working alliance across all time periods, as it had previously been shown to be related in single time period designs.
2. Baseline dispositional shame would be negatively related to baseline willingness to disclose distressing information.
3. The relationship between baseline shame and subsequently-rated working alliance would be mediated by baseline willingness to disclose distressing information.
4. Client-rated and clinician-rated working alliance will show at least a small, positive correlation across treatment.

4.3.3.2 Method

Client Participants

Participants were 18 psychotherapy clients ranging from ages 25 to 62 (M=37.18, SD=11.65) who presented for treatment at an outpatient psychology clinic attached to a large multidisciplinary treatment facility over the 24-month recruitment period. Table 1 presents demographic information for these participants. Recruitment was managed by the administrative staff of the clinic where the study was conducted, and the specific process is described below. Data were gathered using pencil-and-paper questionnaire batteries provided to clients by clinic staff at specific time-points in treatment. Clinicians were not required to make formal diagnoses of each client enrolled in the study; however provisional diagnoses

were provided. The primary presenting concerns identified were PTSD (*n*=5), Depression (*n*=4), Adjustment Disorders (*n*=4), Generalised Anxiety (*n*=2), Social Anxiety (*n*=1), situational stress (*n*=1) and Conversion Disorder (*n*=1).

Individuals were eligible to participate in the study if they were imminently to be receiving care at the clinic, aged over 18, fluent speakers of English, willing and able to give informed consent, and not currently requiring acute care (i.e., not experiencing active and immediate suicidal/homicidal ideation, not requiring hospitalisation). Recruitment exclusions were made by treating clinicians as needed based on the final criterion. No monetary or other incentive was provided to participants.

Clinician Participants

Clinicians completed a short sociodemographic questionnaire prior to study commencement, which requested information on self-identified gender and age, as well as level of qualification, years of experience, and primary therapeutic approach. All clinicians (*N*=6, 3 identifying as female, 3 as male, age *M*=37.60, SD=8.20) involved in the study held General Registration as Psychologists with the Psychology Board of Australia and each had a minimum Masters-level qualification in psychology. Years of practice experience ranged from two to eight (*M*=4.8, *SD*=2.4). The therapeutic orientation was varied – all clinicians endorsed using Cognitive Behavioural Therapy (CBT), however all but one were also trained in Acceptance and Commitment Therapy (ACT) and three in Schema Therapy, with a single clinician also practicing Attachment-based therapy. No requirement was imposed that clinicians use a particular approach with clients involved in the study.

Measures

In addition to the measures described below, participants also completed the majority of dispositional measures described in study 3 (*section 4.3.2.2.1, Measures*), namely, the DASS-

21, OAS, ESS, and DDI. It was decided to omit the TOSCA-3 from the questionnaire battery as the results from the completed pilot study (Carabellese et al., 2019) had demonstrated limited additional benefit from using this scale along with other shame measures, and it was desirable to reduce the burden on participants as much as possible. Unlike the first study, participants completed these as pencil-and-paper forms; however, the items and scoring were identical. These measures were completed during two phases of the study: (a) baseline, prior to attending any therapy sessions and (c) follow-up (after session 6) for those that remained in the study to this point.

The DASS-21 was an optional addition provided to participants by the treating psychologist and data from this measure were ultimately not included in any analyses as the majority of psychologists chose not to use it.

As part of the baseline questionnaire, participants provided a variety of demographic information, including self-identified gender, age in years, level of education, and ethnic or cultural background. Single-question items were also included which asked participants whether they had previously received professional psychological care, and if they had an existing relationship with their current clinician. None of the six participants who had previously attended therapy endorsed any pre-existing relationship with their treating psychologist (i.e., all were new clients).

Furthermore, participants were invited to rate their perceived likelihood of making important life changes, and their confidence that consulting with a psychologist would be helpful to them. Both questions were rated on a five-point Likert-type scale. Aggregate data for these items are presented in Table 1. Client predictions for their likelihood of making important changes through therapy were generally high, as were their ratings of the expected helpfulness of therapy.

Table 1[3]
Descriptive statistics for study 4 client participants (*N*=18)

Gender (%)	
Female	14 (82%)
Male	3 (18%)
Nonbinary	0 (0%)
Mean Age (SD)	37.18 (11.65)
Level of Education (%)	
Some High School	2 (12%)
High School	6 (35%)
Trade/Technical/Vocational Certification	6 (35%)
Graduate Diploma	3 (18%)
Ethnic/Cultural Background (Self-report)	
Australian	13 (76%)
Other	4 (24%)
Previous Therapy Experience	
Yes	6 (35%)
No	12 (65%)
Client Predictions for Therapy*	
Mean likelihood of making changes (SD)	4.06 (0.90)
Mean confidence in helpfulness (SD)	3.94 (0.90)

*Both scales rated out of 5, with higher values being more positive predictions.

Treatment Perceptions Questionnaire (TPQ)

The TPQ (Marsden et al., 2000) is a brief, 10-item scale designed to assess satisfaction with healthcare services. It was originally developed by the authors to assess treatment satisfaction for clients with substance abuse problems, however none of the items are specific to this area. Respondents are presented with 10 prompts and asked to rate their experience from *Strongly Agree* to *Strongly Disagree* (0-4), with some items being negatively worded and the score numbering being reversed. Example items include: “I have received the help that I

[3] Tables numbered individually by study (study 3, study 4) in order of appearance.

was looking for" and "The staff have not always understood the kind of help I want" (reverse scored). For each item, participants are also invited to provide a written response if they wish to do so, and the final page includes a section to provide longer written commentary. Validation studies suggested good internal consistency and construct validity (Marsden et al., 2000). In this study, the TPQ was used to assess clients' satisfaction with treatment after six sessions of psychotherapy. It was chosen in recognition of its brevity and simplicity, as well as the fact that it is freely available for use by researchers.

The Working Alliance Inventory Short Revised Version: Client Variant (WAI-SR-C) and Therapist Variant (WAI-SR-T)

As with study 3, the Hatcher and Gillaspy (2006) revision of the brief WAI was employed to assess working alliance in this study. In addition to the 'client' variant, the 'therapist' (clinician) variant was also used. This version of the WAI-SR is similar to the client variant; however, the items are re-worded to refer to the clinician's appraisal of the client and their relationship. Both versions of the scale have similar psychometric properties and variants of the WAI represent the de facto standard for assessing this construct, being used in a significant majority of research on working alliance (Flückiger et al., 2018). In this study, the WAI-SR was chosen for its superior psychometric properties as well as to maximise consistency with study 3.

Procedure

Pre-Study: Recruitment

Participants were recruited from the pool of new psychotherapy clients presenting at a large multidisciplinary medical clinic affiliated with the university over approximately 24 months. The clinic provides general psychological care for most common forms of mental illness, including anxiety and mood disorders, trauma-related disorders, and others. Clients are

typically referred to the clinic by other healthcare practitioners however they are also able to self-refer.

Potential participants were made aware of the study via a flyer sent out prior to their first presentation at the clinic. This flyer was sent along with new client materials (e.g., induction questionnaires) which are sent to all clients who make an appointment at the clinic. The initial flyer was advisory only and provided interested parties with a general description of the study and its requirements, as well as contact details for the researchers and information about ethical approvals for the study.

At the potential participant's next contact with the clinic (typically to schedule an appointment), they were asked by administration staff if they would be interested in participating in the study. Those who accepted were provided with information packets about the study by e-mail or post and were given the option to contact researchers to learn more. No data were recorded for participants who declined to participate.

The study procedure was split into three phases which were intended to allow data gathering which would permit commentary on hypotheses with a temporal component. This procedure is summarised below, and is also elaborated in Figure 1.

Phase (a): Baseline

Participants were provided with a baseline questionnaire battery upon arrival for their first appointment with a psychologist. This questionnaire was completed in the waiting area prior to receiving any treatment at the clinic. In addition to a range of demographic information, the baseline questionnaire also contained measures assessing internal and external shame, tendency to disclose distressing information, and confidence in treatment (see above). In order to ensure that their answers were not visible to clinic staff, participants were asked to place their completed responses directly into a locked mailbox which was made available at reception.

Phase (b): Active Treatment

Immediately following each psychological consultation (including the first appointment), both clients and clinicians completed the appropriate variant of the WAI-SR (C or T variants). Clients completed this in the waiting room, whereas clinicians were free to complete this in any place not in sight of clients. As before, these were placed directly into the locked mailbox to ensure that clinicians and clients were not able to influence or view the other's responses.

Phase (c): Follow-up

It was decided that a second battery of the main study measures would be provided to participants following the sixth treatment session. This was based on the typical mid-treatment review procedure employed in most Australian psychology clinics, in which clients referred to psychologists under a Mental Health Care Plan are required to undergo a review with their referring doctor after six sessions in order to continue accessing treatment supported by the public health system (Pirkis et al., 2010).

At the conclusion of the sixth session, participants were asked to complete a variant of the baseline questionnaire, which was modified to include a measure of client satisfaction with treatment. This was intended to form the primary point of comparison with baseline data. Of the 18 participants enrolled in the study, 5 (28%) reached session six and completed this questionnaire.

Participants were given the option of continuing to provide working alliance data beyond the session 6 follow-up point. A small number of participants (n=4 at session 7, n=2 at session 8, n=1 at session 9) chose to do so, and both they and their treating psychologist continued to complete measures of working alliance until the conclusion of the study or of treatment.

Ethical approval for the study protocol was granted by the University of Adelaide Human Research Ethics Committee (HREC, approval number H-2018-032).

4.3.3.3 Results

Planned Analyses

As with study 1, it was anticipated that any correlations detected were likely to fall in the small-to-moderate range which is typical of working alliance research (Flückiger et al., 2018). Power analysis suggested a sample of approximately the same size (~120) was desirable to detect a small correlation (r=.20) with power (1 - β) set at .80 and α = .05. Evidently, the sample size of the present study was significantly below this estimate, and analyses were adjusted appropriately where possible to account for this.

Hierarchical linear modelling was used to assess the hypotheses in this study. This methodology was chosen as it allows for the analysis of relationships among variables with hierarchical levels of aggregation. This was considered necessary for these data because several clinicians provided information for more than a single client (i.e., clients were nested within clinicians). Furthermore, repeated observations within the same client/clinician dyad are also considered nested data. HLM was also considered appropriate as it is relatively robust to small sample sizes (Hox, Moerbeek, & Van de Schoot, 2017). A compound symmetry covariance structure was used throughout this analysis.

All analyses were conducted using the combined longitudinal data except where otherwise noted. The statistical software used was SAS 9.4 (SAS Institute Inc., Cary, NC, USA).

Phase (a): Baseline *Measures completed upon arrival at the clinic, immediately preceding session 1.*	
Client Participants (*N*=18) completed:	**Clinician Participants (*N*=6) completed:**
- Sociodemographic Questionnaire - Experience of Shame Scale (ESS) - Other as Shamer Scale (OAS) - Depression, Anxiety, Stress Scale (DASS-21) - Distress Disclosure Index (DDI) - Past Experience of Therapy items - Perceived likelihood of making change - Perceived helpfulness of therapy	- Sociodemographic Questionnaire (inc. level of training, experience).

Phase (b): Active Treatment *Measures completed following each therapy session, including session 1.*	
Session 1	
Client Participants (*N*=18) completed: - WAI-SR-C	**Clinician Participants (*N*=5) completed:** - WAI-SR-T
Session 2	
Client Participants (*N*=12) completed: - WAI-SR-C	**Clinician Participants (*N*=6) completed:** - WAI-SR-T
Session 3	
Client Participants (*N*=9) completed: - WAI-SR-C	**Clinician Participants (*N*=3) completed:** - WAI-SR-T
Session 4	
Client Participants (*N*=5) completed: - WAI-SR-C	**Clinician Participants (*N*=3) completed:** - WAI-SR-T
Session 5	
Client Participants (*N*=7) completed: - WAI-SR-C	**Clinician Participants (*N*=3) completed:** - WAI-SR-T

Phase (c): Follow-up *Measures completed following session 6-9.*	
Session 6	
Client Participants (*N*=5) completed: - WAI-SR-C - Experience of Shame Scale (ESS) - Other as Shamer Scale (OAS) - Depression, Anxiety, Stress Scale (DASS-21) - Distress Disclosure Index (DDI) - Treatment Perceptions Questionnaire (TPQ)	**Clinician Participants (*N*=2) completed:** - WAI-SR-T
Session 7	
Client Participants (*N*=4) completed: - WAI-SR-C	**Clinician Participants (*N*=2) completed:** - WAI-SR-T
Session 8	
Client Participants (*N*=2) completed: - WAI-SR-C	**Clinician Participants (*N*=1) completed:** - WAI-SR-T
Session 9	
Client Participants (*N*=1) completed: - WAI-SR-C	**Clinician Participants (*N*=1) completed:** - WAI-SR-T

Figure 1.
A description of the phased approach of Study 4, including administration times of various measures and Ns at each time point.

Results

Although data were complete at baseline, there were several instances of missing values from session 1 onwards, with the majority being client after-session questionnaires which had not been returned. No attempt was made to impute the missing values as there was not considered to be sufficient non-missing data to provide an accurate estimate of true population parameters (Engels & Diehr, 2003; Sterne et al., 2009). As such the number of valid working alliance observations for clinicians was n=62, whereas it was n=52 for clients. This is noted where relevant in the analyses below.

Although it was originally intended that client satisfaction with treatment (as assessed by the TPQ) would be one of the study's outcome variables, the data from this measure were ultimately not included in any analyses, as only four were returned with interpretable scores. As such, TPQ does not appear in any of the below analyses. Mean baseline ESS-Shame scores (M=54.59, SD=14.68) were somewhat lower than those found in study 3, but comparable to those reported in the instrument's validation study (Andrews et al., 2002). By contrast, mean baseline OAS-Shame scores (M=34.47, SD=15.35) were in a similar range to those found in study 3 (both of which were approximately 10-15 points higher than those reported by Goss et al., 1994). The mean baseline willingness to disclose (DDI) score in these data was 31.31, (SD=10.03).

Dispositional Shame and Working Alliance

In order to investigate the hypothesised relationship between baseline dispositional shame and client- and clinician-rated working alliance across therapy, linear mixed-effects models were performed, with client and clinician WAI scores as the outcome variables and baseline OAS, ESS and DDI scores as predictor variables (individual models). Assumptions of a linear model were found to be upheld by inspection of scatter plots and histograms of

residuals and predicted values. The models were adjusted for clustering on clinician and repeated measurements over time. Results are presented in Table 2.

No significant associations were found between client OAS-shame and total working alliance ratings in any of the models examined. By contrast, client ESS-shame scores showed significant positive associations with total client-rated WAI, as well as the Bond and Goals subscales. These results indicated that for every one-unit increase in ESS-shame, mean client-rated WAI increased by .37 units, with the Bond and Goals mean subscale scores increasing by .16 units and .13 units, respectively. This result suggested that greater dispositional shame as assessed by the ESS is predictive of higher-rated working alliance with all time points considered. No such result was found for clinician-rated working alliance or its subscales.

Dispositional Shame and Distress Disclosure Tendency

In order to investigate the hypothesised association between baseline dispositional shame scores (OAS, ESS) and distress disclosure tendency (DDI), two further linear mixed-effects models were performed. As before, these analyses were adjusted for clustering on therapist, however no adjustment for repeated measures was necessary as only baseline data were used. Results are presented in Table 3.

No significant associations were detected in these analyses, suggesting that neither of the dispositional shame measures used were meaningfully related to tendency to disclose distressing information in these data.

Table 2

Individual linear mixed-effects models of working alliance variables versus dispositional shame variables and distress disclosure index, adjusting for repeated measures and clustering on therapist.

Outcome	Predictor	Mean Difference (Estimated)	95% CI	*p* value
Clinician WAI-Total[a]	OAS-Shame	0.02	(-0.17, 0.22)	0.814
	ESS-Shame	0.08	(-0.13, 0.30)	0.444
	DDI Score	0.27	(-0.11, 0.64)	0.156
Clinician WAI-Tasks	OAS-Shame	0.01	(-0.06, 0.08)	0.786
	ESS-Shame	0.04	(-0.03, 0.11)	0.278
	DDI Score	0.07	(-0.06, 0.20)	0.277
Clinician WAI-Bond	OAS-Shame	0.02	(-0.05, 0.09)	0.615
	ESS-Shame	0.02	(-0.06, 0.10)	0.583
	DDI Score	0.08	(-0.05, 0.22)	0.232
Clinician WAI-Goals	OAS-Shame	0.01	(-0.06, 0.07)	0.847
	ESS-Shame	0.02	(-0.05, 0.09)	0.609
	DDI Score	0.09	(-0.03, 0.21)	0.153
Client WAI-Total[b]	OAS-Shame	0.02	(-0.32, 0.36)	0.906
	ESS-Shame	0.37*	(0.01, 0.73)	0.043
	DDI Score	0.45	(-0.33, 1.23)	0.255
Client WAI-Tasks	OAS-Shame	0.00	(-0.10, 0.11)	0.974
	ESS-Shame	0.09	(-0.03, 0.21)	0.124
	DDI Score	0.14	(-0.09, 0.37)	0.230
Client WAI-Bond	OAS-Shame	0.01	(-0.13, 0.15)	0.907
	ESS-Shame	0.16*	(0.02, 0.30)	0.031
	DDI Score	0.16	(-0.14, 0.47)	0.286
Client WAI-Goals	OAS-Shame	0.01	(-0.11, 0.12)	0.886
	ESS-Shame	0.13*	(0.01, 0.25)	0.033
	DDI Score	0.12	(-0.15, 0.39)	0.361

*$p<.05$

[a] $n = 62$ for therapist ratings of working alliance.

[b] $n = 53$ for client ratings of working alliance.

Note: Only baseline values of OAS, ESS, and DDI score were included in analyses and therefore WAI scores represent the only repeated measures.

Table 3

Individual linear mixed-effects models of distress disclosure tendency (DDI) versus dispositional Other as Shamer Scale Scores (OAS) and Experience of Shame Scale scores (ESS), adjusting for clustering on therapist. (Client *N*=17)

Outcome	Predictor	Mean Difference (Estimated)	95% CI	*p* value
DDI Score	OAS-Shame	-0.16	(-0.53, 0.20)	0.330
	ESS-Shame	-0.30	(-0.64, 0.05)	0.081

Note: Baseline data only, no repeated measures.

Convergence/Divergence of Working Alliance Ratings

It was also of interest to examine the difference or similarity in ratings of working alliance between clinicians and clients. As the working alliance variables were positively skewed, non-parametric Spearman correlation coefficients were calculated between the clinician and client variables. These are presented in Table 4. A moderately strong and statistically significant positive correlation was identified between total client WAI scores and total clinician WAI scores, and small-to-moderate correlations were observed among the majority of subscales. The major exception to this appeared to be the Client 'Bond' subscale scores, which did not show any statistically significant correlations with clinician total or subscale scores.

Table 4

Means, standard deviations and correlations (Spearman's ρ) between Working Alliance Inventory total and subscale scores for clinicians and clients[a]

Variable	M	SD	Clin. WAI Total	Clin. Tasks	Clin. Bond	Clin. Goals	Client WAI Total	Client Tasks	Client Bond	Client Goals
Clin. WAI-Total	39.80	8.81	-							
Tasks	11.53	2.86	.91**	-						
Bond	16.85	3.55	.88**	.66**	-					
Goals	11.42	2.91	.95**	.89**	.73**	-				
Client WAI-Total	49.60	11.28	.42*	.44*	.32*	.44*	-			
Tasks	16.08	3.39	.51*	.53**	.39*	.52**	.93**	-		
Bond	17.28	3.61	.23	.23	.14	.26	.82**	.63**	-	
Goals	18.91	3.52	.43*	.44*	.32	.44*	.96**	.85**	.78**	-

[a]Note: Clinician x Clinician correlations *n*=62, whereas Client x Client correlations *n*=53 and Clinician x Client correlations *n*=52, due to missing data.

*$p<.05$

**$p<.0001$

4.3.4 Discussion

The primary purpose of these studies was to assess the predicted relationship between dispositional shame and working alliance, with a particular emphasis on willingness to disclose distressing information as a possible mechanism to help explain this relationship. These variables were examined in both a community and a clinical sample, which allowed the investigation of the hypothesised relationships in both a highly controlled and a real-world setting, and the integration of multiple perspectives into the analyses. The majority of hypotheses were predominantly unsupported – most notably, the results of neither study showed a statistically significant relationship between shame and working alliance. Specific consideration of each of the major areas of focus is given below.

4.3.4.1 Shame and Working Alliance

In both studies, it was hypothesised that different forms of dispositional shame would be predictive of lower-rated working alliance, both by clients (studies 3 and 4) and clinicians (study 4) and both retrospectively (study 3) and contemporaneously (study 4). This hypothesis

was based on a variety of earlier research which suggested that these two constructs were generally negatively related (Black et al., 2013; Carabellese et al., 2019; Faccini et al., 2020; Hamann et al., 2017; Lynoe et al., 2013; Mensinger et al., 2018). It is surprising, therefore, to note that no such relationship emerged in either study, and indeed a small positive relationship between shame (as measured by the ESS) and client-rated working alliance emerged in study 4.

There are several possible explanations for this unexpected result. The first is that there was simply no negative relationship between the assessed variables in these samples. This would seem to be unlikely, given past research suggesting a negative relationship between shame and working alliance, as well as a positive relationship between shame and psychopathology (Cândea & Szentágotai-Tătar, 2018; Kim et al., 2011) and negative relationship between psychopathology and working alliance (Doran, 2016; Flückiger et al., 2018; Horvath et al., 2011), but it is nevertheless a possibility. It is also inconsistent with the limited past research which has shown a small but reliable negative correlation between shame and working alliance (Black et al., 2013; Faccini et al., 2020; Simonds & Spokes, 2017).

One key difference which distinguishes study 3 from past research in this area was that working alliance ratings were obtained retrospectively rather than contemporaneously, sometimes years after the therapy service had been provided. Previous therapy experience was also not constrained to any particular frequency or past time period. It should be noted that working alliance ratings in similar research have typically been made while currently receiving psychotherapy or with a recent psychotherapy history (Black et al., 2013; Faccini et al., 2020; Farber & Hall, 2002; Simonds & Spokes, 2017), or a regular, consistent, and recent attendance at the same GP clinic (Carabellese et al., 2019). The present-tense wording of the WAI items also suggests that it is intended to be used while therapeutic experiences are relatively current, and indeed the vast majority of studies using the WAI have obtained contemporaneous ratings

(Flückiger et al., 2018). It is therefore reasonable to argue that this non-standard use of the WAI may be partially responsible for the inconsistent data seen in study 3.

A second possibility is that both studies were underpowered to detect the hypothesised relationship. It is notable that the majority of past research in this area has shown the relationship to be reliably small (rs<.25), and neither study satisfied the requirements of the power analyses to detect an effect of this size. Although the overall sample in study 1 (N=177) was sufficiently powered to detect a small effect, the subsample of past psychotherapy attenders (n=104) was not, despite utilising the longest data collection phase permitted by ethical approval. Indeed, it is notable that the correlations were typically of the size and direction predicted, albeit non-significant. It may simply be that more statistical power is required to discern this relationship, and that it may have reached statistical significance in study 3 had the proportion of past psychotherapy-attenders been higher.

With regard to the small, positive associations between dispositional shame and client working alliance ratings in the clinical sample, these are harder still to explain. There is limited research available which assesses both working alliance and shame in a clinical context and as such it is difficult to situate this result relative to past findings. It is also interesting to note that this relationship emerged only for ESS and not other shame measures. Given the limitations already discussed, it is difficult to speculate as to why this may be – however it is a result of interest to be noted for future research.

4.3.4.2 Shame and Disclosure Tendencies (General & Specific)

Both studies' secondary hypotheses that dispositional shame would be negatively related to willingness to disclose distressing information (both generalised and specific) were generally not borne out in these studies, with the exception of one small correlation between one measure of dispositional shame (TOSCA-3) and generalised disclosure tendency in study 3. Taken together, these studies support the notion of a reciprocal relationship between shame and disclosure tendencies but limited to the context-dependent shame assessed by the

TOSCA-3. Neither of the other dispositional shame measures across both studies showed meaningful relationships with disclosure tendencies (generalised or specific). Although this does not align with literature which suggests that shame and disclosure of specific secrets are negatively related (Hook & Andrews, 2005; Kelly, 1998), it is generally consistent with the finding that shame-proneness does not predict a generalised tendency to disclose which has emerged in some other research (DeLong & Kahn, 2014; Farber & Hall, 2002).

With regards to replicating the results of DeLong and Kahn (2014), the results of this study partially replicated those previously reported. Specifically, they reported a correlation of TOSCA-3 with DDI of -.05 (non-significant) whereas the present results showed a small, negative correlation of -.18 (p<.05). Conversely, DeLong and Kahn (2014) reported a TOSCA-3 with Disclosure Composite Score correlation of -.18 (p<.05), whereas in this study the correlation was both smaller and non-significant (r=-.06, p>.05). Interestingly, the OAS correlation with disclosure composite score was more comparable (r=-.14, p=.067), though non-significant. This is suggestive of some relationship between these variables which may warrant further consideration in future.

By contrast, secret-specific shame composite scores were correlated with dispositional shame measures in a similar way to those found by DeLong and Kahn (2014). Specifically, moderately sized positive correlations were found between each of the measures used (ESS, TOSCA-3, OAS) and the shame composite score, which corresponds well with DeLong and Kahn's (2014) reported TOSCA-3 and Shame Composite correlation (r=.41, p<.01).

As to the discrepancy with DeLong and Kahn's (2014) finding that secret-specific disclosure was predicted by shame proneness, there are several reasons this may have emerged. One possible explanation is that the small correlation detected by DeLong and Kahn (2014) reached significance partly as a result of their relatively larger sample size (N=312) versus the comparatively small samples in studies 3 (N=177) and 4 (N=18). It may also be attributable to differences in the sample – for example, it is possible that some cultural

attitudes towards secret-keeping or notions of what is shameful may vary between North America and Australia.

4.3.4.3 Shame and Psychopathology

One of the most robust findings which emerged from study 3 was that dispositional shame measures of all kinds were small-to-moderately positively related to higher scores on assessments of psychological dysfunction. This result is perhaps unsurprising given the volume of past research which indicates that a greater tendency to experience shame is associated with greater psychological distress across a range of disorder categories (Cândea & Szentágotai-Tătar, 2013, 2018; Gramzow & Tangney, 1992; Kim et al., 2011; Tangney et al., 1992). Regrettably, there were insufficient data to assess this relationship in the clinical sample. That said, although the sample in study 3 was a non-clinical group made up primarily of university staff and students, mean DASS-21 Depression and Anxiety subscale scores fell in the extremely severe range, and mean Stress subscale scores fell in the severe range. This was unexpected, however it is consistent with past research which has demonstrated that the prevalence of mental health problems in this population is typically extremely high both in Australia and internationally (Sharp & Theiler, 2018; Stallman, 2010). As such, it may still be possible to generalise these results somewhat to groups experiencing clinically significant psychological disturbance.

4.3.4.4 Dispositional versus Secret-Specific Shame

As predicted, the composite shame score derived from the prompt list regarding specific secrets in study 3 was moderately positively related to measures of dispositional shame. Indeed, the shame composite score showed correlations of similar strength to those intercorrelations between the various dispositional measures. External shame (OAS) and primarily-internal shame (ESS) (but not context-dependent shame [TOSCA-3]) were also predictive of increased scores on the secret-specific shame composite when analysed as part of a regression model. This is an encouraging finding and suggests that this simple, 3-item

measure is generally addressing the appropriate domains for an assessment of shame (i.e., convergent validity). It would be interesting in future research to compare this to a full-scale measure of 'state' shame (i.e. situation-specific shame) such as the State Shame and Guilt Scale (SSGS) (Marschall et al., 1994) to determine whether this may serve as an adequate proxy for such measures.

This result also suggests that a generalised tendency to experience shame (of various kinds) is related to the experience of shame in a specific instance. That dispositional shame should predict specific, situational shame is unsurprising, and is a well-understood phenomenon in a conceptual sense (Tangney, 1996; Tangney & Dearing, 2002; Tracy et al., 2007).

It is also interesting that – although the correlations typically fell within the same general range – the strongest correlation with shame composite scores was the Experience of Shame Scale (ESS) scores, and the ESS was the strongest predictor of increased secret-specific shame in regression models. This may be attributable to the fact that the ESS assesses a wide range of domains which map relatively well onto the secret categories provided in the study and thus may have been particularly pertinent to participants keeping secrets in those areas.

4.3.4.5 Working Alliance and Disclosure Tendencies

As expected, generalised disclosure tendency was positively related to some elements of retrospectively rated working alliance in study 1 - specifically, the 'agreement on tasks' subscale. This suggested that those individuals who were typically more willing to share distressing information provided a more favourable rating of the extent to which they and past therapists agreed on how they should go about 'doing therapy'. Positive correlations of a similar size and direction were found for other working alliance subscales and total alliance; however, these did not reach significance. Once again, this may be partly related to the subsample of past therapy attenders (n=104) being underpowered to detect the effect.

Interestingly, retrospectively rated working alliance was related to greater willingness to disclose specific secrets in study 3, with a small-to-moderate correlation. Although correlational analyses do not allow for temporal or causal inferences, this nevertheless suggests that a favourable view of past therapy is related to a greater openness to sharing specific secret material with a future counsellor or therapist. It is probable that this is related to the outcome expectations identified by DeLong and Kahn (2014), who reported that the relationship between shame and specific disclosures was mediated by anticipated support from counsellors and anticipated risks of disclosure.

Taken together, these results are broadly supportive of past research which suggests that disclosure tendencies and working alliance share a reciprocal relationship, with more disclosure resulting in better alliance, and better alliance facilitating more disclosure (D. Hall & Farber, 2001; Kelly & Yuan, 2009).

4.3.4.6 Client versus Clinician-Rated Alliance

Having access to both client and clinician-rated measures of session-by-session working alliance ratings in study 4 created the valuable opportunity to compare the two. As predicted, client and clinician contemporary ratings of working alliance were moderately positively correlated when taking all sessions into account. Interestingly, the 'Bond' subscales failed to show any significant correlations. This could be attributed once again to a small sample size without adequate power to detect a true effect; however, it is also plausible that the evaluation of feelings of trust and liking was genuinely not consistent between clients and clinicians.

Nevertheless, these results broadly align with those of Shick Tryon et al. (2007), whose meta-analysis indicated that such ratings tend to be moderately positively correlated, and that this correlation does not seem to be meaningfully impacted by the type of treatment, illness, time in therapy or method of alliance measurement.

4.3.4.7 General and Specific Disclosures

Unsurprisingly, generalised tendency to disclose was related to a greater self-rated likelihood of disclosing a specific secret in correlational analyses and predictive of greater disclosure in regression analyses. The correlations found were similar in strength to those found by DeLong and Kahn (2014). This provides further conceptual support for the DDI as a measure of disclosure tendency in terms of its ability to predict a specific disclosure, and also generally supports the notion that a tendency to disclose distressing information is related to greater willingness to share specific secrets in an appropriate context.

4.3.4.8 Strengths, Limitations and Recommendations for Future Research

A number of important methodological issues were present in both studies which must be considered. Most notably and as acknowledged above, both studies were underpowered to detect small relationships. Study 4 (clinical sample) suffered from extensive difficulties with recruitment and retention and as such the analyses which were possible were also limited. Study 3 (community sample) was relatively more robust in terms of sample size; however, the sub-sample of past therapy attenders fell short of the required power to detect the anticipated effects. As such, it must be acknowledged that the effects detected in these studies may have reached significance had the studies been appropriately powered. It would be advantageous for future research to secure larger samples, and potentially expand to multiple clinics to increase potential uptake in clinical populations.

Recruitment difficulties of this sort have long been recognised in clinical research (Holden, Rosenberg, Barker, Tuhrim, & Brenner, 1993; Prescott et al., 1999; S. Ross et al., 1999) and are particularly relevant in a mental health setting, where the most recent available Australian data suggest an average number of 4.5-4.6 mental-health specific services per patient (including GP appointments, consultations with a psychologist, consultations with a psychiatrist, and/or other allied healthcare providers) (Australian Institute of Health and

Welfare, 2020; Seidler et al., 2020). As such, consistent tracking of outcomes over the course of therapy is only likely to be possible for a small proportion of participants regardless.

Both samples were convenience samples, recruited through the university and the university-affiliated health clinic, respectively. Although every effort was made to keep the eligibility criteria broad, this limits the generalisability of the findings of study 3 to a population which is relatively young, educated and predominantly white and English-speaking. This is somewhat less relevant for study 4 given that the clinic where the study took place is open to the public and provides bulk-billed or rebated (i.e., government-subsidised) services to a primarily lower SES community. Nevertheless, this may be problematic given that cultural background and socioeconomic factors are known to influence levels of shame and working alliance reports (Doran, 2016; Tang et al., 2008; Walling et al., 2012). Once again, it would be desirable for future research to expand to multiple clinics and populations to obtain a more representative sample of the population as a whole.

It is important to acknowledge that there was a significant gender disparity in both studies, with a substantially greater proportion of participants identifying as female as compared to male or non-binary identifying participants. Despite this, no specific analyses of gender differences was made as part of the studies – it would be useful in future to compare and contrast these groups to determine whether the results are generalisable or representative across genders.

Similar to DeLong and Kahn (2014), study 3 relied upon unvalidated measures of secret-specific shame and disclosure tendency. Although correlations with other relevant and validated measures emerged as expected, and internal consistency reliability was high, it would be useful to conduct validation research on these measures. Until this is done, the validity of these assessments remains uncertain.

Despite these limitations, these combined studies also had several important strengths. The most obvious of these is that the dual-study approach allowed for two complementary

methodologies which (ideally) addressed each other's shortcomings. For example, although bi-lateral ratings of alliance were impossible in study 3, they were collected in study 4. Similarly, it was not ethically or practically possible to assess specific secret-keeping in the clinical sample, and therefore this was done in a non-clinical context. Furthermore, significant efforts were made to select a battery of measures which permitted nuanced examination of the variables of interest, such as multiple, theoretically distinct measures of shame (i.e., internal and external shame measures) and multiple perspectives on working alliance (i.e., client and clinician). Diverse and multi-method research of this sort increases our ability to comment on hypotheses from multiple perspectives.

4.3.4.9 Conclusions and Implications

Although no statistically significant relationship was detected between shame, alliance and disclosure, these studies nevertheless have several important clinical implications. The first of these is further support for the link between dispositional shame and psychological disturbance. This serves as an important reminder to clinicians to attend carefully to high levels of shame in clients entering treatment, as this is likely to be related to a greater level of psychological distress and may also form an important target for therapeutic interventions.

The results also imply that disposition-level measures of internal and external shame serve as adequate predictors of shame in specific situations or pertaining to specific information, with the ESS being a particularly good, broad assessment given its ability to capture a variety of domains. Although these results suggest that the disclosure is equally likely to take place regardless of shame level, a brief assessment of dispositional shame may help to forewarn clinicians that clients may experience shame provoking discussions as particularly painful or difficult. An assessment of context-specific shame such as the TOSCA-3 may also be able to provide some insight on an individual's likelihood of being forthcoming with distressing information in general, although this result should be interpreted with caution.

Finally, it appears to be the case that a favourable past experience of therapeutic relationships (i.e., positively rated past working alliance) is related to a greater willingness to share specific secrets in future therapy. Although it is difficult to influence this directly, it nevertheless provides additional support for the notion that working alliance is an important factor to attend to in therapy, not only for the client's present experience, but to improve their comfort with sharing in future therapeutic experiences.

4.3.5 Acknowledgements

The data collection for study 4 ('Clinical Sample') would not have been possible without the diligent work of the administrative and clinical staff at the clinic, whose names we cannot reproduce for anonymity reasons. Their patience and kindness in collecting and managing these data were invaluable. Thanks also are due to all participants who gave up their time to be part of both studies.

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CHAPTER 5. CONCLUSION

5.1 Overview

The general aim of this research project was to investigate the hypothesised relationship between dispositional shame and working alliance in healthcare relationships, with a secondary aim of determining if this relationship differed in any meaningful way when considering different forms of shame (e.g., internal vs. external). It was also intended to explore potential mechanisms to account for this relationship (should it be found), with the primary hypothesis being that lower shame may be related to increased willingness to disclose distressing material, which might then have a positive impact on development of the alliance.

These research aims were pursued through four studies: a scoping review assessed the existing evidence linking shame and alliance (and appropriate proxies) in a range of healthcare disciplines (Chapter 2); a pilot study assessed patient-rated alliance with primary care physicians which included a variety of shame measures in a community sample (Chapter 3); a follow-up to the pilot study (also in a community sample) which included a similar battery of shame and alliance measures, but also included measures of general and specific disclosure (Chapter 4, part 1) and; a study which applied this methodology to a clinical setting and also gathered multi-perspective ratings over time (Chapter 4, part 2). Overall, the four studies indicated a small, reliable relationship between shame and working alliance; however, the proposed mechanism of disclosure tendency was not supported and no meaningful differentiation between shame types with regard to working alliance emerged in the synthesis of results.

This chapter summarises the major findings of each study, their implications (both theoretical and practical), strengths and limitations of the research, and future research directions which may be indicated.

5.2 Review of Major Findings

5.2.1 Study 1 – Scoping Review

Initial literature reviews in the early stages of the current research project determined that empirical investigation into shame and alliance had been minimal, with no systematic review or meta-analyses available and few studies deliberately designed to assess for this relationship. Accordingly, the methodology of a scoping review was chosen with the intent of surveying a broad range of healthcare literature. The primary aim was to answer the research question: what is known about the relationship between shame and working alliance?

This aim was achieved through a comprehensive and deliberately broad scoping review, which accessed a variety of healthcare-related databases (PubMed, PsycInfo, Embase and CINAHL) and grey literature. There was no fixed date restriction, capturing data from 1831 to April 2020. Inclusion criteria specified that studies must be quantitative, published in English, and include some assessment of working alliance (or an appropriate proxy), some assessment of shame (or an appropriate proxy), and assess, measure, report or comment on the relationship between these in an interpretable way. A large number of unique results (N=4960) were screened for relevance through title and abstracts, with 28 of these being selected for full-text screening. Of those, 13 were judged to meet the inclusion criteria – 10 published journal articles and three unpublished dissertations. All of the included results dated from the year 2000 or later. The majority of studies were conducted in a psychotherapeutic context; however, the particular client presentations were varied. Other studies took place in a mix of medical, aged care, and community settings.

Overall, the synthesis of results suggested that dispositional shame was modestly negatively related to working alliance, such that greater levels of shame were likely to be related to lower-rated alliance. This evidence was considered to be preliminary for various reasons, the most notable of which being that the measurement of shame and working alliance was not found to be standardised or consistent across studies. A variety of

unvalidated, study-specific and unvalidated measures were used in the included studies. The data were thus difficult to compare and synthesise.

It was noted in this research that none of the included studies were longitudinal and all relied on patient- or client-rated working alliance, with no practitioner ratings reported. Similarly, very few included multiple measures of shame, with only a single study deliberately including measures of internal and external shame. It was also found that no studies had explicitly set out to compare and analyse relationships between shame and alliance, with the majority of reported results being incidental to study hypotheses.

Several practical recommendations were generated as a result of this review. Firstly, wherever possible, working alliance research should endeavour to obtain both patient and clinician perspectives to provide a broader picture of the alliance and to assess whether these differed in any meaningful way. Secondly, such research should be conducted longitudinally if possible, over the course of healthcare involvement, in recognition of the fact that alliance is part of a relationship which develops over time. Thirdly, validated measures of shame and alliance are readily available, and should be used unless a compelling reason exists to do otherwise, as this enhances both the validity of conclusions drawn and the comparability to other published studies. Finally, studies including measures of shame should ideally include multiple shame measures, in recognition of the potential for different outcomes based on different sub-types of shame (e.g., internal vs. external).

5.2.2 Study 2 – Pilot Investigation

The primary aim of the pilot study was to empirically assess the hypothesised relationship between dispositional shame (both internal and external) with patient-rated working alliance and satisfaction with their care. It was also anticipated that the pilot would assist in the validation of measures which were planned to be used in a subsequent clinical study. Notably, this study was conducted partially concurrently with the scoping review (study 1) and was published prior to completion of the review. As such, it was later eligible for

inclusion in the review. The study was conducted with community members (*N*=127, mean age 25.9 years) recruited from the University of Adelaide, primarily staff and students. The particular alliance of interest was between the participants and their general practitioner (i.e., primary care physician). Participants were eligible for the study provided they were adults (>18 years), fluent speakers of English, and had regularly visited a general practitioner (at least bimonthly) over the past year, with the most recent visit being within the past three months. Correlational analyses and mediation analyses were used to assess for the hypothesised relationships.

The study aims were achieved through a quantitative methodology in which participants were asked to complete an anonymous online questionnaire in which they provided contemporaneous ratings of dispositional shame (three measures: TOSCA-3, ESS, OAS) and retrospective ratings of working alliance with their general practitioner, and satisfaction with their care. No data were sought from the physicians.

In summary, the results of the study indicated that only external shame was negatively correlated with retrospectively rated working alliance, with a small effect. In addition to being statistically significant, the correlation between external shame and working alliance was shown to be slightly larger than that between internal shame and working alliance. Both internal and external shame were also negatively related to patient satisfaction with care, and the relationship of external shame to patient satisfaction was mediated by working alliance. As such, the findings of this study indicated that shame was related to working alliance in this setting, as hypothesised.

The pilot study also provided the opportunity to consider which measures should be included in subsequent studies. For example, the TOSCA-3 was included as it is widely used in shame research, however it did not appear to show the same effect size or statistical significance of relationships with alliance as the other shame measures assessed. It was also found to be less tolerable to participants, with some study respondents questioning its

relevance or expressing frustration with the response options available. Based on this, as well as other literature questioning the validity and appropriateness of the TOSCA for assessing dispositional shame (for a review, see *section 1.4.2.1, Test of Self-Conscious Affect*), it was also decided to omit this measure from the clinical study (Study 4) to reduce the burden on participants. By contrast, the ESS and OAS (primarily measures of internal and explicitly external shame respectively) appeared to show subtly different relationships with outcome variables, and it was recommended that both measures be included in future research.

In addition to these practical recommendations, several clinical recommendations were made. Chief among these was that physicians may benefit from brief assessments of patient shame to determine where extra attention may need to be paid to working alliance, with a likely flow-on effect on patient satisfaction. Similarly, assessing working alliance and satisfaction at key treatment time points was suggested as a means of identifying and addressing concerns with care that may arise.

5.2.3 Study 3 – Pilot Follow-up

Similar to the pilot study, Study 3 was conducted with University of Adelaide community members (primarily staff and students, *N*=177, mean age 25.7 years) recruited using the same method as in the pilot. The major aim of the study was to expand on the pilot study by including a hypothesised mechanism of action for the relationship between shame and alliance - willingness to disclose distressing information. The same retrospective-rating methodology was used for working alliance; however, in this case participants were asked to reflect on a relationship with a mental health professional, and as such a secondary aim was to attempt to replicate the results from the pilot study in this context. A final objective was to partially replicate DeLong and Kahn's (2014) methodology around secret-specific disclosures from their study which demonstrated that those with high shame typically anticipated less support from counsellors. It was anticipated that this would allow for commentary on both general and specific tendency to disclose information.

It was hypothesised that dispositional shame (all kinds) would be negatively related to retrospectively rated working alliance, generalised tendency to disclose distressing information, and secret-specific willingness to disclose. It was also predicted that generalised disclosure tendency and working alliance would be positively related. Supplementary hypotheses included that greater shame (using a variety of measures) would be associated with greater psychological distress, and that greater retrospective working alliance ratings would be associated with higher secret-specific willingness to disclose to an imagined future therapist. Correlational analyses and multiple linear regression analyses were used to assess these hypotheses.

All participants completed an anonymous online questionnaire with two parts. In the first part, they responded to a battery of questionnaires which obtained demographic information and assessed domains of dispositional shame (three measures), psychological distress over the past two weeks, and generalised tendency to disclose distressing information. In the second part, participants were asked to imagine a specific secret and rate the intensity of shameful feelings associated with this, as well as the likelihood that they would disclose this secret to an imagined counsellor. Finally, participants who reported prior experience with psychotherapy were asked to retrospectively evaluate their working alliance with the professional they saw and provide some general information about their experience of therapy.

Contrary to the hypotheses, and to the findings of the pilot study, the results did not show any statistically significant correlations between shame measures and retrospectively rated working alliance. Those correlations that were evident were typically small and negative. Similarly, generalised disclosure tendency showed only a single statistically significant small positive correlation with one working alliance subscale (T, agreement on tasks) with the other correlations being of a similar direction and strength but non-significant. As such, the results partially supported the hypothesised relationships between shame and working alliance and

disclosure tendency and working alliance, with the predicted relationships being detected but the majority being non-significant.

Comparably, shame scores evinced small, negative correlations with generalised tendency to disclose, with only one of three shame measures (TOSCA-3) having a statistically significant result, contrary to the smaller relationship found in study 1. No such correlations were evident for the secret-specific disclosure tendency scores. As such, the hypothesis that shame would be related to disclosure tendencies was partially supported, but the results were predominantly not statistically significant.

The results demonstrated that the level of psychological distress in the sample was high, with mean DASS-21 results for depression and anxiety falling in the 'extremely severe' range and stress falling in the 'severe' range. Consistent with a variety of past studies (see *section 1.4, Shame* for a review), all four measures of shame (TOSCA-3, ESS, OAS, Shame Composite Score) showed small to moderate positive correlations with the three domains of psychological distress. The measures of shame were also positively intercorrelated to a moderate extent as expected, including the unvalidated secret-specific shame composite, suggesting that this was an appropriate assessment of shame. As predicted, positive ratings of past working alliance were also predictive of a greater likelihood of disclosing to future imagined therapists.

In attempting to understand these discrepant results, it was noted that the subsample of participants who had previously attended therapy ($n=104$) was not adequately powered to detect a small correlation, and it is reasonable to suppose that those small correlations which were evident may well have reached statistical significance with an appropriately powered sample. Unfortunately, despite making substantial efforts to recruit broadly, the sample attained fell short of this.

The most notable practical implication of this study was a reinforcement of the notion that any relationship detected between shame and alliance is likely to be small and negative.

Despite the discrepancy in statistically significant results between studies, the effect sizes and relationship directions were broadly consistent. As such, it must also be emphasised that adequate statistical power is required to detect a relationship of this type.

The results of these studies also provide an important reminder that retrospective evaluations may not be best suited for the assessment of therapy process variables, particularly when the frequency and time elapsed since treatment are not strictly controlled. The lack of consistency in number and recency of consultations may introduce additional variability in responding which makes it difficult to discern the true nature of working alliance's relationship with other variables. For example, it is likely that a retrospective reflection on 40 sessions of therapy which occurred two years ago will differ substantially from a retrospective reflection of one session in the past week. If retrospective ratings are to be used, future research should make efforts to ensure that the rating periods are as consistent as possible, unless these are the variables that are specifically being studied.

The results of this study nevertheless had several important clinical implications. Firstly, they support the increasing body of research which suggests that high degrees of dispositional shame are associated with greater psychopathology (Cândea & Szentágotai-Tătar, 2018; Kim et al., 2011), as well as supporting past research which indicates that psychological distress is high in university samples (Sharp & Theiler, 2018; Stallman, 2010). As such, clinicians would benefit both from anticipating a high level of psychological distress in university staff and students and paying attention to the relationship of dispositional shame with distress.

A further clinical implication was that more favourably rated past working alliance is related to a greater willingness to disclose specific secrets in future therapy. Although this is perhaps unsurprising, it serves as a reminder to clinicians of the importance of working alliance, both to facilitate successful therapy in the present and increase the likelihood of openness and engagement in future therapy.

5.2.4 Study 4 – Clinical Study

The clinical study was conducted with current psychotherapy clients (*N*=18, mean age 37.2) presenting for treatment at an outpatient psychology clinic. A total of six clinicians also participated in the study, delivering treatment for the client participants, with a mean 4.8 years of clinical experience and varied therapeutic orientations.

The major aim of the study was to extend the methodology of the pilot study into a contemporary clinical environment, assessing for the hypothesised relationship between dispositional shame and working alliance in this setting. It was also an objective to match study 3 in terms of including the potential mechanism of generalised tendency to disclose distressing information to assist in understanding the putative shame-alliance relationship. Finally, study 4 aimed to expand the methodology (and adhere to best practices) by obtaining working alliance ratings longitudinally over the course of treatment (2-10 treatment sessions), as well as from both clinician and client perspectives. An almost identical battery of measures to study 3 was used, with the omission of the TOSCA-3 (due to low predictive power and lower tolerability to participants in the pilot), the lack of secret-specific measures, and the addition of the clinician variant of the Working Alliance Inventory (WAI-SR-T) and Treatment Perceptions Questionnaire (TPQ).

As with the previous studies, it was hypothesised that dispositional shame (of all kinds) would be negatively related to both working alliance (clinician- and client-rated) and to willingness to disclose distressing information, and that the shame-alliance relationship would be mediated by willingness to disclose. It was also anticipated that the multi-perspective ratings of alliance would be positively correlated. Hierarchical Linear Modelling was used to assess the majority of these hypotheses, as a statistical method was required which could take into account nested data (clients within clinicians) as well as repeated observations. This was supplemented by non-parametric correlational analyses. Recruitment proved extremely difficult in the clinical environment, and the final sample was significantly underpowered.

Results were therefore considered to be preliminary in nature and to require more robust examination in future.

The results indicated no statistically significant associations between external shame and working alliance and a small positive association between a primarily internal measure (ESS) and working alliance, which did not support (and indeed contradicted) the hypothesis that greater dispositional shame would be predictive of lower-rated alliance. Similarly, no significant associations were evident between shame and generalised disclosure tendency, and as such the hypothesis that they would be negatively associated was not supported. By contrast, total client-rated working alliance scores across treatment, as well as agreement on goals and agreement on tasks subscale scores were moderately positively related to clinician ratings of these areas, as hypothesised.

The lack of statistically significant findings is likely to be attributable to the low power of the study to detect the hypothesised effects. Only limited commentary on the implications of these results was therefore possible, and it is important not to over-interpret these results. Nevertheless, the results of this study did not support a negative link between shame and alliance, and may indeed contradict it, suggesting a small increase in client-rated alliance when greater shame (as assessed by the ESS) is present at baseline.

Evidently, a clear practical implication from these data was again to underscore the importance of sample size in ensuring that hypotheses can be adequately tested. Significant effort was made to maximise the sample, including the extending the study several times and recruiting additional clinicians within the same clinic. It would perhaps be of benefit for future studies to collect data from multiple sites, or increase clinician numbers, to ensure a more robust sample. Earlier follow-up of clients may also be valuable, as population data suggest that average therapy attendance typically does not reach six sessions (Australian Institute of Health and Welfare, 2020). The choice to follow up participants at session 6 meant that there

was limited follow up data available, as the majority had disengaged from or completed treatment prior to this time.

The primary clinical implication that can be drawn from these data was broad support for the notion that clinician and client ratings of working alliance are typically correlated, but this correlation only reaches moderate strength. In terms of clinical research, this also supports the argument that studies should make every effort to include both provider and consumer assessments of working alliance in healthcare, as perspective differences are evidently still present (Shick Tryon et al., 2007).

5.3 Summary of Implications

There are a variety of theoretical and practical implications of these results. Theoretical implications will be described first, followed by practical implications and recommendations both for research and for treatment. The implications and recommendations discussed below represents a synthesis of all four studies, whereas individual implications and recommendations for each study are detailed in the relevant 'Discussion' sections above.

5.3.1 Theoretical implications

The primary implication of the combined results of the four studies reported in this thesis is that there appears to be a reliable, small, and negative relationship between dispositional shame and working alliance, such that greater levels of dispositional shame – both internal and external – are related to lower ratings of working alliance provided by healthcare consumers. Although this result emerged relatively consistently in the synthesis, it is important to note that some of the results either did not reach statistical significance or were contradictory – such as in study 4 - and as such this overall result must be interpreted with caution.

It is perhaps surprising to discover such a small relationship between shame and working alliance. Researchers have typically conceptualised shame as a highly interpersonal

emotion, which relates to social bonds and social status, serving as a sort of "warning system" for the threat of rejection by others, which has profound impacts on relationships (Cibich et al., 2016; Gilbert, 2007) and as such would be expected to be relevant in healthcare relationships. Furthermore, dispositional shame has typically shown at least moderately strong relationships with a variety of therapy-relevant measures, including those of symptom severity in anxiety and depression (Cândea & Szentágotai-Tătar, 2013, 2018; Kim et al., 2011). The results of study 3 were consistent with these previous findings, which showed higher average DASS scores on all subscales to be related to higher levels of dispositional shame (measured in four ways). If this can be interpreted to mean that shame is an important feature in psychological distress – and therefore in psychotherapy intended to address this – it is puzzling that it does not appear to feature more heavily in alliance.

The answer to this riddle may lie in the construct of working alliance itself. A variety of research has demonstrated that the effect of patient intake characteristics such as demographic details, disorder category, interpersonal problems and social behaviour show relatively small relationships with alliance (Flückiger et al., 2018; Hersoug, Høglend, Monsen, & Havik, 2001; Horvath et al., 2011; Johansson & Jansson, 2010). The same has been found to be true with regards to attachment style, with meta-analytic results by Bernecker, Levy, and Ellison (2014) suggesting a mean weighted correlation of r=-.12 for attachment anxiety and alliance and r=-.14 for attachment avoidance and alliance. Indeed, substantial past research has shown that therapist variables – such as warmth, friendliness, expertise, and patient-therapist ratio - may have a greater role in impacting the alliance than patient variables (Ackerman & Hilsenroth, 2003; Baldwin, Wampold, & Imel, 2007; Del Re, Flückiger, Horvath, Symonds, & Wampold, 2012). It is also reasonable to suppose that if clinicians show these positive characteristics, then the presumed negative effect of shame on alliance may be attenuated, which may also help to explain why shame is related with only a small effect in samples with competent and experienced therapists, such as those who participated in study 4.

With these results as context, it is perhaps less remarkable that the impact of dispositional shame should fall within this same range. It would appear to be the case that a very great variety of variables contribute in a variety of small ways to the development of alliance, and the results of this thesis suggest that shame may have a similarly small role to play. The results of the studies included in this thesis also do not support the notion that any one type of dispositional shame (e.g., internal versus external) has a stronger relationship with alliance than any other – although, based on study 1, external shame may be more highly related to patient-rated satisfaction with care. As such, the primary theoretical implication of these results is that dispositional shame represents another of the many factors which influence the development of working alliance.

A secondary finding of this thesis is the evident scarcity of past scholarship in this area – for example, the totality of quantitative inquiry into a putative shame-alliance link discovered by the scoping review numbered fewer than 20 studies over the past 100+ years. As such, the three quantitative studies described above represent early steps in assessing the role of shame in healthcare relationships in a quantitative way. Although the relationship appears to be small, this is nevertheless a worthwhile endeavour – as Lazare (1987) argued over 30 years ago, shame and humiliation are commonplace in healthcare encounters, and understanding the role they may play can only benefit both healthcare consumers and providers.

Finally, it is important to note that this research did not attempt to examine differences in shame between those individuals who sought help for health problems and those who did not. This was primarily due to the fact that the primary outcome variable of interest was working alliance, and evidently no alliance is present for individuals who have not sought help. Nevertheless, past research has typically conceptualised shame (as well as self-stigma) as a barrier to help-seeking, and shown it to predict less positive attitudes towards seeking help for a variety of mental health problems, such as eating disorders (Ali et al., 2017), post-natal depression (Dunford & Granger, 2017) and problem gambling (Evans & Delfabbro, 2005).

Similar results have been found in medical settings. For example, shame has been shown to act as a barrier to healthcare utilisation for HIV (D. S. Bennett, Traub, Mace, Juarascio, & O'Hayer, 2016; Raveis, Siegel, & Gorey, 1998) and sexual health problems (Gott & Hinchliff, 2003). As such, it could be argued that shame's relevance is greater *before* treatment (i.e., it may prevent an alliance ever developing through delaying or precluding treatment), and that once treatment has commenced, its impact on the alliance is somewhat less. Indeed, choosing to seek treatment in the first instance can be conceptualised as taking the first steps towards Bordin's (1979) agreement on the goals of treatment, insofar as it generally represents an acknowledgement that therapeutic intervention is needed.

5.3.2 Practical Implications and Recommendations

The primary implication of this research for healthcare professionals is that it may be of benefit to monitor or screen for high levels of dispositional shame in patients across a variety of settings. Although the impact on the working alliance is modest, high levels of shame are related to greater psychological distress. Dispositional shame in study 3 was also related to greater state shame felt about a specific secret, and as such is likely to give a reasonable indication of how painful it may be to reveal specific secret information for that person. Given the designation of healthcare consultations as shame-inducing events (Dolezal, 2015; Lazare, 1987), practitioners wishing to anticipate and manage the painful experience of shame would therefore be wise to take shame-proneness (or dispositional shame) into account. In addition to the option of using brief measures of shame as part of an intake battery, clinicians should also validate the difficulty of sharing potentially shameful information, acknowledge the associated distress, and exercise caution and compassion when discussing potentially shame-inducing topics (Gilbert, 1999, 2017; Gilbert & Miles, 2014; Safran & Muran, 1996). Although the evidence suggests that the impact of shame on the alliance may be small, it is probable that those high in shame may conceal shameful information for fear of this pain or may be less

satisfied with their care if the interaction is not managed thoughtfully, with respect to the distress that shame may bring.

In terms of implications for researchers, this research has taken the beginning steps of illuminating the potential role of shame in the development and maintenance of working alliance. Given that shame does appear to be relevant – albeit to a modest extent – it would be useful for researchers to include a brief measure of shame as a covariate in future alliance research. This would be valuable both to determine whether the results of this research can be replicated, and to assess whether they generalise to other populations not considered here. Short measures such as the ESS and OAS, or brief assessments of secret-specific shame, may help to provide additional detail and contribute to our understanding of the relationship between shame and working alliance.

Interestingly, the mean shame scores in this research were generally greater than those found in the validation studies for the various measures – for example, Goss et al. (1994) reported a mean OAS score of 20.00 (*SD*=10.10), whereas the mean OAS scores of studies 2 and 3's university-student participants were 31.24 (SD=15.52) and 29.08 (*SD*=15.70) respectively. Similarly, mean ESS scores (study 2 *M*=64.02, *SD*=18.19, study 3 *M*=63.62, *SD*=16.85) were somewhat higher than those found by Andrews et al. (2002), who reported an average ESS score of 55.58 (*SD*=13.95). This is particularly interesting given that the participants in both Goss et al. (1994) and Andrews et al. (2002) were also university students, albeit from the United Kingdom rather than Australia. Given this discrepancy, it would also be of interest for future research to attempt to ascertain what represents a "clinically significant" level of shame, and to consider comparisons between high-shame and low-shame groups on alliance and/or related variables, such as help-seeking and secret-keeping.

It is interesting to note that the high level of dispositional shame across the three empirical studies in this research was accompanied by a generally positive self-reported working alliance. These results offer an encouraging message – even those individuals with

very high dispositional shame appear to be able to form a strong therapeutic alliance, with only a minimal negative impact of the shame itself.

5.3.3 Limitations

The primary limitation of this research was the difficulty in obtaining adequately powered samples to detect an effect of the predicted size, which was apparent in both study 3 and study 4. In study 3, which applied the retrospective rating methodology of the pilot study to psychotherapy, the subset of individuals who had previously attended therapy was underpowered although the overall sample was appropriately powered. In study 4, which investigated shame and working alliance in a clinical setting, the sample was substantially underpowered. This is likely to have had a meaningful impact on the ability to detect statistically significant effects. It also calls into question the generalisability of findings – particularly in the case of the clinical sample which numbered fewer than 20 participants.

Obtaining adequate sample sizes is an important methodological component of psychological research. In the case of study 3, the online platform was made available for the maximum duration permitted by the ethical approval received and was matched to the length of an academic year (approx. 10 months), whereas the clinical study recruited participants for just over 24 months and was discontinued due to the concurrent expiry of ethical approval and the onset of the COVID-19 pandemic, which made extension impractical as the majority of in-person psychotherapy was suspended for public health reasons. Both studies also had relatively general inclusion criteria. Despite these efforts, the samples remained underpowered. As such, it would be useful for future research to consider either a) longer timeframes for recruitment where practical and/or b) multi-site research incorporating multiple clinics, universities, or other populations.

The majority of the research contained within this thesis was cross-sectional and relied upon retrospective ratings of working alliance. This methodology is atypical in alliance research, which generally obtains alliance ratings either immediately following or during a

course of treatment (Flückiger et al., 2018). Alliance ratings were also obtained only from patients/clients for studies 2 and 3. The decision to use single time-point, single-perspective and retrospective ratings was made for practical reasons, to increase the sample size (i.e., not limiting to individuals currently receiving treatment). This is an important limitation, as it reduced the ability of this research to comment on causal or temporal relationships and restricted the majority of discussion to correlations. Although it can reasonably be supposed that dispositional shame precedes working alliance, this cannot be assumed based on the data from studies 1-3.

Study 4 attempted to replace retrospective reporting with session-by-session alliance ratings. However, it was underpowered, as described above, and so the possible inferences are limited. Future research would benefit from replicating and expanding the methodology of this study – with bi-lateral, contemporaneous ratings of working alliance preceded by baseline dispositional measures – such that causal inferences can be made with greater confidence. Such research must also take care to address issues with sample size, such as by including multi-site collection or other similar approaches.

Finally, all four studies contained within this thesis had an evident bias towards English-speaking, literate, and help-seeking populations. The scoping review excluded material not published in English, and the eligibility criteria for studies 2-4 excluded those who were not fluent English speakers or who were unable to read and understand study materials. Furthermore, the majority of the research was conducted with participants who had either previously presented for treatment (with a general practitioner or mental health professional) or who were currently receiving psychological treatment. Taken together, these facts are problematic for several reasons. One of the most important is that shame is conceptualised very differently in different cultures – for example, Australian Aboriginal understandings of shame are reportedly broader and sometimes carry less negative weight than the definitions presented in this research (Harkins, 1990, 1994). Shame is also generally viewed as an

individual burden in Western cultures, whereas research suggests that it may have a more collective weight in some ethnic and cultural groups with backgrounds in non-Western cultures (Gilbert et al., 2007; Gilbert, Gilbert, & Sanghera, 2004). In addition, there is considerable evidence that healthcare utilisation is often significantly lower among ethnic minorities in predominantly English-speaking countries such as the United Kingdom, Australia, and the United States (De Anstiss, Ziaian, Procter, Warland, & Baghurst, 2009; Masuda et al., 2009; Waller et al., 2009; Youssef & Deane, 2006). Individuals from these communities may have entirely different perspectives on shame, as well as alliance sub-factors such as the goals and tasks of treatment, which are not captured in the present research. As such, it would be advantageous for future research to make greater attempts to capture the perspectives of a diverse range of language and cultural groups wherever possible.

5.3.4 Strengths

As evidenced by the paucity of studies located in study 1's scoping review, one strength of this research is its novelty. A relationship between the tendency to experience shame and working alliance is intuitively appealing and has been spoken about in general terms for many years (e.g., Lazare, 1987); however, to the researchers' knowledge this is the first research project to explicitly investigate this empirically. Research in understudied areas is valuable in increasing our understanding of these phenomena.

Given the preliminary nature of the investigations, this research also adopted an appropriately broad methodology. The literature was first comprehensively reviewed, then studied in two different healthcare settings, followed by an attempt to apply the findings to an in vivo clinical environment. Similarly, the battery of measures adopted for the entire panel of studies was comprehensive and broad, assessing a variety of putative shame domains (e.g., internal, external, context-dependent) and ultimately including both trait and state shame. Attempts were also made to include potential mechanisms (e.g., willingness to disclose) to provide additional information on the hypothesised relationship between shame and alliance.

This not only allowed for a nuanced understanding of shame's role, but it also increased the ability of future researchers to refer to these results regardless of the measure of shame that is chosen. As such, the informativeness and generalisability of these results was enhanced by this systematic methodology.

Finally, the studies reviewed in this thesis generally maintained a strong clinical focus, with a constant emphasis on delivering practical and useful information which would be of interest to practitioners. Although some of the outcomes were less informative than was hoped, this was nevertheless a strength of the research insofar as it was designed such that clinicians could derive maximum benefit and therefore pass this benefit on to healthcare consumers.

5.4 Future Research Directions

There are multiple avenues for future research which may help to better understand the role of shame in healthcare relationships. The most obvious of these would be to replicate the methodology of study 4 in a larger clinical sample, potentially including a multi-site trial, which is appropriately powered to detect a small effect. It would also be interesting to expand this approach to encompass healthcare disciplines other than psychology and general medical practice, such as other medical areas – of which some have already been the focus of alliance research (e.g., renal disease, diabetes, rheumatology, and HIV/AIDS) (Fuertes et al., 2015; Fuertes et al., 2017). Such research could also integrate other allied health areas (e.g., physiotherapy, occupational therapy). Although this increases the complexity of statistical analyses by introducing further nested factors, it would also provide a broader and richer understanding of these variables in healthcare.

Another potential avenue of research would be further investigation of mechanisms by which shame may be relevant in healthcare – both in terms of alliance and of help-seeking. The present research included disclosure tendencies as a hypothesised mechanism, but a variety of other variables could potentially be included. For example, avoidance behaviours

(Carvalho et al., 2015), outcome expectations (DeLong & Kahn, 2014), and level of resilience in the face of shaming experiences (Van Vliet, 2008) have all been implicated as relevant with regards to shame and could reasonably be supposed to have some relationship with the formation of an alliance. Studies including a variety of such potential mechanisms would be of interest in distinguishing shame's role in healthcare relationships and the extent to which it impacts the process of healthcare interventions.

Future researchers may also find it enlightening to conduct such research in specific areas where shame has previously been demonstrated to be highly relevant. These may include psychological disorders such as addiction (Wiechelt, 2007), Social Anxiety Disorder (Hedman, Ström, Stünkel, & Mörtberg, 2013), depressive disorders (Kim et al., 2011) and obsessive-compulsive and related disorders (Weingarden & Renshaw, 2015). Similarly, shame has been shown to be relevant with regards to specific physiological illnesses such as HIV (D. S. Bennett et al., 2016) and sexually-transmitted infections (Chollier & Geray, 2015), which may also be populations of interest. Notably, some of these sub-groups, such as individuals presenting for the treatment of drug and alcohol problems, have also been shown to have difficulties forming and maintaining a strong working alliance (Meier et al., 2005; Meier et al., 2006). It would be of interest to examine whether shame-alliance correlations are more distinct or relevant when these populations are compared with other presenting problems for which shame is potentially less relevant.

Finally, the present research made no effort to assess practitioner shame and its impact on the development of working alliance. Given the long-theorised relationship between shame and avoidance (H. B. Lewis, 1971) and the robust finding that therapist variables have a significant impact on the strength of alliance (Flückiger et al., 2018), it is reasonable to suppose that the dispositional shame of the clinician may be relevant. For example, it has previously been argued that conducting psychotherapy is frequently a venue for experiencing shame and embarrassment (e.g., through unintentionally exposing painful feelings, making errors, or

forgetting important details) and also that therapist shame influences the outcome of therapy and how it is conducted, such as by increasing therapist avoidance of difficult topics (Klinger, Ladany, & Kulp, 2012; Ladany et al., 1999; Ladany, Klinger, & Kulp, 2011). Thus, it would be useful to understand the unique contribution that practitioner shame may have to alliance.

5.5 Final Comments

This research represents the exploratory steps into understanding the relationship between dispositional shame (or shame-proneness) and working alliance in healthcare relationships. It has endeavoured to apply best research practices as much as possible, beginning with a comprehensive review of the literature, followed by a pilot study to establish an appropriate methodology for assessing the putative relationship, and two subsequent studies which endeavoured to identify and elaborate on this relationship in both a community and a clinical psychology setting. Taken together, the results of these studies are indicative of a reliable, small, and negative relationship between dispositional shame and working alliance, however the evidence remains modest and preliminary.

The results of this research help to understand the role that shame may have to play in the development and maintenance of a functional working alliance in healthcare. Furthermore, they also provide a foundation and best practice recommendations for future research to integrate and develop this concept. Although the predictive power of shame may be small, the results also serve as a reminder to clinicians that attending to shame in a clinical consultation, and responding appropriately, is likely to be beneficial for the promotion of a strong and lasting alliance.

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APPENDIX A. COPIES OF APPROVALS FOR STUDY 2

Dr Michael Proeve
School of Psychology
University of Adelaide

School of Psychology
University of Adelaide
Adelaide SA 5005
Ph. 61 8 8313 5693

Dear Michael

Re: School of Psychology: Human Research Ethics Subcommittee Approval – Application 16/81 received 16th September 2016

Title: Retrospective working alliance with general practitioners in general health. Student: Daniel Carabellese

Thank you for your application, which was submitted to the full HREC but marked for low-risk review. Accordingly it was forwarded by the HREC to the School of Psychology Human Research Ethics Subcommittee for review.

I am writing to confirm that approval has been granted, subject to the following:

(1) The NHMRC guidelines (2.1) indicate that to be considered low-risk, a study must be considered likely to, in the worst instance, cause emotional discomfort but not distress. I understand that you consider the study to be low-risk. **Accordingly the Participant Information Sheet (PIS) needs to be amended to refer to potential discomfort (rather than distress) resulting from the study.** If on the other hand you did consider distress to be a potential risk of the study, you would re-submit your application to the HREC and mark it for full review.

(2) Please re-word the PIS to make it even more clear that Dr Proeve is available as a potential first contact to all participants, whether or not they have scored high on the distress questionnaires. For example, the word 'Otherwise' could be replaced with a more informative phrase, and a new paragraph could commence with that sentence.

(3) Dr Matthew Smout is mentioned in the PIS but not in the application. Please either remove his details from the PIS, or submit an amendment to the approved protocol, by adding his details and signature to the application.

Approval is granted for 12 months from the date specified below.
Yours sincerely, Linley Denson

Dr Linley Denson. Acting Chair & Deputy Convenor
School of Psychology Human Research Ethics Subcommittee.
Phone: (08) 8313 5693 Email: linley.denson@adelaide.edu.au
Date: 19th September 2016

APPENDIX B. COPIES OF APPROVALS FOR STUDY 3

School of Psychology
University of Adelaide
North Terrace, Adelaide SA 5005
Ph. 61 8 8313 5693
Fax 61 8 8313 3770

School of Psychology: Human Research Ethics Subcommittee
Approval Sheet

Dear MICHAEL

The members of the subcommittee have considered your application:

Code Number: 19/50

Title:

SHAME AND DISCLOSURE OF DISTRESS

With [Student name, if applicable] DANIEL CABALLERO

I am writing to confirm that approval has been granted for this project to proceed. Approval is granted to 12 months from the date specified below.

Yours sincerely,

[signature]

Deputy Convenor, Human Research Ethics Subcommittee

Name: PAUL DELFABBRO

Date: 8/5/19

Phone Number: 8313 4936

Email: paul.delfabbro@adelaide.edu.au

APPENDIX C. COPIES OF APPROVALS FOR STUDY 4

RESEARCH SERVICES
OFFICE OF RESEARCH ETHICS, COMPLIANCE AND INTEGRITY
THE UNIVERSITY OF ADELAIDE

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CRICOS Provider Number 00123M

Our reference 32267

21 February 2018

Dr Michael Proeve
Psychology

Dear Dr Proeve

ETHICS APPROVAL No: H-2018-032
PROJECT TITLE: Relationships between the client and the psychologist

The ethics application for the above project has been reviewed by the Human Research Ethics Committee and is deemed to meet the requirements of the *National Statement on Ethical Conduct in Human Research (2007)*.

You are authorised to commence your research on: 21/02/2018
The ethics expiry date for this project is: 28/02/2021

NAMED INVESTIGATORS:

Chief Investigator:	Dr Michael Proeve
Student - Postgraduate Doctorate by Research (PhD):	Mr Daniel James Carabellese
Associate Investigator:	Associate Professor Rachel Roberts

CONDITIONS OF APPROVAL: Thank you for the response dated 19 February 2018 to the matters raised.

Ethics approval is granted for three years and is subject to satisfactory annual reporting. The form titled Annual Report on Project Status is to be used when reporting annual progress and project completion and can be downloaded at http://www.adelaide.edu.au/research-services/oreci/human/reporting/. Prior to expiry, ethics approval may be extended for a further period.

Participants in the study are to be given a copy of the information sheet and the signed consent form to retain. It is also a condition of approval that you immediately report anything which might warrant review of ethical approval including:

- serious or unexpected adverse effects on participants,
- previously unforeseen events which might affect continued ethical acceptability of the project,
- proposed changes to the protocol or project investigators; and
- the project is discontinued before the expected date of completion.

Yours sincerely,

Professor Paul Delfabbro
Convenor

The University of Adelaide

Ref: Time Extension for Covid19 impact

This is a computer generated email, please do not reply directly

Project No. H-2018-032

Project Title: Relationships between the client and the psychologist Chief Investigator: Proeve, Michael

Dear Investigator

This project has been given an automatic 12 month time extension by the ethics committee to reduce the burden associated with the impact of Covid19.

Please note the new ethics approval expiry date is 28/02/2022.

Yours sincerely,

Office of Research Ethics, Compliance and Integrity Research Services, The University of Adelaide Level 4, Rundle Mall Plaza, 50 Rundle Mall SA 5005 https://www.adelaide.edu.au/research-services/ethics-compliance-integrity/

CRICOS Provider Number 00123M

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APPENDIX D. REVIEWER AMENDMENTS NOT IMPLEMENTED AND RATIONALE

1. *"thesis is concerned exclusively with the understanding of the term 'shame' as it has been used in the Western empirical tradition". I believe the experience of reflected shame, even though being influenced by cultural norms, is as relevant in the Western tradition as in other cultural backgrounds and should have been integrated in an integrative shame model"*

The material on reflected shame has been removed, as this was considered outside the scope of the thesis. The material relating to Australian Aboriginal conceptualisations of shame has been maintained as this was considered pertinent, particularly in a thesis prepared in Australia.

The integrative shame model has been elaborated on in **Section 1.4.1.2** in recognition of this critique.

2. *"In the Discussion you make an interesting point about congruence of therapist-client ratings of alliance as being a significant issue. This point might be unpacked further so that the argument is stronger."*

After some discussion, it was determined that the data reviewed in the Scoping Review do not provide sufficient grounds to comment on this in any meaningful way that would not be speculative. It was decided to omit any further consideration of this on that basis.

3. *"Also in the Discussion I would want to see more depth of consideration particularly of the distinction between conceptualising and investigating alliance in psychotherapeutic vs. non-psychotherapeutic contexts e.g. differences in the*

use of the relationship to achieve change/wellness, the different length and intensity of the relationship, and the different nature of the disclosures involved."

Given the paucity of studies located by the scoping review and the lack of variety in settings, this was also considered outside the scope and impossible to comment on in a meaningful way that was not purely speculative, thus further elaboration on this point was omitted.

4. *"In the Discussion you devote a lot of space to the different versions of the WAI. Whilst this is important, as a reader I would want more critical consideration of measures used other than the WAI as it is this variability that will be adding significant 'noise' to the understanding of the relationship between shame and alliance plus questioning the operationalisation of these constructs."*

A detailed comparison of different measures was considered outside the scope of the review, and was judged to be more appropriate to a systematic, rather than a broad scoping review. Nevertheless, the following brief paragraph was added in section 2.3.6:

Despite this, it is interesting to note that those studies which used non-WAI instruments to assess working alliance-like constructs (Hamann et al., 2017; Jaakkola et al., 2014; Mensinger et al., 2018) showed correlations with shame of a similar strength and direction with shame measures where these were reported (excepting Mensinger et al., 2018, where the negatively-worded measure of "Healthcare Stress" was positively correlated with shame to a similar extent, as would be expected from the other findings). As such, it would appear that working alliance and its proxies maintain this small, negative relationship with shame regardless of the measure used.

5. *"I think an opportunity was missed to consider cross-cultural issues. This is set up in the Introduction but appears only in brief and towards the end of the paper which can have the effect of it seeming less important."*

After review, this was also considered to be outside the scope of this broad review article. Furthermore, there was considered to be insufficient variability in the countries of included studies to make any meaningful comparison at this time.

6. *"If aiming to disseminate, I would unpick the findings around congruence of client and clinician ratings of bond further (page 143). You note the null finding might be due to sample size and yet the tasks and goals correlations were significant. Is there some explanation here about congruence being more modest for bond than the other dimensions given that it is less tangible than goals and tasks?"*

This is an interesting suggestion, however after some discussion, it was decided not to elaborate further on this, both because there was no specific intention to disseminate and also because the result was not considered sufficiently meaningful to warrant speculation.

7. *"Methods: In the Methods section, on p.113 it is stated that "age, level of education, and ethnic or cultural background" were assessed. However, I could not find the data regarding ethnic or cultural background presented, and it would be important to do so to have a clear picture of the characteristics of this particular sample."*

These data could not be included for reasons elaborated below. A paragraph was added in **Section 4.3.2.2** which reports:

Although participants were asked about their ethnic or cultural background, the data collected by the write-in box provided was unfortunately uninterpretable, and therefore was not included. Table 1 presents demographic information for these participants.

8. *"In the presentation of the regression analysis results, it would be relevant to report the data on the percentage of variance of the outcome variable predicted by each of the significant models."*

The relevant output provided by the AHMS statisticians does not allow for calculation of outcome variance predictions. It was considered sufficient to include the odds ratio outputs that were generated, rather than re-analysing the data to derive these scores.

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